STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews, and record reviews, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Residents #1 and #2) of ten residents reviewed for call lights. 1. Resident #1 was observed in bed (closest to the door) and her call light was observed hung on a dresser drawer beside the bed closest to the window separated by a wheelchair and privacy curtain. 2. Resident #2 was observed in bed and her call light was rolled up and hung on the wall between Resident #2's bed and the bed closest to the window. These failures could place residents at risk of not having their needs and preferences met and a decreased quality of life. Finding included: Record review of Resident #1's Face Sheet dated 10/18/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: unspecified intracapsular fracture of right femur, (hip fracture) fall on same level from slipping, tripping and stumbling without subsequent striking against object, nontraumatic chronic subdural hemorrhage (collection of blood on the brain's surface), and nondisplaced avulsion fracture (chip fracture) of right talus (bone in foot that connects the ancle to the leg). Record review of Resident #1's baseline care plan dated 10/11/2024 reflected, substantial / maximum assist for eating, hygiene, toileting, showers, dressing, bed mobility, and transfers. She was incontinent of bowel and bladder and cognition reflected impaired and confused. Resident #1 had a history of falls and call light was noted as a safety device used. Record review of Resident #1's progress note, dated 10/11/2024 at 9:38 PM reflected, At [8:00 PM Resident #1] was admitted to the facility from [hospital], DX FOR FALL WITH acute chronic intracranial subdural hematoma, this nurse welcome patient to the facility and instruct patient to always use the call button to call for help to prevent fall, call light at reach and bed on lowest position and will continue to monitor. Record review of Resident #1's fall risk assessment dated [DATE], reflected a sore of 50, which indicated a high risk for falling. (continued on next page)

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
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Face Sheet dated 10/18/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: acute kidney failure (kidneys stop working suddenly), hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting non-dominant left side (one side paralysis), diabetes mellitus (a group of diseases that affect how the body uses sugar), hypomagnesemia (low level of magnesium), muscle weakness, unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), and hypertension (high blood pressure). Record review of Resident #2's significant change MDS, dated [DATE], reflected a BIMS score of 3 which indicated severe cognate impairment. Functional abilities included dependent for toileting, hygiene, dressing and transfers. She was always incontinent of bowel and bladder. Resident #2 had a history of falls in the last month. Record review of Resident #2's care plan dated 09/19/2024 reflected, [Resident #2] demonstrates desire and behavior to lay prone on floor mat for comfort to sleep. Intervention: Anticipate and meet the resident's needs. [Resident #2] will allow staff to assist to desired position on floor mat for rest periods. Focus: [Resident #2] is High risk for falls. [Resident #2] has had an actual fall without injury. Interventions: Be sure [Resident #2's] call light is within reach and encourage the (sic) her to use it for assistance as needed. He (sic) needs prompt response to all requests for assistance. Fall mats to be placed bedside (sic). Record review of Resident #2's fall risk assessment dated [DATE], reflected a sore of 60, which indicated a high risk for falling. In an interview and observation on 10/18/2024 at 9:45am, Resident #3 said Resident #1 recently came to the facility after falling at home and required a lot of assistance. Resident #1 was observed in her bed (lowest position) and Resident #3 was in his wheelchair beside his bed closest to the window. This state surveyor asked Resident #1 if she used her call light to ask for assistance when she needed it, she said she did. Resident #3 said staff always told Resident #1 to ring the call light when she needed assistance. When asked where Resident #1's call button was, Resident #1 looked around and said she did not know. Resident #3 said he was looking for it too. This state surveyor pointed out to both Residents #1 and #3 that the call light was hung on a dresser drawer beside the bed closest to the window separated from Resident #1 by a wheelchair and privacy curtain. Resident #3 then pressed the call button. In an interview on 10/18/2024 at 9:50 AM, LVN A said Resident #1 was a fall risk and came to the facility after falling at home. She said Resident #1's call light should be in her reach so she could call for assistance when she required it. She said she rounded at least every two hours as did the CNAs. She said she was not sure why the call light was not placed in Resident #1's reach. An observation on 10/18/2024 at 9:55 AM revealed the Director of Therapy responded to the call light that was lit outside Resident #1's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/18/2024 at 10:13 AM, the Director of Therapy said she noticed Resident #1's call light while she was passing this state surveyor and LVN A in the hall. She said she went to respond to the call light. She said when she went into Resident #1's room, the call button was wrapped around the bedside table on Resident #3's side of the room and not accessible to Resident #1. The Director of Therapy said Resident #1 was new to the facility and was a fall risk and should have access to her call button to ensure her safety and that she could call for assistance if she needed to. In an interview on 10/18/2024 at 10:20 AM, the DON stated Resident #1 came to the facility from the hospital and was a fall risk. She said she should always have access to her call light to ensure she could get any assistance she might need. The DON said she expected call lights to be placed within reach of all residents. In an interview on 10/18/2024 at 12:25 PM, CNA B said she did not notice Resident #1's call light was not in her reach. She said residents needed to have access to their call light to call for assistance. An observation on 10/18/2024 at 1:10 PM revealed, Resident #2 in bed (lowest position). Resident #2's call light was rolled up and hung on the wall between Resident #2's bed and the bed closest to the window. In an interview on 10/18/2024 at 1:13 PM, LVN C said Resident #2's call light should be in her reach. She said the CNAs just put Resident #2 down to sleep and they must have forgotten to place the call light. She said she was not sure which CNAs. LVN C said all residents needed to have access to call lights, regardless if they used them or not, to ensure their needs were met and they had a means to call for assistance. In an interview on 10/18/2024 at 1:22 PM, the Social Worker stated residents should have access to call light to ensure their needs were met. She said all staff were responsible to ensure call lights were placed within reach of residents. In an interview on 10/18/2024 at 2:06 PM, CNA D said she did not put Resident #2 down to nap, so she did not know why the call light or fall mats were not placed. She said all residents should have access to call lights to prevent accidents because residents would try to get up on their own if they cannot call for assistance. She said she was trained on these but did not recall when the last in-service was. In an interview on 10/18/2024 at 3:15 PM, the DON repeated that she expected all staff to round at least every two hours and check that call lights were in reach of residents to ensure resident's safety. She said she rounded randomly as a follow up but all staff were responsible to ensure resindets were safe. In an interview on 10/18/2024 at 3:05 PM, the VP/acting ED said the facility did not have a policy that directly addressed call light placement. Record review of the facility's policy titled, Falls and fall risk, managing, revised March 2018, reflected, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Accidents and hazards - investigating and reporting, revised July 2017, reflected, .3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one resident (Resident #2) of ten residents reviewed for care plans. The facility failed ensure Resident #2's care plan was followed to ensure fall mats were placed on either side of Resident #2's bed while she was in it. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #2's Face Sheet dated 10/18/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: acute kidney failure (kidneys stop working suddenly), hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting non-dominant left side (one side paralysis), diabetes mellitus (a group of diseases that affect how the body uses sugar), hypomagnesemia (low level of magnesium), muscle weakness, unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), and hypertension (high blood pressure). Record review of Resident #2's significant change MDS, dated [DATE], reflected a BIMS score of 3 which indicated severe cognate impairment. Functional abilities included dependent for toileting, hygiene, dressing and transfers. She was always incontinent of bowel and bladder. Resident #2 had a history of falls in the last month. Record review of Resident #2's care plan dated 09/19/2024 reflected, [Resident #2] demonstrates desire and behavior to lay prone on floor mat for comfort to sleep. Intervention: Anticipate and meet the resident's needs. [Resident #2] will allow staff to assist to desired position on floor mat for rest periods. Focus: [Resident #2] is High risk for falls. [Resident #2] has had an actual fall without injury. Interventions: Be sure [Resident #2's] call light is within reach and encourage the (sic) her to use it for assistance as needed. He (sic) needs prompt response to all requests for assistance. Fall mats to be placed bedside (sic). Record review of Resident #2's fall risk assessment dated [DATE], reflected a sore of 60, which indicated a high risk for falling. An observation on 10/18/2024 at 1:10 PM revealed, Resident #2 in bed (lowest position) no fall mats on either side of the bed. The fall mats were observed folded up and leaned against the window wall of the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/18/2024 at 1:13 PM, LVN C said there should be fall mats on either side of Resident #2's bed because Resident #2 had a history of crawling from her bed to the floor to sleep. She said the CNAs just put Resident #2 down to sleep and they must have forgot to place the call light and fall mats. She said she was not sure which CNAs. In an interview on 10/18/2024 at 1:22 PM, the Social Worker stated Resident #2 was a fall risk and needed to have fall mats on either side of her bed when she was in bed. She said nursing and therapy staff provide training on fall interventions but was not sure when the last training was provided. In an interview on 10/18/2024 at 2:06 PM, CNA D said she did not put Resident #2 down to nap, so she did not know why the fall mats were not placed. She said fall matts needed to be in place to ensure Resident #2's safety. She said she was trained on these but did not recall when the last in-service was. In an interview on 10/18/2024 at 3:15 PM, the DON repeated that she expected staff to round at least every two hours and check that fall interventions were in place. She said all staff were responsible to ensure residents were safe and their needs were met. The DON said she rounded as well to check on residents. She said Resident #2 required a fall mat on either side of her bed because she had a history of crawling from her bed to the floor to sleep. Record review of the facility's policy titled, Falls and fall risk, managing, revised March 2018, reflected, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Record review of the facility's policy titled, Accidents and hazards - investigating and reporting, revised July 2017, reflected, .3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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** 35152 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #2) of ten residents reviewed for accidents. The facility failed to ensure fall mats were placed on either side of Resident #2's bed while she was in it. Resident #2 was observed in bed (in the lowest position), closest to the door and fall mats were observed folded and leaning against the window wall across the room. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #2's Face Sheet dated 10/18/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: acute kidney failure (kidneys stop working suddenly), hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting non-dominant left side (one side paralysis), diabetes mellitus (a group of diseases that affect how the body uses sugar), hypomagnesemia (low level of magnesium), muscle weakness, unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), and hypertension (high blood pressure). Record review of Resident #2's significant change MDS, dated [DATE], reflected a BIMS score of 3 which indicated severe cognate impairment. Functional abilities included dependent for toileting, hygiene, dressing and transfers. She was always incontinent of bowel and bladder. Resident #2 had a history of falls in the last month. Record review of Resident #2's care plan dated 09/19/2024 reflected, [Resident #2] demonstrates desire and behavior to lay prone on floor mat for comfort to sleep. Intervention: Anticipate and meet the resident's needs. [Resident #2] will allow staff to assist to desired position on floor mat for rest periods. Focus: [Resident #2] is High risk for falls. [Resident #2] has had an actual fall without injury. Interventions: Be sure [Resident #2's] call light is within reach and encourage the (sic) her to use it for assistance as needed. He (sic) needs prompt response to all requests for assistance. Fall mats to be placed bedside (sic). Record review of Resident #2's fall risk assessment dated [DATE], reflected a sore of 60, which indicated a high risk for falling. An observation on 10/18/2024 at 1:10 PM revealed, Resident #2 in bed (lowest position) no fall mats on either side of the bed. The fall mats were observed folded up and leaned against the window wall of the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676474	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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	In an interview on 10/18/2024 at 1:13 PM, LVN C said there should be fall mats on either side of Resident #2's bed because Resident #2 had a history of crawling from her bed to the floor to sleep. She said the CNAs just put Resident #2 down to sleep and they must have forgot to place the call light and fall mats. She said she was not sure which CNAs. She said all residents needed to have access to call lights to ensure their needs were met. In an interview on 10/18/2024 at 1:22 PM, the Social Worker stated Resident #2 was a fall risk and needed to have fall mats on either side of her bed when she was in bed. She said nursing and therapy staff provide training on fall interventions but was not sure when the last training was provided. In an interview on 10/18/2024 at 2:06 PM, CNA D said she did not put Resident #2 down to nap, so she did not know why the fall mats were not placed. She said fall matts needed to be in place to ensure Resident #2's safety. She said she was trained on these but did not recall when the last in-service was. In an interview on 10/18/2024 at 3:15 PM, the DON repeated that she expected staff to round at least every two hours and check that fall interventions were in place. She said all staff were responsible to ensure residents were safe and their needs were met. The DON said she rounded as well to check on residents. She said Resident #2 required a fall mat on either side of her bed because she had a history of crawling from her bed to the floor to sleep. Record review of the facility's policy titled, Falls and fall risk, managing, revised March 2018, reflected, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Record review of the facility's policy titled, Accidents and hazards - investigating and reporting, revised July 2017, reflected, .3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device.