

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: 675592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER C C Young Memorial Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4849 W. Lawther Dr. Dallas, TX 75214	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 13 residents (Resident #67, and Resident #146) reviewed for rights. The facility failed to ensure the staff in the main dining room served Resident #67, and Resident #146, at the same time the other residents were served the lunch meal. These failures could place residents at risk of feeling like their dignity was being violated or the facility was not their home. Findings included: Record review of Resident #67's admission MDS assessment, dated 04/29/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #67 had diagnoses which included: metabolic encephalopathy (change in brain function), dementia (forgetfulness), and hypothyroidism (low thyroid production). Resident #67 had severe cognitive impairment and required assistance of one staff for activities of daily living, including eating assistance. Record review of Resident #146's admission MDS assessment, dated 01/07/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #146 had diagnoses which included: metabolic encephalopathy (change in brain function), dysphagia (swallowing difficulty), chronic kidney disease (kidneys do not fully function), and diabetes (increased sugar levels). Resident #146 had moderate cognitive impairment and required assistance of one staff for activities of daily living. Observation on 01/13/2026 beginning at 12:05 p.m. revealed the other residents at Resident #67's table were served their lunch meal at the table where she was sitting. As the other residents received their meals they began to eat. Resident #67 continued to sit at the table watching the other residents eat. There was a staff member assisting another resident to eat right next to Resident #67, as she sat there and watched. Observation on 01/13/2026 at 12:09 p.m. revealed the other residents at Resident #146's table had begun to receive their lunch meals. The staff served the entire table of residents except Resident #146. Resident #146 continued to sit at the table and watch the other residents eat their meals. Observation on 01/13/2026 at 12:22 p.m. revealed Resident #146 was served her lunch meal. Observation on 01/13/2026 at 12:28 p.m. revealed the staff serving Resident #67 her lunch meal. In an interview on 01/13/2026 with Resident #146 at 12:30 p.m. revealed that the resident could understand but could only nod yes and no. The Resident communicated that she was new here, but she had been getting her meal with the rest of the residents off and on. The Speech Therapist, sitting with the resident, stated she was working with the resident concerning her swallowing difficulty. The Speech Therapist stated she works with the resident one to two meals each day and the meals are served inconsistently to the table. Sometimes Resident #146 must wait to be served while the other residents have their meal served, and other times, she has her meal. In an interview and record review on 01/13/2026 at 12:35 p.m. Resident #67 revealed she did not want the chicken pot pie the main meal, Resident #67 stated she wanted a sandwich. Review of Resident #67's meal ticket showed the chicken pot pie marked off and the sandwich checked. Resident # 67 stated she could not recall when she had changed her mind. Resident #67 stated she did not like sitting at the table watching someone else eat their food. An (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 01/13/2026 with Unit Manager B at 12:45 p.m. revealed that all residents at the same table should be served at one time. This prevents residents from sitting watching the other residents eat their meal. Unit Manager B stated that sometimes that does not happen because the kitchen does not serve the trays out that way. Unit Manager B stated that it is the residents' rights, and the serving line and specialty service (alternate items) need to be better coordinated to get all the residents in the dining room served appropriately. An interview on 01/13/2026 at 1:11 p.m. with the Administrator revealed the residents have a specialty menu also, that they can choose foods from, indicating this could cause a resident to have to wait for their food. The Administrator stated the staff will be trained when the meals are served in the dining room all the residents at one table should be served at the same time. In an interview on 01/14/2026 at 1:16 p.m. DON revealed when servicing meals in the dining room all tables should be served at the same time. The DON stated even if another resident joined the table later or ordered a specialty item the tray should be brought to that resident when they joined the table. It is the right of the residents to not have to sit at the table and watch someone else eat, when they have nothing to eat themselves. In an interview on 01/13/2026 at 1:45 p.m. CNA C revealed that all residents at the same table should be served their meals at the same time, but the kitchen does not send them out to the tables that way. The CNA said they can ask for the trays; the kitchen sends out the trays as they serve each ticket. The CNA stated she did not know if there was any organization to the process. CNA C stated it is the right of the residents to not have to sit and watch another resident eat, and they have been trained about that. Record review of Policy titled The Dining Experience revised dated 2023 reflected The dining experience will be person centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutrition and/or special dietary needs and for preferences and are served at a safe and appetizing temperature. Procedures: . 13. individuals at the same table will be served and assisted at the same time.		

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, and record review the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the resident through the means other than a postal service for 7 of 7 residents reviewed for rights to forms of communication with privacy. The facility failed to deliver mail to the resident within twenty-four hours of delivery on premises or the facility's post office box according to their policy. This failure could place residents at risk of not receiving mail in a timely manner and could result in a decline in residents' psychosocial well-being and quality of life During a confidential group interview, 5 of 7 residents stated mail was not distributed at the facility on Saturdays. 2 of 7 residents stated mail was never distributed to them. 1 of the 7 confidential residents stated mail was distributed to her whenever they felt like it. The residents stated they were unaware who was responsible for distributing mail. In an interview on 01/14/2026 at 1:30 p.m. with the Admin she stated that Life Enrichment is responsible for delivering mail. She stated that Life Enrichment also delivers mail on the weekend as well. She stated that the package deliveries usually go directly to the resident. In an interview on 01/14/2026 at 2:10 p.m. with the Life Enrichment manager revealed that her staff delivers mail within 24 hours. She stated that mail that comes in on Saturday is delivered on the following Monday. She stated that there may be a time when the mail is delivered to another of the 7 buildings on the campus. She stated it may take a while for the mail to make it to this building, but her team delivers it to the Residents as soon as they get the mail. In an interview on 01/14/2026 at 3:00 p.m. with the ADM revealed her expectation was that the Life Enrichment team was delivering mail on Saturdays. She stated she was unaware that mail was not being delivered and she would get with her staff to confirm mail was to be delivered on Saturdays as well as Monday-Friday. Record review of the facility's Mail Delivery Policy revised 07/17/2019 reflected: Policy Statement: Mail will be delivered Monday through Saturday excluding federal holidays by a member of the Life Enrichment Staff or representative. Life Enrichment Staff will ensure that all personal resident mail is delivered to the appropriate party in a timely matter (within 24 hours). All informal mail will be delivered directly to resident, Examples: Cards catalogues, newsletters, personal correspondence. All formal mail will be either a) forwarded to families b) placed in the family's predetermined location c) delivered to residents who are responsible for their own finances or families agree they are able to manage this mail. Examples are bills letters from insurance companies, information from doctors.(Saturdays) weekend staff will not be responsible for forwarding mail to families or identifying and locating predetermined location. On Saturday s, all formal mail will be put under the door of the Life Enrichment Director, All informal mail will be delivered directly to residents.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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 safety. The facility failed to ensure dietary staff wore appropriate hair and beard restraint while in the kitchen. The facility failed to maintain the sanitizing solution used in the manual dishwashing process at the proper chemical concentration required for effective sanitation. These failures could place residents at risk for contamination, foodborne illness, and infection resulting in possible physical harm to residents receiving the food. Findings included: Observation of the kitchen on 01/13/2026 at 10:32 a.m. revealed the following: Observed the Director of Dining Services walking through the kitchen and interacting with staff, not wearing appropriate hair restraint over his mustache. Observed the Executive Chef walking through the kitchen, interacting with staff, and handling food trays that had food on them not wearing an appropriate hair restraint over his goatee. Observed the Porter, in the kitchen on 01/13/2026 at 10:45 a.m. complete a test of the sanitizing water he was using to clean the dishes and the test strip read zero. Observation of the kitchen revealed the following: Observed [NAME] A, in the kitchen on 01/14/2026 at 10:26 a.m. preparing pie shells not wearing appropriate hair restraint over his mustache. Observed [NAME] B, in the kitchen on 01/14/2026 at 10:32 a.m. transporting trays that had food on them to other areas of the kitchen not wearing a hair restraint appropriately, her braids were hanging out of her hairnet across her forehead. During an interview with the Director of Dining Services on 01/13/2026 at 11:43 a.m., he stated that hairnets were required to be worn in the kitchen, and that a facial hair restraint was only required if approximately one-quarter of the face was covered with hair and only for staff who were cooks or servers. He further stated that staff who were not preparing food were not required to wear facial hair restraints and acknowledged that the impact of not using appropriate hair and facial hair restraints could include contamination of food products in the kitchen. During an interview and observation with the [NAME] on 01/13/2026 at 10:45 a.m., he was asked to check the sanitizing chemicals in the water he was using to manually wash dishes. He used a test strip and compared the strip, which turned orange, to the indicator colors on the test strip container. When asked what the color of the test strip indicated, he stated it showed the temperature of the water and that the water was okay. The color indicator on the test strip container showed that orange represented zero chemical concentration in the water. During an interview with the Executive Chef on 01/13/2026 at 10:48 a.m., he was asked what the test strip indicated, and he stated that the test strip was used to measure the chemical-to-water ratio in the sanitizing solution and to determine whether the concentration of sanitizer in the water was within the acceptable range for proper dish sanitation. He explained that the orange on the test strip meant there were not enough chemicals in the water. During an interview with the Executive Chef on 01/13/2026 at 11:20 a.m., he stated that hairnets were required to cover all the hair on the head, and that facial hair restraints were only required for staff who were cooks or servers. He further stated that staff who were not preparing food were not required to wear facial hair restraints. During an interview with [NAME] A on 01/14/2026 at 10:28 a.m., [NAME] A stated that hairnets were to be worn by everyone who entered the kitchen, and that facial hair restraints were required for beards but not for mustaches. [NAME] A further stated that the impact of not wearing a hairnet could have resulted in hair getting into the food and the food being ruined for service to residents. During an interview with [NAME] B on 01/14/2026 at 10:32 a.m., [NAME] B stated that hairnets were to be worn by everyone in the kitchen, and that staff with facial hair, including mustaches, were to wear facial hair restraints over their facial hair. [NAME] B stated that the impact on residents of staff not wearing required hair or facial hair restraints could have affected residents' psychological well-being and trust in the facility and could have potentially affected the quality of care and services provided. During an interview with the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Executive Chef on 01/14/2026 at 2:33 p.m., he said that he educated the kitchen staff on how to properly test chemicals when manually washing dishes and how often it needed to be completed. Record review of the facility's Food Storage Policy, dated with no month, 2023 revealed, All employees will: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. The surveyor did not receive a facility policy addressing the required chemical concentration level for manual dishwashing. Review of the U.S. FDA Food Code 2022 reflected: 2-402 Hair Restraints 2-402.11 Effectiveness (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one of four (CNA A) staff members and two of ten residents (Resident #27 and #103) reviewed for infection control procedures. CNA A failed to perform hand hygiene after direct contact with Residents #27, and #103 while serving meals in the dining room. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #27's admission MDS assessment, dated 4/18/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #27 had diagnoses which included: Coronary Artery Disease (clogged arteries), Heart failure (weak heart), and hypertension (high blood pressure). Resident #27 was severely cognitively impaired and unable to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #103's admissions MDS Assessment, dated 06/25/2025, revealed an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #103 had diagnoses which included: dementia (brain disease that effects memory), hypertension (increased blood pressure), and depression (mental illness). Resident #103 moderately impaired for cognition and unable to make decisions and required one staff for assistance with activities of daily living. Observation on 01/13/2026 beginning at 12:05 p.m., revealed CNA A had entered the dining room, and did not use hand sanitizer. CNA A served a lunch tray to Resident #103, touched the table in the dining room, touched the hand and shoulder of Resident #103 and prepared the meal tray for the resident to eat the lunch. CNA A did not have gloves on. CNA A was observed not to wash her hands or use hand sanitizer, available in the serving area. Observation on 01/13/2026 beginning at 12:05 p.m., revealed CNA A was observed to serve Resident #27 a bowl of soup, stepped away, went and obtained a drink from the refrigerator for Resident #27, signed the drink out on a log next to the refrigerator and then took it to Resident #27. CNA A returned to the serving line not washing her hands or using the hand sanitizer. Further observation at 12:15 p.m. revealed CNA A served the lunch meal to Resident #27 without washing hands or using hand sanitizer. She did not complete hand hygiene before going to the next resident. Further observation revealed Unit Manger B instructing CNA A to use hand sanitizer at which time the CNA did so. In an interview on 01/13/2026 at 12:45 p.m. CNA A stated she did not complete hand hygiene after having direct contact with residents. CNA A stated she was supposed to use the hand sanitizer in between serving each tray. CNA A said she had been educated on completing hand hygiene. CNA A stated she did not sanitize her hands, because she was trying to get the lunch meal served, so the residents would be happy. An interview with the DON on 01/14/2026 at 1:16 p.m., revealed that all staff must complete hand hygiene after having contact with residents. He stated all staff were trained to wash their hands with soap and water prior to tray service, then use hand sanitizer between each tray. The DON stated if the staff do not use appropriate hygiene, they can spread germs to the residents and themselves. Record review of an in-service log dated 12/07/2025 revealed CNA A received handwashing and hand sanitizing training, to prevent the spread of infection. Further review of in-service logs revealed an in-service conducted on 01/13/2026 reflected: when passing trays in the dining room, sanitize after serving every tray. CNA A received this training after surveyor intervention. Record review of the Facility's Policy titled Handwashing/Hand Hygiene revised October 2023 reflected: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative Practices to Promote Hand Hygiene 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indications for Hand Hygiene 1. Hand hygiene indicated: .d. after touching a resident; e. after touching the residents environment; .		