STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675440	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Dallas Nursing & Rehabilitation	3808 S Central Expwy Dallas, TX 75215

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review the facility failed to ensure each resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for one (Resident #1) of seven residents reviewed for self-determination. The facility failed to promote Resident #1's self-determination by not honoring his choice to receive medications at a later time on 1/24/2025. This failure could place residents at risk for poor self-esteem and decreased self-worth due to their needs and preferences not being met. Findings included: Record review of Resident #1's MDS (type indicated option selected was none of the above) dated 1/23/2025 revealed Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. No BIMS score was listed on the assessment to indicate if the resident had any cognitive impairment. Record review of Resident #1's face sheet dated 1/28/2025 revealed Resident #1 had diagnoses of sepsis (infection that has spread to multiple organs), polyneuropathy (multiple nerves are damaged), muscle spasm, and paraplegia (weakness of both legs or arms). Record review of Resident #1's care plan with a revision date of 1/24/2025 revealed Resident #1 was resistive to care, and interventions included allowing the resident to make decisions about treatment regime. Record review of Resident #1's physician order with a revision date of 1/27/2025 for trazodone 25 mg revealed the physician ordered trazodone 25mg one tablet by mouth at bedtime for insomnia (difficulty sleeping). Record review of Resident #1's January 2025 MAR revealed trazodone was scheduled for 9:00 p.m. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/28/2025 at 3:11 p.m., Resident #1 stated that a nurse tried to give him his other medications (not pain medications) on 1/24/2025 around 8:00 p.m., and he refused because he did not want them that early. Resident #1 stated he told them to bring his medications later, and they did not. Resident #1 stated it made him upset, and he cursed at the staff. Resident #1 stated the staff did not need to bring his medications that early because he was not ready to go to bed. Record review of Resident #1's progress note dated 1/24/2025 at 9:41 p.m., LVN A documented Resident #1 refused to take his medication because the hospital always brought them at 10:00 p.m. LVN A documented that the MA would not be there at 10:00 p.m., and she told Resident #1 that she would bring the medications at 9:00 p.m. In an interview on 1/28/2025 at 5:00 p.m., LVN A stated a MA attempted to give Resident #1 his medications on 1/24/2025, but Resident #1 refused. LVN A reported she then spoke with Resident #1, and he told her to bring his medications later. LVN A stated she did not go back to Resident #1's room to give his medications because he was angry. LVN A stated the medication was trazodone, and there was no risk to the resident for missing one dose. In an interview on 1/28/2025 at 3:28 p.m., the DON reported she was responsible for monitoring and ensuring medications were administered as ordered. The DON stated she checked the MARs once a week to ensure they were completed, and medications were administered. The DON stated the risks to the residents if medications were not received timely could be uncontrolled blood pressure or behaviors. The DON did not state the risk to the residents if they were unable to use their own self-determination in their care. Review of facility policy titled Resident Rights, with a revision date of December 2016, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . e. self-determination.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for one (Resident #3) of 66 residents reviewed for assistive devices. A portable heater was found in use in Resident #3's room without direct supervision. This failure could place residents at risk for accidents or injuries. Findings include: Record review of Resident #3's Face sheet dated 01/28/2025 revealed that Resident #3 was a [AGE] year-old male that was initially admitted to the facility on [DATE] with diagnosis that included Diabetes Mellitus, Age-Related Cognitive Decline and Partial traumatic Amputation of left foot at Ankle Level. Record Review of Resident #3's Quarterly MDS Assessment and Care Screening dated 11/07/2024 revealed that Resident #3 had a BIMS score of 12 which indicated moderate cognitive impairment. The resident required the use of a wheelchair and required supervision or touching assistance for all transfers and personal hygiene. Record review of Resident #'3 Care Plan, dated 11/13/2024 revealed that Resident #3 has an Activity of Daily Living self-care deficit related to osteomyelitis [infection of the bone] of left foot post-surgical intervention, impaired cognition and makes poor decisions. In an observation and interview on 01/28/2025 at 11:24 AM revealed Resident #3 was observed in his room, seated comfortably in a wheelchair. A portable heater was noted to be operating behind the resident within 2 feet of the resident's bed and privacy curtain. The resident stated that the facility had given him the portable heater to use because his in-wall unit was not working for the last two days. He stated that the air conditioning part of the in-wall unit worked fine but that the heat was not working. He stated that he liked it warm in his room. In a set of observations from 01/28/2025 at 11:42 AM to 01/28/2025 to 11:42 AM revealed all other resident rooms were checked for portable heaters. No other portable heaters were found. In an observation and interview on 01/28/2025 at 1:45 PM revealed the Maintenance Supervisor was observed removing the wall air conditioning/heater unit from Resident #3's room. The portable heater was no longer present in Resident #3's room. The Maintenance Supervisor stated that he had taken the portable heater out of Resident #3's room and he was in the process of replacing Resident #3's in-wall air conditioner/heater unit. He stated that Resident # 3 had been using the portable heater for the last 2 days and that the heater had an automatic turn-off switch if the portable heater fell over or was tipped. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/28/2025 at 2:09 PM LVN A stated that she was not aware of anyone doing fire watches in the facility. She stated that fire watches meant that the staff had to check the entire facility every 15 minutes to make sure there were no fires in case the fire alarm system stopped or a power outage. In an interview on 01/28/2025 at 2:29 PM LVN B stated that she had not heard anything about the facility having to do any fire watches or that Resident #3 had a portable heater in his room. She stated that she had been working for the last three days and that she had been unaware of any portable heaters in the building. She stated that she had thought portable heaters were not allowed in nursing facilities. In an interview on 01/28/2025 at 3:30 PM the ADM stated that a portable heater could pose a fire risk to residents if a blanket, curtain or pillow got too close to it for a period of time. He stated that he had not done any fire watches while the portable heater was in use in Resident #3's room, and that the portable heater had been in use for the last two days. In an interview on 01/28/2025 at 3:34 PM Maintenance Supervisor stated that portable heaters could cause fires if left unmonitored because something flammable could get next to a heater and possibly start a fire. He stated that he had replaced the in-wall unit in Resident #3's room and had meant too the day before but had not been able to get to it. He stated that he had replaced it a few hours ago and that there were no other portable heaters in use in the facility. A policy for Portable Heaters in Nursing facilities was requested on 01/28/2025 at 3:17 PM but was not presented before the conclusion of the investigation.

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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** 50222 Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for two residents (Resident #1 and Resident #2) of four residents reviewed for pharmaceutical services in that: 1. The facility failed to administer pain medications to Resident #1 as ordered upon admission after the resident requested pain medication on 1/23/2025. The facility also failed to return and administer Trazodone to Resident #1 as ordered on 1/24/2025. 2. The facility failed to acquire, administer, and accurately document two scheduled doses of gabapentin on 1/24/25 to Resident #1 as ordered. 3. The facility failed to acquire and administer intravenous antibiotic medications to Resident #2 as ordered upon admission for the dose scheduled on 1/9/25. 4. The facility failed to obtain a pharmacy delivery receipt for Resident #2's medications per facility policy. 5. The facility failed to administer and accurately document medications for Resident #2 on the facility MAR for January 2025. These failures could place residents at risk of not receiving medications as ordered by their physician, inadequate disease management, and uncontrolled pain. Findings included: 1. Record review of Resident #1's MDS (type indicated option selected was none of the above) dated 1/23/2025 revealed Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. No BIMS score was listed on the assessment to indicate if the resident had any cognitive impairment. Record review of Resident #1's face sheet dated 1/28/2025 revealed Resident #1 had diagnoses of sepsis (infection that has spread to multiple organs), polyneuropathy (multiple nerves are damaged), muscle spasm, and paraplegia (weakness of both legs or arms). Record review of Resident #1's care plan with a revision date of 1/24/2025 revealed Resident #1 was resistive to care, and interventions included allowing the resident to make decisions about treatment regime. Record review of Resident #1's physician order with a revision date of 1/23/2025 for oxycodone 10mg revealed the physician ordered oxycodone 10mg one tablet by mouth every four hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's physician order with a revision date of 1/27/2025 for trazodone 25 mg revealed the physician ordered trazodone 25mg one tablet by mouth at bedtime for insomnia (difficulty sleeping). In an interview on 1/28/2025 at 10:18 a.m., Resident #1 reported he did not receive any medications until 24 hours after he had arrived at the facility. Resident #1 stated he requested pain medication from the nurse around 9:30 p.m. on 1/23/2025, and the nurse told him they did not have any narcotics available. Resident #1 stated he needed his pain medication because he had pressure sores and was unable to sleep without them. Resident #1 stated the facility had obtained all of his medications and currently were giving them to him like they were supposed to. Record review of Resident #1's progress note dated 1/23/2025 at 11:30 p.m., revealed LVN A documented Resident #1 arrived at the facility at 9:00 p.m., and stated he needed a pain pill before he could be assessed. Record review of the pharmacy manifest dated 1/24/2025 revealed gabapentin, methocarbamol, trazodone, and oxycodone for Resident #1 was not delivered until 1/24/2025 at 10:37 p.m. In an interview on 1/28/2025 at 2:01 p.m., the DON reported medications were automatically ordered from the pharmacy when the medication orders were entered into their electronic medical records system. The DON reported that orders were entered as soon as a resident was admitted and was physically in the building. The DON reported the pharmacy delivered medications twice a day at 10:00 a.m. and 10:00 p.m. In an interview on 1/28/2025 at 3:06 p.m., LVN A stated Resident #1 was admitted to the facility late on 1/23/2025 and requested specifically oxycodone. LVN A reported the medication was not available in the emergency medication kit, so she asked Resident #1 if he would take a different pain medication. LVN A reported Resident #1 declined the other pain medications and refused to allow her to assess him. LVN A stated Resident #1 did not state a pain level and cursed at her when she told him she did not have his specific pain medication available. LVN A stated she contacted the pharmacy but did not contact the DON or doctor, and the pharmacy told her they would send the medication that night. LVN A stated she documented the incident in the progress notes. LVN A reported when medications were needed prior to being delivered by the pharmacy then some medications could be found in the emergency medication kit but not oxycodone. LVN A also stated if the facility was unable to obtain scheduled medications, then the doctor should be notified, and it should be documented on the MAR. LVN A stated the risks to the residents if they did not receive their medications as ordered varied depending on the medication. LVN A did not state any further risks. In an interview on 1/28/2025 at 2:01 p.m., the DON stated they did not have oxycodone in the emergency medication kit, but there was Tylenol #3 or tramadol in the emergency medication kit that could be offered. The DON stated if a new admission required a narcotic then the hospital would have to send a prescription or the resident would have to wait until the medication was delivered by their pharmacy. The DON stated she had requested stronger pain medications from the pharmacy and their nurse consultant for the emergency medication kit but was told the facility would need a hardwired internet connection which they did not have at this time. The DON stated a hardwired internet connection was needed for narcotics to be stored in the emergency medication kit but did not explain why. The DON stated the resident could be at risk for pain if pain medications were not available, but that they had other pain medicine that could be used until the resident's medications were delivered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/28/2025 at 3:11 p.m., Resident #1 stated the nurse offered him tramadol but that was pointless because it did not work. Resident #1 stated he went out on pass the next day (1/24/2025) and did not discuss his pain medication with anyone else until that night. Resident #1 stated they brought his pain medication just after midnight on 1/25/2025. Resident #1 stated that a nurse tried to give him his other medications (not pain medications) on 1/24/2025 around 8:00 p.m., and he refused because he did not want them that early. Resident #1 stated he told them to bring his medications later, and they did not. Record review of Resident #1's January 2025 MAR revealed trazodone was scheduled for 9:00 p.m. Record review of Resident #1's progress note dated 1/24/2025 at 9:41 p.m., LVN A documented Resident #1 refused to take his medication because the hospital always brought them at 10:00 p.m. LVN A documented that the MA would not be there at 10:00 p.m., and she told Resident #1 that she would bring the medications at 9:00 p.m. In an interview on 1/28/2025 at 5:00 p.m., LVN A stated a MA attempted to give Resident #1 his medications on 1/24/2025, but Resident #1 refused. LVN A reported she spoke with Resident #1, and he told her to bring his medications later. LVN A stated she did not go back to Resident #1's room because he was angry, and she did not administer his medications. LVN A did not state if she reported the incident to anyone. LVN A stated the medication was trazodone, and there was no risk to the resident for missing a dose. Record review of Resident #1's MAR dated 1/28/2025 revealed gabapentin (medication to treat nerve pain) was marked as refused on 1/24/2025 at 8:00 a.m. and 2:00 p.m. Record review of the undated inventory list for the emergency medication kit revealed gabapentin was not a medication provided in the emergency medication kit. 2. Record review of Resident #2's admission MDS dated [DATE] revealed Resident #2 was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses of multidrug-resistant organism (bacteria resistant to several antibiotics), septicemia (infection in blood), and diabetes. Section O revealed Resident #2 was receiving intravenous antibiotics, and the BIMS assessment revealed a score of 15 (indicating no cognitive impairment). Record review of Resident #2's baseline care plan with a signed date of 1/09/2025 revealed Resident #2 was receiving intravenous medications and antibiotics. Record review of Resident #2's orders on 1/28/2025 revealed orders for the following medications: Daptomycin (intravenous antibiotic) use 800mg intravenously one time a day ferrous sulfate (iron) give one 325mg tablet by mouth in the morning fluconazole (antifungal) give four 200mg tablets by mouth one time a day furosemide (treats heart failure) 20mg give 0.5 tablet by mouth in the morning Jardiance (treats diabetes) give one 10mg tablet by mouth in the morning (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	carvedilol (treats blood pressure) give one 6.25 mg tablet by mouth two times a day gabapentin (treats nerve pain) give one 300mg capsule by mouth two times a day llacosamide (anticonvulsant) give one 150 mg tablet by mouth two times a day pantoprazole (treats indigestion) give one 40mg DR tablet by mouth two times a day miralax (treats constipation) give one scoop by mouth in the morning for constipation sennosides (treats constipation) give two 8.6mg tablets by mouth two times a day for constipation methocarbamol (treats muscle spasms) give one 500mg tablet by mouth three times a day atorvastatin (treats high cholesterol) give one 40mg tablet by mouth at bedtime. Record review of Resident #2's progress note dated 1/06/2025 at 10:41 p.m., LVN A documented Resident #2 was admitted to the facility with a left foot wound infection and had an order to continue daptomycin (intravenous antibiotic). Record review of Resident #2's progress note dated 1/07/2025 at 12:36 p.m., LVN B documented Resident #2 was on daptomycin (intravenous antibiotic). Record review of Resident #2's progress note dated 1/08/2025 at 2:22 p.m., LVN B documented Resident #2 continued to take intravenous antibiotics. Record review of Resident #2's MAR dated 1/28/2025 revealed blanks on the MAR for the following medications on 1/07/2025: Daptomycin (intravenous antibiotic), ferrous sulfate (iron), fluconazole (antifungal), furosemide (treats heart failure), Jardiance (treats diabetes), carvedilol (treats blood pressure), gabapentin (treats nerve pain), lacosamide (anticonvulsant), pantoprazole (treats indigestion), miralax (treats constipation), sennosides (treats constipation), methocarbamol (treats muscle spasms). The MAR also revealed blanks on the MAR for the following medications on 1/08/2025: Atorvastatin (treats high cholesterol), pantoprazole, miralax (treats constipation), sennosides (treats constipation), methocarbamol (treats muscle spasms), and lacosamide (anticonvulsant). The MAR also revealed daptomycin was scheduled every day at 12:00 p.m. from 1/07/2025 until 1/10/2025, but only one dose of the daptomycin (intravenous antibiotic) was documented as administered and that was on 1/08/2025. In an interview on 1/28/2025 at 9:31 a.m., a family member for Resident #2 reported the facility did not give Resident #2 any medications for a day and a half after he was admitted on [DATE] and did not provide his intravenous antibiotics as ordered. The family member reported it took two days to get the antibiotics, and the facility ran out before they were completed. The family member reported the facility told her the antibiotic was too expensive, so they could not order the required amount. The family member stated Resident #2 chose to go to the hospital in order to get his intravenous antibiotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/28/2025 at 1:24 p.m., LVN B stated she administered Resident #2's daptomycin (intravenous antibiotics) every day as ordered except on 1/09/2025. LVN B stated she documented administering the medication on the MAR. LVN B stated the pharmacy was unable to deliver the medication due to the weather, so she notified the doctor. LVN B stated the doctor told her to extend the number of days the medication was supposed to be given. LVN B stated she documented in the progress notes that the physician was notified. LVN B stated there was no harm in missing one dose of intravenous antibiotics. Record review of Resident #2's progress note dated 1/09/2025 at 11:33 a.m., LVN B documented daptomycin had not been delivered, and the pharmacy stated the medication was delayed due to the weather. LVN B documented the pharmacy reported the medication would be delivered the next business day. LVN B documented that she contacted the doctor and received orders to administer the dose as soon as it was delivered and to extend the stop date by one day. In an interview on 1/28/2025 at 2:01 p.m., the DON stated if there was a blank on the MAR then the medication must have been missed. The DON reported the pharmacy delivered medications twice a day, and it could take up to 12 hours to get medications after a resident was admitted because they did not order medications until after the resident was admitted to the facility. The DON stated medications were automatically ordered from the pharmacy when the orders were entered into their electronic monitoring system which would be done when the resident admitted to the facility. In an interview and observation on 1/28/2025 at 3:28 p.m., the DON reviewed the pharmacy receipt binder but was unable to find any records for Resident #2's daptomycin being delivered. The DON stated there was a record because it reflected there were five more doses delivered, but they were not received by the facility. The DON stated Resident #2 received two doses of daptomycin, but the pharmacy was unable to deliver the additional five doses because of the weather. The DON stated they initially only ordered two doses because the medication was very expensive and required authorization from their corporate team. The DON stated Resident #2 chose to discharge to a hospital instead of waiting for the antibiotics to be delivered later that day. The DON reported she was responsible for monitoring and ensuring medications were administered as ordered. The DON stated she checked the MARs once a week to ensure they were completed, and medications were administered. The DON stated her expectation was for the MARs to be accurate and for medications to be delivered within 24 hours for a new admission. The DON stated the risks to the residents if medications were not received timely could be uncontrolled blood pressure or behaviors. The DON reported the risks to the residents if their MARs were not completed was that medications could appear to not be given and another nurse could administer the medication again causing the resident to be overmedicated. The DON stated there was no risk to the residents if pharmacy receipts were not kept because the records could be obtained from the pharmacy. The DON stated she would request the pharmacy's delivery manifest and provide it. Record review of the pharmacy manifest dated 1/07/2025 revealed two doses of daptomycin were delivered at 11:29 a.m. on 1/07/2025. Record review of the pharmacy manifest dated 1/9/2025 revealed five doses of daptomycin were delivered at 1:39 a.m. on 1/9/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/28/2025 at 5:12 p.m., NP C reported if oxycodone was unavailable then tramadol could be given to assist with pain control until oxycodone was received. NP C stated it was not ideal for oxycodone to be missed for more than 24 hours, but it depended on the pharmacy. NP C stated she expected the facility to get the medicine as soon as possible and notify the doctor or NP if they were unable to obtain the medications. NP C stated the facility was at the mercy of the pharmacy to deliver the medications and did not give a time frame that she expected new admissions to have medications within. NP C stated the nurses could call and obtain an order to hold a medication until it came in. NP C stated there was not usually any harm to a resident if they missed medications for one day or missed one dose of intravenous antibiotics. NP C did not state if she was notified that anyone had missed any medications. Review of facility policy titled Administering Medications, with a revision date of December 2012, revealed Medications shall be administered in a safe and timely manner, and as prescribed. The policy also revealed Medications must be administered in accordance with the orders, including any required time frame, and medications must be administered within one (1) hour of their prescribed time. Review of facility policy titled Pharmacy Services Overview, with a revision date of April 2007, revealed The facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals. The policy also revealed The facility shall contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs . help the facility to assure that medications are requested, received, and administered in a timely manner as ordered by authorized prescribers. Review of facility policy titled Charting Errors and/or Omissions, with a revision date of December 2006, revealed Accurate medical records shall be maintained by this facility. Review of facility policy titled Charting and Documentation, with a revision date of July 2017, revealed The following information is to be documented in the resident medical record: . b. Medications administered, and documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of facility policy titled Accepting Delivery of Medications, with a revision date of April 2007, revealed A nurse shall sign the delivery ticket, indicating review and acceptance of the delivery, and shall keep a copy of the delivery ticket, and the delivery ticket shall be archived in a designated location. Review of facility policy titled Medication Orders and Receipt Record, with a revision date of April 2007, revealed The facility shall document all medications that it orders and receives, and the facility shall retain medication order/receipt records for at least one year or as otherwise required. Review of facility policy titled Pharmacy Services - Role of the Provider Pharmacy, with a revision date of April 2010, revealed The provider pharmacy shall agree to provide services that comply with applicable facility policies and procedures; accepted professional stands of practice, and laws and regulations, including . provide routine pharmacy service seven days a week . deliver medications to the facility, and help ensure that all deliveries are correct and proper documentation related to delivery is provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675440	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Dallas Nursing & Rehabilitation	3808 S Central Expwy Dallas, TX 75215

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Pharmacy Services - Role of the Infusion Therapy Provider, with a revision date of April 2007, revealed the facility shall ensure that infusion therapy services are available, if it accepts and/or manages individuals who require infusion therapy products.