STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676215	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation & Wellness Centre of Dallas LLC	4200 Live Oak St Dallas, TX 75204

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 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 ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences one (Resident #1) of one resident reviewed for quality of care. The facility failed to ensure Resident #1's oxygen liter flow rate matched the physician's orders. This failure could place residents at risk of not receiving appropriate treatment and care, and decreased quality of life and overall health.Findings included: Record review of Resident #1's face sheet, dated 09/27/2025 revealed an [AGE] year-old male, originally admitted on [DATE] and readmitted on [DATE], with diagnoses including iron deficiency anemia (low blood iron levels), cerebral infarction (stroke), other symptoms and signs involving cognitive function following cerebral infarction, muscle weakness, protein-calorie malnutrition, alcoholic cirrhosis of liver without ascites (scarring and damage to the liver due to heavy alcohol consumption), vascular dementia (dementia cause by brain damage form impaired blood flow), gastro-esophageal reflux disease (chronic condition where stomach acid flows back into the esophagus), dysphagia (difficulty swallowing), apraxia (neurological condition causing difficulty to make certain movements), hypertension (high blood pressure), cognitive communication deficit, dysarthria and anarthria (difficulty using muscles for speech and producing speech sounds), paroxysmal atrial fibrillation (type of irregular heartbeat), and history of transient ischemic attack (temporary blockage of blood flow to the brain). Record review of Resident #1's MDS assessment, dated 07/20/2025, revealed he had a BIMS (brief interview for mental status) score of 04 (indicating severe cognitive impairment) and an active diagnosis of chronic obstructive pulmonary disease (lung condition caused by damage to the lungs that causes inflammation, limiting airflow). Record review of Resident #1's care plan, last review/revised on 07/18/2025 revealed the resident had the potential problem of resident has the risk for shortness of breath related to COPD, the problem start date was 12/26/2022. Record review of Resident #1's hospital discharge documents, dated 09/18/2025 and 09/19/2025, with discharge instruction summary revealed the resident had a discharge diagnosis of pneumonia. Other instructions included Disposition: Transfer to hospice facility. Oxygen: Continue NC 3 L/min for comfort. Antibiotics discontinued as focus has shifted to comfort care . Continue comfort-based measures only. Record review of Resident #1's hospital progress notes dated 09/19/2025 revealed on 09/18/2025 at 20:03 (8:03 PM), Resident #1's oxygen was changed from 3 LPM (via nasal cannula) to 2 LPM (via nasal cannula). The comment on the progress note reflected O2 Waned (weaned) RN notified RN notified RN notified - by 1L. The record showed the oxygen was kept at 2 LPM, with the last recorded time at 09/19/2025 at 18:09 (6:09 PM). Resident #1's oxygen saturation level was measured at 99-100% while he was on 2 LPM. Record review of Resident #1's progress notes on 09/19/2025 at 19:25 (7:25 PM) by LPN B reflected: Resident arrived to floor via ambulance stretcher. He is admitted LTC with diagnosis PNA. VS taken B/P 98/60 T96.9 P69 R16 SAT 97%. Resident is wearing oxygen @ 3LNC. Record Review of Resident #1's physician's orders reflected:Order: Oxygen at [_3_] LPM via N/C; Directions: every shift for For SOB and to maintain pulse ox > 90% per protocol; Start Date: 9/20/2025 06:00. Record review of Resident #1's progress note dated 09/20/2025 and created at 05:36 (5:36 AM) reflected: Resident is on follow up for readmit back to facility. Adjusting well back to facility. Staff assist with incontinent care and ADL's Remain on O2@3L via N/C. Continues to be NPO at this time. Hospice Confirmation is pending. Record review of Resident #1's progress notes dated 09/20/2025 created at 21:20 (9:20 PM) by LPN A reflected: This nurse did rounds on resident around 1500 and saw that resident's eyes were opened and looked at this nurse when his name was called, but he did not say anything. Cont to (be) on oxygen per n/c at 2LPM. During an interview on 09/27/2025 at 3:19 PM with LPN A revealed that she had came to work on 09/20/2025 and did her rounds at 3:00 PM. She said she had seen Resident #1, and he was on oxygen at 2 L/min via nasal canula. When asked who ordered the 2 L (per min), LPN A stated she assumed the doctor did because that was what the resident was on when she got to the facility. She said when she did her rounds at (3:00 PM), Resident #1 was fine. She said she looked at him and he raised his eyes at her. She further stated he was not in distress at that time, and he had just gotten done being changed and he was fine. LPN A stated she did not check the oxygen order for the resident, when she saw it was on it (2 L/min) that was what she left it at. She stated the facility had standing orders for oxygen for anyone with low saturation (oxygen levels) and did not check to see if there were written orders for oxygen