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	05/18/2026

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 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** Based on interview and record review, the facility failed to ensure each resident received adequate supervision for 1 of 5 residents (Resident #1) reviewed for supervision. Resident #1 walked out of the facility unattended and was missing from the building for approximately 24 hours on 05/16/26 at 7:00 PM to 05/17/26 at 6:50 PM. This failure could place residents at risk for Elopement. Findings included: Record Review of a Resident #1's face sheet, dated 05/18/26, reflected the resident was a [AGE] year-old female who admitted on [DATE]. Resident #1 had diagnoses which included dementia (a loss of thinking, remembering, and reasoning skills), cerebral infarction (disrupted blood flow to the brain), hemiplegia and hemiparesis (physical impairments following cerebral infarction), hyperlipidemia (high level of lipids (fats) in the blood), and hypertension (high blood pressure).Record Review of Resident #1's initial admission Elopement assessment dated [DATE] reflected her Elopement Risk rating was a 7 which indicated Resident #1 was at low risk to wander. Record Review of Resident #1's annual MDS assessment, dated 01/29/26, reflected she had a BIMS score of 8, which indicated she was moderately cognitively impaired. Record Review of Resident #1's Elopement assessment dated [DATE] reflected her Elopement Risk rating was a 7 which indicated Resident #1 was at low risk to wander. Record review of Resident #1's Quarterly MDS assessment reflected the MDS assessment was in progress. The resident's electronic record reflected the Quarterly MDS assessment needed to be completed by 05/15/26. Record Review of Resident #1's care plan did not indicate Resident #1 could go out on pass without supervision. Record Review of Resident #1's care plan did not indicate Resident #1 needed special supervision. Record Review of Resident #1's care plan, revised 05/17/26 reflected Resident #1 had impaired cognitive function related to diagnosis of dementia and cognitive function and social well-being related to CVA, BIMS 13 (indicated Resident #1 was cognitively intact) and varies. Interventions included ask yes/no questions in order to determine the resident's needs, cue, reorient and supervise as needed, keep the resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion, monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Record Review of Resident #1's Progress Notes written by LVN B and dated 05/17/26 at 2:32 PM reflected This morning while doing rounds [Resident #1] was not in her room. Night nurse asked where the resident is, she stated that she might be outside smoking. During breakfast, the resident was not back yet. This writer went the back of the smoking patio but Resident #1 was missing there. Search initiated in the building from room to room but resident still missing. We went round the building and outside the building but resident still missing. Administrator and Family notified. Record Review of Resident #1's Progress Notes written by LVN B and dated 05/17/26 at 3:21 PM, reflected Resident missed her morning medication and Medical Director was notified. Record Review of Resident #1's Progress Notes written by LVN B, dated 05/17/26 at 8:15 PM, reflected Resident came back in the building at 6:50 PM. The police requested to see if [Resident #1] was ready to go to the hospital for checkup and [Resident #1] denied. [Resident #1] stated that she is an (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adult and she does not need lecturing. Record Review of the sign out sheet dated 05/16/26 and 05/17/26, indicated Resident #1 did not sign out. Record review on 05/18/26 of a list of resident's names who could sign out reflected the following, Only residents on this list are able to sign themselves out of this building. If their name is not on this list, they are not allowed to go out of the building on their own. The list did not indicate Resident #1 could sign out. Record Review of the Police Report, dated 05/17/26, reflected the resident went missing on 05/16/26 at 7:00 PM. The report reflected, Officers responded to the incident on 05/17/26 at 12:33 PM and received a call regarding a missing person. Upon arrival, responding officers made contact with the administrator who explained that an elderly resident who was identified as [Resident #1], had been missing since approximately 7:00 PM on 05/16/2026. The Administrator reported [Resident #1]was last seen wearing a multi-shade/dark blue top and yellow slippers. The Administrator also informed responding officers that [Resident #1]1 was diagnosed with dementia. The Administrator provided responding officers with the medical documentation that showed [Resident #1's]diagnosis. The Administrator stated that [Resident #1] had been staying at the [facility] for approximately one year and that she had not gone missing before. While on scene, responding officers also spoke with [Family Member] who also stated [Resident #1]was diagnosed with dementia. [Family member] on scene provided responding officers with a photo of [Resident #1]. Responding officers canvassed the surrounding areas and did not locate [Resident #1]. While searching responding officers spoke with multiple individuals who stated that they knew [Resident #1]but could not provide accurate location for whereabouts. Responding officers notified youth operations who dispatched a detective to the scene. Record Review of Resident #1's Elopement assessment dated [DATE], reflected her Elopement Risk Rating was a 9, indicating she was at risk to wander. In an interview on 05/18/26 at 9:55 AM, the Administrator stated Resident #1 left the building on 05/16/26 and returned around 7:53 PM, on 05/17/26. The Administrator stated Resident #1 said that she wanted to have a relationship with a guy in the community, and she did not want anyone to know she left the building. The Administrator stated he was notified by LVN B on 05/17/26 at 9:00 AM that Resident #1 was not in the building, and she had not touched her breakfast tray. The Administrator stated he needed to verify if Resident #1 signed out, but he did not think she did. The Administrator stated when Resident #1 returned, she was educated on leaving the facility without informing staff first. In an interview on 05/18/26 at 11:06 AM, Resident #1 stated she did not remember the day she left the facility. She stated she did not sign out. Resident #1 stated she did not tell anyone she was leaving because she did not want anyone to know she had left. Resident #1 stated it was the first time she left the building. She stated if she wanted to sign out staff did not let her sign out to leave the building. Resident #1 stated she went to a nearby city. Resident #1 would not specify where she went or how she got out of the building. In an interview on 05/18/2026 at 11:09 AM, Resident #2 stated she was outside in the front of the building smoking a cigarette when Resident #1 asked her to use her lighter for a cigarette. Resident #2 stated Resident #1 was dressed so pretty in a pink spaghetti strap dress with yellow shoes. She stated she turned around and next thing she knew Resident #1 was gone, and she did not see where she went. She stated she thought Resident #1 left on Friday 05/15/26. Resident #2 stated while she was outside on Sunday 05/17/26 smoking a cigarette in the front she saw a red van pull up and Resident #1 got out of the van and returned to the facility. Resident #2 stated she had been in the facility 3 months now, and she had never seen Resident #1 leave the building like she did. In an interview on 05/18/26 at 11:27 AM, the Family Member of Resident #1 stated they were notified on 05/17/26 around 10:30 AM that Resident #1 was missing from the building. The Family Member stated they received a call from one of the staff members on Sunday morning 05/17/26, and they asked was Resident #1 with Family member. The Family Member stated she told the staff Resident #1 was supposed to be there in the building. The Family Member stated that they told the staff they were on the way to the facility. The Family Member stated when they arrived at the facility and Resident #1 still had not come back yet. The Family Member stated once they had arrived at the facility no one called the police yet, and once (continued on next page)

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