

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
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)		
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews the facility failed to ensure residents had the right to send and receive mail, and to receive letters, package and other materials delivered to the facility or the resident through a means other than a postal service, including the right to privacy of such communications for 6 of 6 residents (confidential residents) reviewed for resident rights. The facility failed to ensure staff distributed mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. During a confidential resident group meeting 6 of 6 members in the group stated they never received mail on Saturdays because the Business Office didn't work on Saturdays but they did have a receptionist. During an interview on 12/15/2025 at 3:20 p.m., with the Administrator, he stated that he was acting as the Business office staff person for now. He stated that for both he and the receptionist were passing the mail. During an interview on 12/16/25 at 9:22 a.m., the Receptionist stated the mail is dropped off with her at the front desk. She stated that both she and the Administrator passed out the mail. She stated there is someone at the front desk on the weekends, but when she comes in on Monday the mail had not been passed out. She stated that she has not opened any mail she just passed it out. During an interview on 12/16/25 at 02:15 p.m., the Administrator stated that mail should be passed out on the weekends by the weekend receptionist on Saturday.		

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for nursing services. The facility failed to provide RN coverage for 8 consecutive hours daily for 10/19/24; 10/20/24 11/16/24; 11/17/24 12/07/24; 12/08/24; 12/14/24; 12/15/24; 12/21/24; 12/22/24; 12/28/24; 12/29/24 01/04/25; 01/05/25; 01/11/25; 01/12/25; 01/18/25; 01/19/25; 01/25/25; 01/26/25 02/22/25; 02/23/25 04/19/25; 04/20/25; 04/26/25; 04/27/25 05/03/25; 05/04/25; 05/10/25; 05/11/25; 05/17/25; 05/18/25; 05/24/25; 05/25/25; 05/31/25 06/01/25; 06/07/25; 06/08/25; 06/14/25; 06/15/25; 06/21/25; 06/22/25; 06/23/25 08/10/25; 08/16/25; 08/17/25; 08/23/25; 08/24/25; 08/30/25 08/31/25 09/06/25; 09/07/25; 09/13/25; 09/14/25; 09/20/25; 09/21/25; 09/27/25; 09/28/25 This failure had the potential to affect residents in the facility by leaving staff without supervisory coverage for RN-specific nursing activities. During an interview on 12/16/25 at 12:35 p.m., with the DON revealed she was hired on 08/11/2025 and was the only RN to provide RN coverage. The DON stated that they had held interviews for RNs, but the requested pay was too high. She stated the importance of RN coverage was to ensure oversight of nursing including cardiac life support. She stated since she started, the facility had no RN weekend coverage. She stated she was not able to provide RN coverage 7 days a week for 8 hours, but least four hours each day on weekends. She stated the facility does not use agency staffing to provide RN coverage. During an interview on 12/16/25 at 3:31 p.m. with the Administrator revealed the hours that were submitted on the PBJ were correct. He stated the only RN the facility had was the DON. He stated the DON provided RN coverage during the week and she worked four hours on Saturdays and Sundays, but she was unable to provide 8-hour daily coverage. He stated the facility did not use agency staff to provide RN coverage. He stated the facility nurses on the weekends were LVNs not RNs. The Administrator stated the importance of having RN coverage was for oversight. He stated he was aware of the regulations requiring 8 hour in-facility RN coverage in the facility daily. He stated RN's scope of practice covered areas the LVN's scope of practice did not cover. He stated the facility had RN weekend coverage job posting up and had not been able to fill the job posting to date. Review of facility's employee list reflected there were no other RN nurses on the facility's employee list. Record Review of facility's PBJ Staffing Data Report for Quarter 2 (January 1-March 31), Quarter 3 (April 1-June 30), and Quarter 4 (July 1-September 30) 2024 reflected the facility triggered for no RN hours. Review of facility's policy Staffing revised October 2017 reflected the facility provides sufficient nursing staff with the skills and competencies necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. 2. Staffing numbers and the skill requirements of the direct care staff are determined by the needs of the residents based on each resident's care plan.		

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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 interviews the facility failed to store food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety, The facility failed to correctly label and date items in the dry storage and refrigerated areas. The facility failed to correctly label and date 4 bulk containers. These containers held flour, rice, breadcrumbs, and potatoes. There were no corresponding labels to indicate what the items were and when they were placed there and when they should be used by. The pantry had open packages of dry oats, breadcrumbs, and tortillas without the corresponding labels without the use by dates on the packages. There was no indication of when these items were opened and when the items should be discarded. These failures could place residents at risk for food-borne illness and cross contamination. Observation of the kitchen on 12/14/2025 at 9:25 a.m., revealed in the kitchen storage area, 5 bins of dry goods, rice, flour, breadcrumbs, potatoes and beans with only 1 date marked on a label. The labels on these bins did not list the exact item inside, when it was placed and when it should be discarded. Observation of the dry storage area, a room outside of the kitchen in a service corridor on 12/14/2025 at 9:37 a.m., revealed previously opened packages with no dates on them. There was a package of tortillas with no label on it to indicate what it was, when it was opened and when it should be discarded. There was a package of puree rice with a date of 09/18 and nothing else on the label. In an interview with the weekend cook on 12/14/2024 at 9:26 a.m., she stated that she had only worked at the facility a few weeks. She stated that she worked double shifts Saturday and Sunday. She stated the food had already put up when she arrived to work. She stated she was still getting a feel for the facility but had worked as a cook before coming here. She stated there were only 2 people working on the weekend. In an Interview with the Dietary Manager on 12/15/2025 at 10:15 a.m., she stated she had worked at the facility a few months. She stated that she was trying to work with what she has. She stated that she was trying to get the kitchen in order. She stated the packages are supposed to be labeled after they are taken from the box and opened. She stated the staff were labeling the items like they should. She believed it may be the weekend staff who are not labeling the packages after they open them. She stated she will get with all staff and retrain them. Interview with the Administrator on 12/16/2025 at 2:15 p.m., he stated the Dietary Manager was new and is doing a good job so far. He did not know the packages were not meeting the labeling requirement for dates and identification.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for two (Resident #5 and Resident #10) of five residents reviewed for PASRR Level 1 screenings. The facility failed to submit a new PASRR Level 1 screening when Resident #5 received a bipolar diagnosis. The facility failed to provide resident assessments to the habilitation coordinator within 20 days for Resident #10. This failure could place residents at risk of not receiving necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Review of Resident #5's Face Sheet, dated 12/16/25, reflected a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses including unspecified dementia without behavioral disturbance, psychotic disorder with delusions, post-traumatic stress disorder, and bipolar disorder. Review of Resident #5's MDS Assessment, dated 10/30/25, reflected he had documented diagnoses of Bipolar Disorder, Psychotic Disorder and Post-Traumatic Stress Disorder. Review of Resident #5's PASRR Level I Screening, dated 10/31/23, reflected he did not qualify for a PASRR Level II Evaluation at that time. There was no evidence that Resident #5 had a mental illness, intellectual disability, or developmental disability. Review of Resident #5's electronic medical record reflected no evidence that any additional PASRR Screenings/Evaluations had been completed since the initial PASRR Level I Screening was conducted on 10/31/2023. Review of Resident #10's Face Sheet, dated 12/16/25, reflected a [AGE] year-old male, who was admitted to the facility on [DATE], with diagnoses including Duchenne or [NAME] muscular dystrophy (genetic disorder characterized by the progressive loss of muscle. It is a multi-systemic condition, affecting many parts of the body, which results in deterioration of the skeletal, cardiac, and pulmonary muscles), chronic pain syndrome, unspecified dementia without behavioral disturbance, major depressive disorder. Review of Resident #10's MDS Assessment, dated 09/04/25, reflected he had a diagnosis of Duchenne or [NAME] Muscular Dystrophy. Review of Resident #10's Preadmission Screening and Resident Review Report of Specialized Services Non-Compliance to Consumer Rights and Services, dated 08/31/2025, reflected that the facility failed to submit assessments for all three therapy disciplines within 20 day deadline to the PASRR staff. During an interview on 12/15/25 at 11:00 a.m., the PASRR Habilitation Coordinator (HC) revealed that 3/10/25 Resident #10 selected his PASRR specialty mattress. The PASRR HC stated she contacted the facility MDS Coordinator on 04/29/2025 to find out what the status of Resident #10 physical, occupational and speech assessments were as they had not been received. The PASRR HC stated that the facility had 20 days to send in the three therapy assessments to have PASRR services approved. The PASRR HC stated since Resident #10 missed the 20-day deadline, that meant that the resident missed out on services and would have to wait for another quarterly meeting to start the process again. During an interview on 12/15/25 at 11:25 a.m., the MDS Coordinator said she had been the MDS Coordinator for the facility for 5 years and worked remotely. The MDS Coordinator stated she was responsible for all PASRR forms in the facility. MDS Coordinator stated that a mental illness, intellectual disability and developmental disability would result in a positive Level 1 PASRR screening. The MDS Coordinator stated that she was not apart of the PASRR meetings until August. She only submitted documents the social worker sent her. The MDS Coordinator stated Resident #5's initial PASRR Level I Screening was completed on 10/31/2023. Resident #5 did not qualify for services at that time, as there was no indication that Resident #5 had a mental illness, intellectual disability, and/or developmental disability. The MDS Coordinator said she was not aware Resident #5 was later diagnosed with bipolar disorder. The MDS Coordinator stated that when two items caused a change to the resident's MDS, that would trigger her to look for a new diagnosis. The MDS Coordinator stated that with new diagnoses Resident #5 should have had a PASRR Level II Evaluation completed to determine if he qualified for services. She stated she planned on conducting a (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility-wide audit to ensure no other residents had missed receiving a required PASRR Screening/Evaluation. The MDS Coordinator stated she did not believe there was a risk in Resident #5 not receiving a new PASRR Screening/Evaluation upon his new diagnosis of bipolar disorder, as Resident #5 also had a diagnosis of Dementia, which would prevent resident from receiving services. The MDS coordinator stated that Resident #10 had a PASRR meeting in March, but she was not involved. The MDS Coordinator stated that it was not until the PASRR habilitation coordinator contacted her in April asking for Resident #10's assessment was when she found out Resident #10 needed the assessments uploaded. The MDS Coordinator stated that when she was contacted the facility had missed the 20-day deadline. The MDS Coordinator stated that the facility has 20 days after a resident selects their services to have assessments uploaded to be approved. Failure to have the assessment uploaded would cause the residents to miss out of specialized services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (Resident #58) of ten residents reviewed for pharmaceutical services. 1. The facility failed to ensure that there was no expired insulin inside the medication room on 12/15/2025. 2. The facility failed to ensure LVN B did not put her personal beverage on the medication cart while passing medications on 12/15/2025. 3. The facility failed to ensure MA G did not put her personal beverage on the medication cart while passing medications on 12/15/2025. These failures could place the residents at risk of not receiving medications as ordered by the physician and potential interference with medication preparation. Findings included: Record review of Resident #58's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old male resident admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #58's Comprehensive MDS Assessment, dated 10/15/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #58's Comprehensive Care Plan, dated 10/17/2025, reflected the resident had diabetes mellitus and one of the interventions was to administer diabetes medications as ordered. Record review of Resident #58's Physician's Order, dated 10/26/2025, reflected Humalog (man-made insulin) Injection Solution 100 UNIT/ML (Insulin Lispro) Inject subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA ((high blood sugar in the blood stream)). An observation on 12/15/2025 at 10:09 AM revealed that during inspection of the medication room, a vial of Humalog, with opening date of 09/24/2025, was inside the medication room's refrigerator. During an observation and interview on 12/15/2025 at 10:11 AM, LVN A stated she was not sure when the expiration date of the Humalog was. She said she would ask the ADON. She took the insulin and went out of the medication room. In an interview on 12/15/2025 at 10:22 AM, the ADON stated they already disposed of the Humalog because it was already expired. She said, for Humalog, the shelf life is 28 days after opening, meaning it would be expired after 28 days. She said the risk would be either the resident could have adverse reactions, or the insulin would be less effective because it was already expired. She said the nurses, as well as herself, were responsible in auditing the refrigerator in the medication room for expired medications. She said there was a list of insulins posted in the nurse's station with the number of days they could be stored after opening. She said this was an oversight on her part. She said she would audit the refrigerator inside the medication room to check the dates the insulins were opened. In an interview on 12/15/2025 at 10:26 AM, LVN B stated she was Resident #58's nurse and she was the one administering his insulin. She said she did not use the Humalog vial because the facility was using the Humalog KwikPen. She said the Humalog vial was from the resident's former facility and came with him when he was admitted to the facility. She said, still, even though she was not using the insulin, it should not be inside the fridge because it could be accidentally used and might cause side effects to the resident. She said she was also responsible in auditing the items inside the fridge of the medication room. Observation on 12/15/2025 at 7:06 AM revealed LVN B's personal tumbler was on top of the nurse's cart that she was using to pass medications. During an observation and interview on 12/15/2025 at 7:22 AM, LVN B stated she could not have her personal tumbler on the cart when passing medications or doing treatments because it could cause cross contamination. She said it could be an infection control issue or could create clutter on the medication cart. She said the only required supplies and medications should be on top of the medication cart. She took her personal tumbler and put it inside the nurse's station. Observation on 12/15/2025 at 8:15 AM revealed MA G's water bottle was on top of the medication (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart that he was using to pass medications. An interview and observation on 12/15/2025 at 10:34 AM revealed the water bottle was still on top of MA G's medication cart. MA G stated he should not have the water bottle on top of his cart because of cross contamination, and he might accidentally use it for the residents or might accidentally be mixed with the medications he was preparing. In an interview on 12/16/2025 at 8:26 AM, the ADON stated no personal beverages should be on the medication carts because aside from being clutter that might contribute to medication error, staff might bring some microorganism from their home to the medication cart. She said she would coordinate with the DON to do an in-service about not placing any personal beverages on top of the cart and to check the expiration dates of the medications. In an interview on 12/16/2025 at 9:04 AM, the Administrator stated that the DON or the designee should frequently check the medication room and medication carts for expired medications to prevent any adverse effects. He said personal beverages should not be on the cart to prevent any potential medication error. He said the expectation was for the staff to frequently check for expired medications and for the staff not to put any of their personal beverages on top of the cart or even inside the cart. He said he would coordinate with the DON and the ADON about the issue. In an interview on 12/16/2025 at 9:36 AM, the DON stated the nurses were responsible for checking the expiration dates of the medications every time they administer them. She said even though the nurse was not using it, the insulin should not be inside the fridge because it was beyond 28 days. She said Humalog should only be used for 28 days after it was opened. She said expired medications could either cause adverse reactions or could be less effective. She said there was a breakroom near the nurse's station where the staff could put their personal belongings as well as their drinks. She said aside from the risk of cross contamination, some residents might take it and drink the content. She said the expectations were for the medication room to be audited thoroughly for expired medications and no personal beverages were in any cart. The DON said she would do an in-service pertaining to all the issues mentioned and would monitor the staffs' compliance. She said their policy might not include putting personal beverages on the carts, but it was the best practice. Record review of the facility's policy, Administering Medications Operational Policy and Procedure Manual for Long-Term Care revised December 2021 reflected Policy Statement: Medications shall be administered in a safe and timely manner . Policy Interpretation and Implementation . 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of fifteen residents (Resident #34 and Resident #42) reviewed for infection control. 1. The facility failed to ensure CNA E performed hand hygiene during Resident #34's incontinent care on 12/15/2025. 2. The facility failed to ensure CNA D performed hand hygiene and changed her gloves during Resident #42's incontinent care on 12/15/2025. 3. The facility failed to ensure CNA F did not walk down the hallway wearing a gown and gloves on 12/15/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: Record review of Resident #34's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #34's Comprehensive MDS Assessment, dated 12/10/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #34's Comprehensive Care Plan, dated 12/14/2025, reflected that the resident was frequently incontinent and one of the interventions was to assist during toilet use. An observation on 12/15/2025 at 11:32 AM revealed CNA E was about to do Resident #34's incontinent care. She washed her hands and put on a pair of gloves. She wet a small towel and put some soap in it and started to clean the perineal area using the front to back technique. She took off her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on the pair of gloves. She cleaned the perineal area again. She then rolled the resident and cleaned the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief, threw it in the trash can, and changed her gloves. She did not sanitize her hands before putting on the new pair of gloves. She took the new brief from the resident's overbed table and fixed it under the resident. In an interview on 12/15/2025 at 11:54 AM, CNA E stated hands should be sanitized before putting on a pair of new gloves because her hands might be dirty from cleaning Resident #34's bottom and touching the new gloves with dirty hands rendered the new gloves dirty. She said she would be mindful the next time she would do incontinent care to prevent any infection such as urinary tract infections. Record review of Resident #42's Face Sheet, dated 12/16/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with benign prostatic hyperplasia. Record review of Resident #42's Comprehensive MDS Assessment, dated 10/06/2025, reflected that the resident had severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated that the resident was incontinent (unable to control) for bladder and bowel. Record review of Resident #42's Comprehensive Care Plan, dated 10/13/2025, reflected that the resident had an ADL self-care performance deficit and needed supervision for toileting. Observation on 12/15/2025 at 8:08 AM revealed CNA D was about to do Resident #42's incontinent care. She washed her hands and put on a pair of gloves. She took a brief from the resident's overbed table, opened it, and put it at the resident's side. She pulled some wipes and put them on top of the overbed table. She did not sanitize the overbed table before placing the wipes on it. She unfastened the brief and pushed it between the resident's legs. She then cleaned the resident's perineal area using the wipes she put on the overbed table. She then changed her gloves but did not sanitize her hands before putting on the pair of gloves. She turned the resident and cleaned the resident's bottom. After cleaning the resident's bottom, she took the brief from the resident's side and placed it under the resident. She rolled back the resident and fixed the brief. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. In an interview on 12/15/2025 at 8:19 AM, CNA D stated she did not clean Resident #42's overbed table before putting the wipes on it. She said she should have cleaned the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	table first or just pulled the wipes from its container. She said she was not sure if the table was clean or not. She said the right thing to do was to change her gloves after cleaning the resident's bottom because she touched something soiled. She said using soiled gloves could cause transfer of germs to the new brief. She said the hands should also be sanitized if she changed her gloves. She said she would be mindful the next time she did incontinent care because her actions could cause infection. An observation and interview on 12/14/2025 at 12:59 PM revealed CNA F was walking in the hallway with gowns and gloves on. She said she should have discarded the gown and the gloves before going out of the resident's room to prevent cross contamination. She said she just came out of the room of the resident that had a catheter, that was why she was wearing a gown and gloves. In an interview on 12/16/2025 at 8:26 AM, the ADON stated the staff should be mindful that they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after touching soiled items like a soiled brief, soiled linens and even after cleaning the residents' bottom. She said the hands should be sanitized before putting on new gloves to make sure that the gloves that they were to use were clean. She said gowns and gloves were not worn in the hallway especially if the staff already went inside a resident's room that required PPE. She said the staff might already had contact with the resident that was on EBP and could spread to others any potential microorganisms. She said she would coordinate with the DON to do an in-service about infection control. In an interview on 12/16/2025 at 9:04 AM, the Administrator stated that staff should sanitize their hands to decrease potential infections and must not wear gowns and gloves in the hallway to prevent potential spread of infections. He said he would coordinate with the DON and the ADON about the issue and to monitor closely the staff's compliance to the policy. In an interview on 12/16/2025 at 9:36 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene when changing their gloves and change their gloves after touching something soiled. She said hand hygiene and changing the gloves should be done to prevent using soiled items. She said the staff should discard the gown and the gloves before going out of the room because there was no way of knowing what the staff touched inside the resident's room. She said the expectation was for the staff to practice hand hygiene when required and to practice proper handling of gowns and gloves. She said she would re-educate the staff with regards to infection and control and disposing of the gowns and gloves before going out of the room. Record review of the facility's policy Personal Protective Equipment - Using Gloves Nursing Services Policy and Procedure Manual for Long-Term Care September 2010 reflected Purpose: To guide the use of gloves . Objectives . 1. To prevent the spread of infection . Removing Gloves . 5. Discard the glove into the designated waste receptacle inside the room. Record review of the facility's policy Personal Protective Equipment - Using Gowns Nursing Services Policy and Procedure Manual for Long-Term Care September 2010 reflected Purpose: To guide the use of gowns . Objectives . 1. To prevent the spread of infection . Removing the gown . 6. If the gown is disposable, discard it into the waste receptacle inside the room. Record review of the facility's policy Handwashing/Hand Hygiene Operational Policy and Procedure Manual for Long-Term Care revised August 2015 reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . m. After removing gloves . 9. The use of gloves does not replace hand washing/hand hygiene . Applying and Removing Gloves . 1. Perform hand hygiene before applying non-sterile gloves.		

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 12/16/2025
NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215	
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 (Halls 100 and 600) of 4 halls reviewed for environmental concerns. 1. The facility failed to ensure rooms' electrical outlets were covered in room [ROOM NUMBER] on hall 600. 2. The facility failed to ensure rooms were free from holes in the walls in room [ROOM NUMBER] on hall 600. 3. The facility failed to ensure windows were in a good state of repair in room [ROOM NUMBER] on hall 100. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant and unsafe. During an observation on 12/14/25 at 9:15 a.m., room [ROOM NUMBER] on hall 600 had an outlet that did not have a cover, no wires exposed. During an observation on 12/14/25 at 9:22 a.m., in room [ROOM NUMBER] on hall 600, there were two holes found in the walls. One hole was located at the bottom right of the clothes storage area and the second hole was in the corner of the room near the window. During an observation on 12/14/25 at 10:45 a.m., room [ROOM NUMBER] on the 100 hall had a broken window with glass on the windowsill. During an interview on 12/16/25 at 3:02 p.m., the Maintenance Director revealed he was responsible for the repair of the rooms. The Maintenance Director stated that the clinical staff had access to the rooms and would let him know if something was broken or needed to be fixed/replaced. He stated he also did rounds of the rooms. The Maintenance Director stated that he was not aware there were holes in the walls in room [ROOM NUMBER] and was not aware of room [ROOM NUMBER]'s uncovered outlet. He stated that he was only aware of the broken window in room [ROOM NUMBER]. He stated that he was notified on 12/16/25 that a resident threw their tray and it broke the window. The window was double-lined so only the inside panel of the glass broke, he tried to remove the broken glass but was unsuccessful. The Maintenance Director stated they removed the residents from the room until the window could be repaired. During an interview on 12/16/25 at 3:31 p.m., the Administrator stated it was the requirement of the maintenance department staff to ensure rooms are functioning properly. The Administrator stated he was not aware of holes in walls, or any outlet covers that were missing, but was aware of the broken window and stated that the resident was moved to another room until the cosmetic damage is repaired. The Administrator stated that all residents should have rooms that function properly. Requested facility policy for safe environment policy on 12/14/25 at 1:16 p.m. but did not receive it prior to exit.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one (Resident #23) of eight resident reviewed for quality of care. The facility failed to ensure that LVN A used the proper procedures when providing wound care to Resident #23's diabetic ulcer on his right heel on 12/15/2025. This failure could place the residents with wounds at risk for infection or worsening of existing wounds. Findings included: Record review of Resident #23's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with non-pressure chronic ulcer (skin injuries that occur without the influence of pressure) of right posterior (back) heel. Record review of Resident #23's Quarterly MDS Assessment, dated 11/27/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needed little support) with a BIMS score of 14. The Quarterly MDS Assessment indicated that the resident had a non-pressure chronic ulcer of right posterior heel. Record review of Resident #23's Comprehensive Care Plan, dated 12/01/2025, reflected the resident had a diabetic (high blood sugar) ulcer (slow-healing wound due to diabetes) on his posterior heel and one of the interventions was to administer treatment as ordered. Record review of Resident #23's Physician Order, dated 12/09/2025, reflected Clean wound to the right posterior lower heel, with N/s or wound cleanser, pat dry and apply Anasept (antibiotic ointment), collagen (protein-based dressing to promote wound healing) and a dry dressing three times a week. in the morning every Mon, Wed, Fri for wound care. [sic] An observation on 12/15/2025 at 11:09 AM revealed LVN A was about to provide wound care to Resident #23's right heel. She prepared the normal saline, gauzes, Anasept, and collagen. She put the gauzes in two separate plastic cups. She sanitized the resident's overbed table and waited for it to dry. She then placed a wax paper on top of the overbed table and put the items needed for wound care. She poured normal saline in one of the plastic cups to wet the gauzes. She started cleaning the wound by getting a wet gauze and cleaned the wound from inside to outside. She took another wet gauze, cleaned the wound again, and discarded the gauze. With the second gauze, she cleaned the inside of the wound, then the surrounding skin of the wound, and then tapped again the inside of the wound before discarding the gauze. She took some gauze to pat dry the wound. She dried the wound, the surrounding skin of the wound, and used the same gauze to pat dry the wound again. In an interview on 12/15/2025 at 11:38 AM, LVN A stated the right procedure in cleaning the wound was to clean the wound from inside to outside. She said when she cleaned the wound again, she should have thrown the gauze away after she used it to clean the surrounding skin to avoid touching the inside of the wound with the gauze that she used to clean the outside of the wound. She said she needed to be careful not to introduce the germs from the surrounding skin of the wound into the wound that could cause infection. She said the same principle applied when drying the wound. In an interview on 12/16/2025 at 8:26 AM, the ADON stated the best practice was to clean the wound from the cleanest to the dirtiest and then discard the gauze after one stroke. She said the gauze used to clean the skin around the wound should not be used to clean the inside of the wound again because it would only introduce additional bacteria to the wound. She said the expectation was to keep the bacteria out and not introduce them to the wound that could result in infection. She said she would coordinate with the DON to do an in-service for all the staff doing wound care about the proper procedures in doing wound care. In an interview on 12/16/2025 at 9:04 AM, the Administrator stated that the expectation was for the staff to practice the right procedure of wound care to avert any harm to the residents. He said the objective of wound care was to clean the wound and not introduce microorganisms that could eventually cause infection. In an interview on 12/16/2025 at 9:36 AM, the DON stated the wound should be cleaned from the least contaminated area and the gauze should be discarded after every stroke. She said using the same gauze used to clean around the wound, could only introduce the (continued on next page)		

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Printed: 07/18/2026
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No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215	
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bacteria, if there were any, into the wound. She said using the same gauze that cleaned the skin around the wound would only re-introduce germs into the wound. She said the order did say to pat dry, but it did not say to pat dry with the gauze that already was inside of the wound that was soiled. She said the expectation was for the staff doing wound care would do the right procedure. She said she would do an in-service about wound care. Record review of the facility's policy Wound Care Nursing Services Policy and Procedure Manual for Long-[NAME] Care revised October 2010 reflected Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.		

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for one (Resident #43) of sixteen residents reviewed for medication storage. The facility failed to ensure Resident #43 did not have a bottle of nasal spray on his side table on 12/14/2025. This failure could place the residents at risk of accidental overdose, misuse of medications, not receiving the medication's full therapeutic benefits, and possible side effects. Findings included: Record review of Resident #43's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with asthma (lung disorder caused by narrowing of the airways). Record review of Resident #43's Comprehensive MDS Assessment, dated 10/03/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had asthma. Record review of Resident #43's Comprehensive Care Plan, dated 10/10/2025, reflected the resident had asthma and one of the interventions was to give medications as ordered. Record review of Resident #43's Physician Order on 12/14/2025, reflected no order for nasal spray. Record review of Resident #43's Assessment Notes on 12/14/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. During an observation and interview on 12/14/2025 at 9:26 AM revealed Resident #43 was in his bed, awake. It was observed that there was a nasal spray on the resident's side table, in plain view. The resident said it was his nasal spray, and it had always been on his side table. He said he was not sure if the staff knew he had a nasal spray inside the room. During an observation and interview on 12/14/2025 at 10:46 AM, LVN H stated that the nasal spray should not be inside Resident #43's room unless he had an assessment that he could administer it himself. He said if the resident needed a nasal spray, the staff should be the one administering it and it should be stored inside the cart. He went inside Resident 43's room and talked to the resident. LVN H said he would also call the doctor to get an order for the nasal spray. He said he did not see the nasal spray when he made his morning round. In an interview on 12/16/2025 at 8:26 AM, the ADON stated no medications should be stored inside the residents' rooms because the residents might administer them incorrectly and there should be physician orders for such medications as well. She said the nasal spray should be stored in the cart and not inside the resident's room and the staff should be the one administering it. She said the expectation was for the staff to scan the residents' rooms for any medications. She said confused residents might go inside the room and use the nasal spray and might have an allergic reaction. She said she would coordinate with the DON to do an in-service about medication storage. In an interview on 12/16/2025 at 9:04 AM, the Administrator stated that he was made aware of the issues about the medication inside the residents' rooms. He said the Resident #43 would go out to the community and would buy the nasal spray. But still the staff should have seen it, especially if it was in plain view. He said the expectation was for the staff to be mindful in scanning the residents' rooms for any medication to ensure resident safety. He said he would coordinate with the DON and the ADON on what to do so the issue discussed would be addressed. In an interview on 12/16/2025 at 9:36 AM, the DON stated no medications should be stored inside the residents' rooms. She said if Resident #43 needed a nasal spray, the staff should be the one administering it to ensure proper use of the medication and there should be an order for. She said the nasal spray should be stored inside the cart. She said the resident, other confused residents, or a visitor might accidentally use it and could be allergic to it. She said the expectations were for the staff to always scan the residents' rooms to make sure the residents were not storing any medications. She said she would do an in-service about (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication storage. Record review of the facility policy, Storage of Medications Operational Policy and Procedure Manual for Long-Term Care revised April 2007 reflected Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . Policy Interpretation and Implementation . 2. The nursing staff shall be responsible for maintaining the medication storage . 10. Only persons authorized to prepare and administer medications.		