

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility failed to ensure 3 (Resident#1, Resident#2 and Resident#3) of 4 residents care plans included services provided to the residents The facility failed to provide Resident#1,2, and 3, with care plans that reflected the intervention of a wander guard for residents. This failure could affect how to meet the resident's needs.Findings included: Record review of Resident#1's face sheet, dated 10/09/25 reflected, she was a [AGE] year-old female who was originally admitted on [DATE] and diagnosed with unspecified Dementia (decline in cognitive function that cannot be definitively attributed to a specific type of dementia), psychotic disturbance (a mental health condition characterized by a significant loss of contact with reality), mood disturbance (a persistent change in a person's emotional state, going beyond typical ups and downs to affect their ability to function) and anxiety (common mental health condition characterized by excessive worry, fear, and nervousness), hypertension (a condition where the force of blood against the artery walls is consistently too high), Hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development), Edema (a condition where excess fluid accumulates in the body's tissues, causing swelling), Psychotic disorder with hallucinations due to physiological condition (a mental health condition where psychotic symptoms like hallucinations and delusions are a direct result of a medical illness) and Psychotic disorder with delusions due to known physiological condition (diagnosis characterized by the presence of delusions (false beliefs) that are directly caused by an underlying medical condition). Record review of Resident #1's MDS, dated [DATE] reflected her BIMS score was 06 which indicated serve cognitive impairment. Record review of Resident#1 MDS reflected Resident #1 did not exhibit wandering behavior at the time the MDS was completed. Record review of Resident#1 care plan, dated 10/09/25 reflected, no documentation of Resident#1 having a wander guard. Record review of Resident#1's progress notes dated 08/13/25 reflected Resident#1 actively exit seeking, not easily redirected. Record review of Resident#1 order summary, dated 10/09/25 reflected: Ensure Resident#1 wander guard was present on her left leg. Every 10 hours for wandering. Order started on 08/20/25 and was ongoing. Record review of Resident #2's face sheet, dated 10/09/25 reflected, he was a [AGE] year-old male who was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with unspecified Dementia (decline in cognitive function that cannot be definitively attributed to a specific type of dementia), psychotic disturbance (a mental health condition characterized by a significant loss of contact with reality), mood disturbance (a persistent change in a person's emotional state, going beyond typical ups and downs to affect their ability to function) and anxiety (common mental health condition characterized by excessive worry, fear, and nervousness), sequelae of cerebral infraction (paralysis, aphasia, and cognitive impairment), neuroleptic induced Parkinsonism (a temporary movement disorder that can occur as a side effect of taking certain medications called neuroleptics, also known as antipsychotics), chronic kidney disease stage 4 (severe kidney damage, where the kidneys are functioning at 15-29% of their normal capacity), hypertension, anemia, cognitive communication deficit, difficulty in walking and Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder) Record review of Resident#2's MDS, dated [DATE] reflected his BIMS score was 03 which indicated serve cognitive impairment. Resident#2 had a presence and frequency of wandering daily. Record review of Resident#2 care plan, dated 10/09/25 reflected, no documentation of Resident#1 having a wander guard Record review of Resident#1's progress notes dated 10/09/25, reflected from 08/08/25 to 10/09/25 :On 08/13/25 Resident#2 actively exit seeking, not easily redirected. Record review of Resident#2 order summary, dated 10/09/25 reflected: Ensure Resident#1 wander guard was present on her left leg. Every 10 hours for wandering. Order started on 08/20/25 and was ongoing. Record review of Resident #3's face sheet, dated 10/09/25 reflected he was a [AGE] year-old male who was admitted on [DATE] and diagnosed with unspecified Dementia (decline in cognitive function that cannot be definitively attributed to a specific type of dementia), psychotic disturbance (a mental health condition characterized by a significant loss of contact with reality), mood disturbance (a persistent change in a person's emotional state, going beyond typical ups and downs to affect their ability to function) and anxiety (common mental health condition characterized by excessive worry, fear, and nervousness), Hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development), unspecified, difficulty in walking (This code is used to describe difficulty walking when the underlying cause cannot be classified into a more</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews, the facility failed to ensure 2 out of 4 residents (Resident#1 and Resident#2) received adequate supervision and assistance devices to prevent incidents. The facility failed to ensure Resident #1 and Resident #2's wander guards worked properly. These failures could place residents at risk of elopement. Findings included: Record review of Resident #1's face sheet, dated 10/09/25 reflected, she was a [AGE] year-old female who was originally admitted on [DATE] and diagnosed with unspecified Dementia (decline in cognitive function that cannot be definitively attributed to a specific type of dementia), psychotic disturbance (a mental health condition characterized by a significant loss of contact with reality), mood disturbance (a persistent change in a person's emotional state, going beyond typical ups and downs to affect their ability to function) anxiety (common mental health condition characterized by excessive worry, fear, and nervousness), hypertension (a condition where the force of blood against the artery walls is consistently too high), Hypothyroidism (abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development), Edema (a condition where excess fluid accumulates in the body's tissues, causing swelling), Psychotic disorder with hallucinations due to physiological condition (a mental health condition where psychotic symptoms like hallucinations and delusions are a direct result of a medical illness) and Psychotic disorder with delusions due to known physiological condition (diagnosis characterized by the presence of delusions (false beliefs) that are directly caused by an underlying medical condition). Record review of Resident #1's MDS, dated [DATE] reflected her BIMS score was 06 which indicated serve cognitive impairment. Record review of Resident#1 MDS reflected Resident #1 did not exhibit wandering behavior at the time the MDS was completed. Record review of Resident #1's care plan, dated 10/09/25 reflected, no documentation of Resident #1 having a wander guard. Record review of Resident #1's progress notes dated 08/13/25 reflected Resident #1 actively exit seeking, not easily redirected. Record review of Resident #1's order summary, dated 10/09/25 reflected: Ensure Resident #1's wander guard was present on her left leg. Every 10 hours for wandering. Order started on 08/20/25 and was ongoing. Record review of Resident #1's TAR, dated 10/09/25 reflected: Ensure wander guard is present on her left leg every 10 hours for wandering. Start date of 08/20/25 and a discontinued date of 10/09/25. Ensure wander guard is present on her left leg, check functioning placement, skin integrity every shift for wandering. Order started on 10/09/25. Record review of Resident #2's face sheet, dated 10/09/25 reflected, he was a [AGE] year-old male who was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with unspecified Dementia (decline in cognitive function that cannot be definitively attributed to a specific type of dementia), psychotic disturbance (a mental health condition characterized by a significant loss of contact with reality), mood disturbance (a persistent change in a person's emotional state, going beyond typical ups and downs to affect their ability to function) and anxiety (common mental health condition characterized by excessive worry, fear, and nervousness) mother sequelae of cerebral infraction (paralysis, aphasia, and cognitive impairment), neuroleptic induced Parkinsonism (a temporary movement disorder that can occur as a side effect of taking certain medications called neuroleptics, also known as antipsychotics), chronic kidney disease stage 4 (severe kidney damage, where the kidneys are functioning at 15-29% of their normal capacity), hypertension, anemia, cognitive communication deficit, difficulty in walking and Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder) Record review of Resident #2's MDS, dated [DATE] reflected his BIMS score was 03 which indicated serve cognitive impairment. Resident#2 had a presence and frequency of wandering daily. Record review of Resident #2's care plan dated 10/09/25 reflected, no documentation of Resident#1 having a wander guard. Record review of Resident #2's progress notes dated 10/09/25, reflected from 08/08/25 to 10/09/25 on 08/13/25 Resident #2 was actively exit seeking, not easily redirected. Record review of Resident #2's order summary, dated 10/09/25 reflected: Ensure Resident #2's wander guard was present on his left leg. Every 10 hours for wandering. Order started on 08/20/25 and was ongoing. Record review of Resident #2's TAR, dated 10/09/25 reflected: Resident is wearing a wander guard device to left ankle every shift for wandering. Order discontinued on 10/09/25. Monitor wander guard to lower extremity every shift every shift for wander guard No order start date posted. Ensure wander guard is present on her left leg, check functioning placement, skin integrity every shift for wandering. No order start date posted. To ensure that wander guard is functioning correctly, every shift take resident to front door to ensure that alarm sounds. If</p>		