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	04/22/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure that all alleged violations involving misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #1) of five residents reviewed for reporting.The facility failed to ensure a report for an allegation of misappropriation of resident property was submitted within 24 hours to the State Agency after Family Member A alleged Resident #1 was missing property on 01/27/2026.This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.In a record review of Resident #1's face sheet printed 04/22/2026 revealed diagnoses of Malignant neoplasm of unspecified part of unspecified bronchus or lung (a cancerous tumor); Asthma (a chronic, long-term disease); Hodgkin's lymphoma (cancer); Hypothyroidism (underactive thyroid); Neoplastic (Malignant) Related Fatigue (Cancer-Related Fatigue); and Anorexia (a serious, often chronic eating disorder).There was no completed MDS or care plan of Resident #1, due to Resident #1 being in the facility for less than 72 hours prior to passing away.In a record review of Resident #1's progress notes revealed she was admitted to the facility on [DATE] and passed away 01/26/2026. During an interview on 04/22/2026, at 12:47 p.m., LVN A, stated that in January she received a call about a missing diamond ring and she immediately told the prior Director of Nursing and she told her not to worry about it, Administrator A was taking care of it and she never heard about it again.During an interview on 04/22/2026, at 1:04 p.m., Family Member A stated that Administrator A called him on 01/27/2026 and informed him that the ring could not be found. Family Member A reported that during his visit with Resident #1 on 01/25/2026, she had been wearing her wedding ring on her left hand and her anniversary ring on her right hand. He further stated that Resident #1 had lost weight due to her cancer, making the ring easier to remove; however, he indicated it would not have fallen off on its own. He added that he had personally searched through her bedding and clothing but was unable to locate the ring. In a record review of the facility's grievances from 01/2026 through 03/2026 revealed only one grievance related to missing items, submitted by Family Member A on 01/27/2026, regarding a missing anniversary ring. Further review revealed Administrator A indicated that neither he nor staff were able to locate the ring. As a result, the grievance could not be resolved, as the ring remained missing and no individual was identified as responsible.In a record review on 04/22/2026; of TULIP there were no intakes from this facility for this allegation.During an interview on 04/22/2026, at 2:56 p.m., Administrator B stated that Administrator A was no longer employed at the facility. She stated she started working at the facility April 2, 2026. Administrator B stated she had been unaware of the issue but, now that she was, she would initiate an investigation. She said the policy states that an allegation of abuse or neglect needs to be reported within 2-hours or 24-hours if the allegation does (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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not involve abuse and no one was seriously injured.In a record review of the facility's Abuse Investigation and Reporting Policy dated July 2017 revealed, .ReportingAll alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator or his/her designee, to the following persons or agency:The state licensing/certification agency responsible for surveying/licensing the facility;.Law enforcement officials.An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than;Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.