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	12/05/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure care plans were developed in consultation with the resident's representative for 1 of 4 residents (Resident #1) reviewed for Comprehensive Care Plan in that:The facility failed to ensure Resident #1, or the resident's representative were invited to participate in the resident's care plan meeting.This failure placed residents at risk for a loss of independence, psychosocial well-being, and the opportunity for them to participate in the planning of their care.Findings included: Record review of Resident #1's face sheet dated 10/15/2025, revealed a [AGE] year-old male admitted to the facility 09/11/2017. His diagnoses included Alzheimer's disease with late on set (memory and cognition issues, impaired judgment), heart failure unspecified (a condition where the heart is unable to pump enough blood to meet the body's needs, but the specific cause or type of heart failure is unknown), hypertension(condition where the blood pressure in the arteries is consistently elevated above normal levels), and psychotic disorder with delusions due to known physiological condition (psychiatric 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 Resident #1's BIMS score of 3, which indicated severe impairment.In an interview on 10/14/2025 at 10:50 a.m., Resident #1 did not respond to any questions. Resident #1 smiled when asked questions. Resident #1 was observed sitting in the day room at a table alone. Resident #1 appeared clean and appropriately dressed. In an interview on 10/14/2025 at 3:16 p.m., the SW stated she had been employed at the facility for about three months. She stated it was her responsibility to work with the MDS coordinator to coordinate and schedule care plan meetings. She stated the facility's IDT and the resident; the resident's RP was included in care plan meetings. She stated she sent out invitations by contacting the RP via phone so the RP could be included. She stated the RPs had the option to attend care plan meetings via phone. She stated since she's been in her position, she had not coordinated a care plan meeting for Resident #1. She stated that the RP's or family not being included in care plan meetings could become a problem in the future. In an interview on 10/15/2025 at 9:32 a.m., Resident #1's responsible party revealed Resident #1 was admitted to the facility 8 years ago and she's never been invited or included in a care plan meeting. She stated when she voiced her concerns about being included in care plan meetings, the facility stated they would include her, but he never received an invite from the facility. She stated the facility had contacted her for consent of medical decisions for Resident #1 but no communication about care plan meetings. She stated she knew she was supposed to be included in Resident #1's care plan meetings. In an interview on 10/15/2025 at 2:25 p.m., the MDS Coordinator stated she's been employed at the facility for 4 years. She stated it was the SW responsibility to coordinate care plan meetings. She stated it was the SW responsibility to reach out to RP and/or family members to be included in care plan meetings. She stated Resident #1's last care plan meeting was 8/20/2025. She stated she could not recall if Resident #1's RP was invited or attended the care plan meeting. She stated she could not provide a sign-in sheet for the care plan meeting dated 8/21/2025. She stated RP's or family members not included in care plan meetings could lack advice or recommendations to address behaviors and concerns. In an interview on 10/16/2025 at 1:20 p.m. ADM stated was employed at the facility since July 2025. He stated the SW was responsible for coordinating care plan meetings under the direction of the MDS Coordinator. He stated the IDT, the residents, RPs, and family members should be included in care plan meetings. He stated care plan meetings should be documented and the SW maintained a file for sign in sheets. He stated he had not attended a care plan meeting for Resident #1 since he's been employed at the facility. He stated the importance of including RPs or family members could benefit residents that are cognitively impaired. He also stated any concerns RPs or family members had could not be addressed. Record review of Resident #1's Multidisciplinary Care Conference assessment dated [DATE] revealed the registered nurse, dietary, social worker, activities, therapy, and nursing administration attended the meeting. No indication of the RP or family attended the meeting. Record review of Resident #1's Multidisciplinary Care Conference assessment dated [DATE] revealed therapy, MDS nurse, and licensed nurse attended the meeting. No indication of the RP or family attended the meeting. Record review of Resident #1's Multidisciplinary Care Conference assessments for 5/22/2025 and 08/21/2025 were requested but the facility could not provide the assessments. Record review of Resident #1's medical chart revealed documentation of completed MDS assessments dated 02/27/2025, 05/22/2025, and 08/21/2025. Record review of the facility's

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the resident's representative when there was an incident resulting in injury for 1(Resident #2) of 4 residents reviewed for notification of changes. The facility failed to notify Resident 2's representative when resident fell from his bed causing delayed swelling to his face and arm.This failure could place residents at risk of not receiving the support and advocacy of their families after an incident.Findings included: Record review of Resident #2's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type 2 diabetes mellitus with foot ulcer, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (artery that supplies blood to heart due to fatty deposits), congestive heart failure, and chronic kidney disease stage 3. Record review of Resident #2's MDS dated [DATE] reflected Resident #2's BIMS score of 9 which indicated moderate cognitive impairment. Resident #2's functional abilities required a wheelchair and transfer to and from a bed to a wheelchair required assistance of 2 or more staff.In an interview on [DATE] at 11:00 a.m., LVN C stated prior to the start of her shift on [DATE], she was informed by LVN D Resident #2 had a fall on [DATE] while attempting to transfer from his bed to the wheelchair without assistance. She stated on [DATE] at approximately 7:00 a.m. when she made rounds, she noticed swelling to Resident #2's face and right arm. She stated she notified Resident #2's Physician and was instructed to send Resident #2 to the hospital. She stated she also notified Hospice and Resident #2's family members. She stated Resident #2's family member informed her she was not notified on [DATE] and [DATE] was her first time hearing about a fall. She stated it was the nurse's responsibility to notify the physician and family when there was an incident/accident or change in condition. She stated it was important to notify the family so the family can make decisions if needed and be aware of the condition of their loved one. In an interview on [DATE] at 12:24 p.m., the ADON stated she was informed Resident #2 had a fall on [DATE] and there was delayed pain and swelling observed on [DATE] by LVN D. She stated LVN D notified Resident #2's family about the change in condition from the fall on [DATE], and the family member stated she was not informed about Resident #2 having a fall on [DATE]. She stated nurses are expected to immediately notify the Physician and the family about incidents and change of conditions, etc. She stated it was important to notify the family because something could happen later with residents and the family would be aware. She stated staff were in service on falls every month or as needed. She stated she in serviced staff on documentation and charting after this incident.In an interview on [DATE] at 1:46 p.m., LVN E stated Resident #2 had a fall on [DATE] when he attempted to transfer from the bed to the wheelchair without assistance from staff. He stated Resident #2 was a 2 person assist and required a Hoyer lift for transfers from the bed to the wheelchair. He stated after assessing Resident #2, he notified the physician, Hospice, and Resident #2's family members. He stated he contacted Resident #2's family member via phone and informed her about the fall. He stated it was the nurse's responsibility to notify the family regarding incidents/accidents, so the family was aware of the resident's care. He stated he documented the fall (progress notes) and indicated everyone that was notified and followed the physician's directives. He stated staff were in service on falls often and when there's an incident. He stated he could not recall the last in service on falls. He stated he could not recall if there was an in serviced after Resident #2's fall.In an interview on [DATE] at 12:12 p.m., LVN F said Resident #2 did not fall on her shift, but she was informed by LVN E on [DATE] at the beginning of her 10:00 p.m. to 6:00 a.m. shift that Resident #2 had a fall [DATE]. She stated she did not notify Resident #2's family member because per charting, LVN E noted he notified Resident #2's family member. She stated it was the nurse's responsibility to notify the family member if a resident had a fall. She stated it was important to notify the family members because it was dealing with the care of the residents, and the family had the right to know the conditions and changes the residents had and to make sure the residents are receiving proper care. She stated staff were in serviced on documentation and charting was maybe in [DATE].In an interview on [DATE] at 1:04 p.m., Resident #2's family member stated Resident #2 had a fall during the weekend of [DATE]. She stated she was not notified about the fall until [DATE]. She stated the ADM informed her Resident #2 had a fall and he was on his way to the hospital. She stated the ADM did not provide details about the fall. Resident #2's family member stated Resident #2 expired [DATE] at the hospital.In an interview on [DATE] at 1:20 p.m., the ADM stated on [DATE] he was informed by staff that Resident #2's family member had concerns about not being contacted by the facility regarding Resident #2's fall on [DATE]. He

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 1 of 5 residents (Resident #4) reviewed for abuse and neglect.The facility did not thoroughly investigate an incident in which Resident #4 made a grievance that a staff member was rough with her and did not stop perineal care when requested.This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm.Findings included: Record review of Resident #4's Face Sheet, dated 10/16/2025, reflected a [AGE] year-old resident with an initial admission date of 04/24/2024 and diagnoses including dementia (decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life), atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), interstitial pulmonary disease (a group of chronic lung diseases characterized by inflammation and scarring (fibrosis) of the tissues between the air sacs (alveoli) in the lungs),Seizures (sudden, uncontrolled electrical discharges in the brain), Cognitive Communication Deficit (a communication challenge caused by impaired thinking abilities, such as memory, attention, or problem-solving, rather than a language or speech impairment), Age-related osteoporosis (condition that weakens bones, making them more prone to fractures), Alcohol dependence, 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 #4's Quarterly MDS Assessment, dated 08/14/2025, reflected the resident had a BIMS score of 13, reflecting the resident had intact cognition.Record review of provider investigation report written by previous facility Administrator on 10/13/2025 revealed on 06/03/2025 Resident #4 alleged that during his shower a hospice aide touched him in a sexual inappropriate manner and called him racial slurs. The provider investigation report revealed no alleged perpetrator was named, no documentation hospice was notified, no safe surveys were included, and no abuse and neglect in-services were provided. The investigation report was completed by Previous Administrator.In an interview on 10/15/2025 at 2:00 p.m., the Hospice DON revealed she was not notified of the alleged allegation of abuse until 10/14/2025 when the current Administrator contacted her. In an interview on 10/14/2025 at 10:11 a.m., Resident #4 stated that he did not recall any staff member or hospice staff touching him in an inappropriate sexual manner or using racial names. In an interview on 10/16/2025 at 1:20 p.m., the Administrator stated that he became the facility administrator on 07/17/2025 and did not participate in the investigation that concerned Resident #4's allegation of abuse on 06/03/2025. The Administrator stated the expectation was for any staff member who heard an allegation of abuse, neglect, and or exploitation (ANE) to immediately report the allegation to himself the Administrator. The Administrator stated that the alleged perpetrator should be annotated on provider investigation, all investigation findings, corrective actions and items completed during investigation should be included in the provider investigation report. The Administrator stated the potential for harm to residents when investigations are not completed would be their allegations of ANE would go unheard, undocumented, and uninvestigated and risk for additional abuse.In an interview on 10/16/2025 at 1:20 p.m., the Administrator stated that he became the facility administrator on 07/17/2025 and did not participate in the investigation that concerned Resident #4's allegation of abuse on 06/03/2025. The Administrator stated the potential for harm to residents when investigations are not completed would be their allegations of ANE would go unheard, undocumented, and uninvestigated. The Administrator was not able to locate more information on the PIR prior to exit. He stated relevent facts should be included in an investigation. (The Administrator was not asked specically about responsibility of thorough investigation.)Record review of facility policy titled, Accidents and incidents - Investigation and Reporting, dated 2001 revised 2014 reflected, All accidents or incidents involving residents, employees, visitors, occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation2. The following data, as applicable, shall be included in the Report of Incident/accident form:e. The name of witnesses and their accounts of the accident or incidentf. The time the injured person's physician was notified, as well as the time the physician responded and his or her instructionsk. Any corrective action taken

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for one (Residents #3) of four residents reviewed for dental services. The facility failed to promptly, within 3 days refer Resident #3 with lost or damaged dentures for dental services. This failure could affect residents by placing them at risk for oral complications, dental pain, and diminished quality of life.Findings included:Record review of Resident #3's face sheet dated 10/14/2025 revealed [AGE] year-old male admitted to the facility 09/30/2024. His diagnoses included Alzheimer's disease with late on set (memory and cognition issues, impaired judgment), chronic obstructive pulmonary disease (lung disease) and nontraumatic subacute subdural hemorrhage (bleeding near brain).Record review of Resident #3's MDS dated [DATE] reflected Resident #3's BIMS score of 7 which indicated severe impairment. Oral/dental status did not indicate no natural teeth or tooth fragments (edentulous) or discomfort or difficulty with chewing. Record review of Resident #3's Care plan dated 10/06/2025 reflect Resident #3 had his own teeth and are intact.Record review of Resident #3's Nutritional assessment dated [DATE] reflected the resident's dental status teeth intact. Current and texture of diet indicated regular with no chewing or swallowing difficulties noted. Attempted interview on 10/14/2025 at 9:35 a.m., via phone with Resident #3's family member was unsuccessful. Left a message requesting a call back.In an interview and observation on 10/14/2025 at 9:54 a. m., Resident #3 stated he could not recall if he had any dentures or if he misplaced his dentures. Resident #3 could not recall what happened to his missing teeth. Resident #3 stated he ate his meals. Observation of Resident #3 revealed the resident had no lower or upper teeth.In an interview on 10/14/2025 at 12:24 p.m., the ADON stated she never received any concerns from staff regarding Resident #3 having difficulty chewing or swallowing. She stated she thinks Resident #3 had a regular texture diet. She stated she was never informed Resident #3 had missing dentures. She stated it was the SWs responsible for submitting a referral if resident dentures were misplaced or broken. She stated that residents not having dentures could cause them to have issues chewing, swallowing, or choking.In an interview on 10/14/2025 at 3:16 p.m., the SW stated she had been employed at the facility since the end of August 2025. She stated at the end of September 2025 she received a verbal complaint from Resident #3's sister about missing dentures since November 2024. She stated she submitted a referral to the dental provider via fax but could not provide a date or copy of the referral, but Resident #3 had been added to the list of the upcoming dental appointments in December 2025. She stated it is important for residents to have dentures as needed to prevent any issues with eating and ensure the residents had the appropriate diet. In an interview on 10/15/2025 at 10:15 a.m., the DOR stated if there were concerns about a resident having issues chewing or swallowing due to missing dentures, a nurse can downgrade a resident's diet. She stated for an upgraded diet; therapy would need to properly assess the residents before doing so. She stated aspiration, coughing or drooling while eating would be signs for a changed diet. She stated she was informed on 10/14/2025 that Resident #3 had no teeth and missing teeth. She stated she informed Speech Therapy and Speech Therapy would follow up to have the resident properly assessed for a diet change. She stated if a resident had missing teeth did not mean they cannot eat and does not put a resident in harm's way because some residents can still eat with missing teeth. She stated if there are concerns and the concerns are not properly addressed, then the resident could aspirate. Attempted interview on 10/14/2025 at 11:11a.m., via phone with Resident #3's family member was unsuccessful. Left a message requesting a call back.In an interview on 10/15/2025 at 11:35 a.m., the Dietitian stated it was her responsibility to change a resident's diet as needed. She stated she only assessed for chewing. She stated a nurse can downgrade a diet if needed. She stated Resident #3 diet was regular texture and prior to today she's never been notified about Resident #3 having missing dentures. She stated she checked Resident #3's weight and there were no concerns regarding weight loss. She stated she spoke with Resident #3 and asked if she would like his diet to be changed to mechanical soft and he stated yes. She stated that a resident not having an appropriate diet could affect their nutritional needs.Attempted interview on 10/14/2025 at 11:11 a.m., via email with Resident #3's family member. Requested telephone call. No response was received.In an interview on 10/16/2025 at 1:20 p.m., the ADM stated he had been employed at the facility since July 2025. He stated it was SW's responsibility to submit referrals for missing or broken dentures. He stated any concerns regarding a resident's diet should be communicated with the nursing management staff to determine the needs of the resident. He stated since he had been here, he had

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for four of five dietary staff members reviewed for qualified dietary staff.The facility failed to ensure four (Cook A, [NAME] B, [NAME] C and Dietary Aide G) dietary staff members had their Texas Food Handler's License.This failure could place residents at risk of not having met their nutritional needs and place them at risk of foodborne illnesses.Findings included: A request for food handlers' licenses was made for all kitchen staff via email to the Administrator on 10/14/2025 at 3:10 p.m. and they were not provided. Record reviews of the four dietary staff members (Cook A, [NAME] B, [NAME] C and Dietary Aide G) personnel files on 10/15/2025 at 11:30 a.m. revealed all four dietary staff did not have a Food Handler's Certificate. All four dietary staff had been employed longer than 30 days.A request for job description was made for job description for kitchen staff members sent via email to the Administrator on 10/15/2025 at 2:15 p.m.During an interview with [NAME] A on 10/14/2025 at 9:33 a.m., he stated that he had been at the facility for 1.5 months and he did not have his food handlers license, was not aware he had to have one. During an interview with [NAME] B on 10/14/2025 at 10:17 a.m., she stated she had been at the facility since June 2025 and did not have her food handlers license and was not aware of how long she had to obtain it. She stated that without proper knowledge of how to prepare food properly would lead to residents getting sick. During an interview with [NAME] C on 10/14/2025 at 2:06 p.m., she stated she had been at the facility since April 2025 and did not have her food handlers license, but the new dietary manager spoke to her about completing it today. During an interview on 10/15/25 at 4:17 p.m., the DM revealed she was hired nine days ago and assumed that the dietary staff had their food handlers license , but on 10/14/2025 that she could not locate any current food handler certificates for the four staff (Cook A, [NAME] B, [NAME] C and Dietary Aide G) who worked in the kitchen. The DM manager stated that she is responsible for ensuring kitchen staff maintain current training on their responsibilities in the kitchen. To ensure the dietary staff were trained would be noted by license posted on the wall and in a book that the DM maintained with everything that the state required. She said not having a current certification places the residents at risk of not having food prepared correctly. During an interview on 10/16/25 at 1:20 p.m., the Administrator said it was important for anyone who prepared or cooked in the kitchen to have their food handler's license to ensure everyone knew the best practices across the board. He said they needed to know how to follow the rules and regulations, ensure proper sanitation, and how to not cross-contaminate. He said he would have to refer to the policy when asked how long after hire should the certification be completed. He stated that it is the DM responsibility to ensure kitchen staff was trained under the instruction of the Administrator. A request for food handlers licenses was made for all kitchen staff during the interview with the Administrator who did not provide them prior to exit.Record review of the Texas Department of State Health Services accessed on 10/16/2025 at 1:10 p.m.atcms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes (Statues and Laws - Retail Food Establishments | Texas Laws indicated:Rules & Regulations - Chapter 228 - Texas Food Establishments Rules (TFER) dated 11/07/2024Subchapter B - Management and Personnel (d) All food employees, except for the certified food protection manager, shall successfully complete an accredited food handler training course, within 30 days of employment.(e) The food establishment shall maintain on premises a certificate of completion of the food handler training course for each food employee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review of the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food and kitchen safety.1. The facility failed to ensure both handwashing sinks were in proper working order.2.The facility failed to ensure drainage in the dishwashing room was in working order.3. The facility failed to ensure the kitchen remained free of bugs and insects (pests).These failures could place residents at risk for food-borne illness and cross contamination.Findings included:Observations of the Kitchen on 10/14/2025 at 09:30 a.m., with [NAME] A revealed the following: -Handwashing sink #1 /eyewash station leaked from a pipe beneath the sink. There was a large black rectangular basin there beneath the sink to catch the water.-Handwashing sink #2 was non-functioning. There was no running water that came from the faucet when the handle was turned on the hot or cold side.-Dishwasher - water would not drain. In the center of the dishwasher room, there was a wet vacuum (designed for wet debris pickup), which had a long (an inch or two longer than a 12-inch ruler) black slender cylindrical tube (vacuum attachment); it extended up beyond the drain opening approximately 5 inches to soak up/suction water when it backed up. Once the wet vacuum was full staff would pour the water into a drain nearby.-Pest droppings (small black pellets) in all three sections of a nonfunctioning dishwashing sink on the back wall near the fridge, and on the floor beneath another nonfunctioning sink in the back of the kitchen. Additionally, there were five gnats in the nonfunctioning handwashing sink #2.In an Interview with [NAME] A on 10/14/2025 at 9:33 a.m., he stated the black tube protruding out of the kitchen floor (drain in the center of the floor) was a wet vacuum attachment. It was there to allow the staff to use a wet vacuum to suction up the water to prevent overflowing onto the floor when the drain beneath the dishwasher machine or the dishwasher sink started to fill up. He stated the drain under the dishwashing sink and dishwasher did not drain well due to a drainage problem. [NAME] A stated that the sink and plumbing issues have been like this for the month and half he had been there. During an interview on 10/15/25 at 4:17 p.m., the DM stated that the plumbing issues were her top priority with the handwashing sink and dishwasher. She said that she was told that a plumber was supposed to come out to assess the damage but could not provide a date. The DM stated that her expectation of the kitchen was for it to always be clean to prevent any possible food borne illness. In an Interview with the Administrator on 10/16/2025 at 1:20 p.m., he stated that he learned about the broken sink and drainage problem in the kitchen prior to 10/13/2025 but was not sure of the exact date. The Administrator stated that the facility hired a plumber on 10/14/2025 and he was going to assess the concern in the kitchen as the previous plumbing company had not done a sufficient job. He stated his expectation was for the drainage issues to be fixed in the kitchen. Additionally, he was made aware of the pest issues on 10/14/2025 and his expectation was to shut down the kitchen for a day to allot time for the kitchen to be deep cleaned to help rid of pests as having pests could lead to illness.Review of the facility's Nutrition Services Policy & Procedures: Food Receiving and Storage, Version 1.3, Effective Date: 2001, Revised October 2017, reflected: Policy Interpretation and Implementation: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times.

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	12/05/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain the kitchen equipment in good repair for 1 of 1 range hood reviewed for safe operating equipment.The facility did not ensure the range hood in the kitchen was in good repair.This failure could place the staff and residents at risk of a fire and not having safe operating equipment.Findings included:During an observation and interview on 10/14/18 at 9:30 a.m., [NAME] A tried to turn on the range hood and the range hood did not come on. He stated the range hood had not worked since he had been working there for a month and half. [NAME] A did state that the kitchen there had been times when the kitchen was smokey if someone cooked on high. During an interview on 10/14/2025 at 9:45 a.m., the DM stated she had been at the facility for nine days and there was a quote for the range hood to be replaced. The DM stated that to her knowledge a company had come out and stated that the motors had gone out on the range hood and needed to be replaced and the facility was quoted roughly $4,000 so they needed another quote. The DM stated when she arrived at the facility she called in someone she knew and that person stated all that needed to be done was the belts replaced, and the range hood serviced. Request for quote of the range hood was requested verbally to the DM on 10/14/2025 during our 9:45 a.m. interview. During an interview on 10/14/2025 at 10:17 a.m., [NAME] B revealed that the range hood inside the kitchen had not worked for at least four months she had worked there and that there was occasions that the kitchen was full of smoke, because they were unable to use the range hood. [NAME] B revealed all residents in the facility eat from the kitchen. Request for a quote of the range hood was requested via email to the Administrator on 10/15/2025 at 2:15 p.m.An interview with the DM on 10/16/2025 at 11:03 a.m., indicated all residents received food from the kitchen. The facility census on 10/14/2025 was 68. In an Interview with the Administrator on 10/16/2025 at 1:20 p.m., he stated that he learned about the nonfunctional rangehood problem in the kitchen prior to 10/13/2025 but was not sure of the exact date. The Administrator stated that there had been a work order and quote for the range hood to be fixed but was told that the motors were gone out and needed to be replaced and it would be $4,000 so the facility got a second quote which was for the belts to be replaced and serviced. The Administrator stated that the person fixed the range hood on 10/16/2025.Observation of the kitchen on 10/16/2025 at 3:05 p.m., the range hood in the kitchen had been repaired and in working order. Review of Maintenance Service policy dated 2001, revised December 2009 revealed the maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all time.

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	12/05/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 kitchen reviewed for pest.The facility failed to ensure the kitchen was free of gnats and rodent droppings on 10/14/2025, 10/15/2025 and 10/16/2025.These failures could place residents at risk for insect borne illness, not having a home free of pests and a comfortable environment in which to live. Findings include:In an interview on 10/14/2025 at 9:30 a.m., [NAME] A revealed he saw rats and/or mice in the kitchen of the facility many times. [NAME] A stated he had seen pest droppings in the kitchen. [NAME] A stated that there are gnats in and near the hand washing sink. Observation on 10/14/2025 at 10:00 a.m. there was pest droppings (small black pellets) in all three sections of a nonfunctioning dish washing sink on back wall near the fridge, another nonfunctioning sink in the back of the kitchen and on the floor beneath that sink. Additionally, there was five gnats in the nonfunctioning hand washing sink near the dishwasher. In an interview on 10/14/2025 at 10:17 a.m., [NAME] B revealed the kitchen was full of mice and/or rats in the pantry, five was just caught in the trap, but there was droppings on sinks (they don't use), there was gnats that flew around the kitchen all day. In an interview on 10/14/2025 at 2:06 p.m., [NAME] C revealed that she had to place the bread in the freezer due to rat and/or mice eating through the packaging and eating the bread. [NAME] C also observed rat/mice in the pantry once when she went and got an item one jumped out and hit her arm. [NAME] C stated that pest control came twice per month they spray. In an interview on 10/15/2025 at 10:37 a.m., the Maintenance Director stated the facility did not have a rodent problem until the facility broke up the concrete on the back patio but from June to current there was rodents. The Maintenance Director stated he had been treating the issue with sticky bait; the rodents will get on there and die. The Maintenance Director stated he had not seen any rodents in a while and that no one from the kitchen staff had reported to him that there was rodents in the kitchen. The Maintenance Director was shown the pest droppings and seemed surprised. The maintenance director informed the state surveyor that pest control comes to the facility twice per month and as needed and that residents and staff can verbally communicate with him their pest control concerns as well as all staff was able to write in the pest control book that he checked daily. Record review of the Pest Management Binder found: Last sighting log on 10/06/25 reflected 10 mice captured and 15 fruit flies. It was noted by the pest control technician that they inspected the kitchen common areas found some fruit flies by dishwasher, storage room and treated fruit flies and to prevent ants, roaches, and crawling insects. It is noted that pest control came to the facility twice per month from June to current.In an Interview with the Administrator on 10/16/2025 at 1:20 p.m., he stated that pest control is at the facility twice per month and as needed. He was made aware of the pest droppings in the kitchen during this investigation. He stated the harm oof pest droppings to the staff and residents is the potential for infection. His expectation is that the kitchen should be cleaned daily and free of pest droppings. The Administrator was not sure when the last time the pest droppings had been cleaned up. He stated the responsibility of the cleaning falls on the dietary manager under the instruction of the Administrator. Record review of the facility's undated policy and procedure titled Pest Control reflected Purpose: to provide an environment free of pests. Policy: 1. The facility will have pest control that provides frequent treatment of the environment for pests. It will allow for periodic treatment when a problem is detected. There will be emphasis on pest control in the kitchens, cafeterias, laundries, loading docks, construction activities and other areas prone to infestation. Monitoring of the environment will be done by the facility's staff. Pest control problems will be reported promptly. Screens will be maintained in all windows that open to the outside.