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	05/13/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to review and revise the person-centered, comprehensive care plan for 2 (Resident #7 and Resident #8) of 6 residents reviewed for comprehensive care plan revisions. 1. The facility failed to update Resident #7's care plan for skin laceration to her right toe. 2. The facility failed to update Resident #8 and Resident 8's care plan non-pressure wound to his thigh. This failure could put residents at risk of not receiving the appropriate care, services, or treatments they need.Findings included: 1. Record review of Resident #7's Comprehensive MDS assessment, dated 03/11/2026, reflected a [AGE] year-old female admitted [DATE]. Her BIMS score was a 09, which implied moderate cognition. Her diagnosis included Chronic Obstructive Pulmonary Disease (a progressive, irreversible lung disease that restricts airflow and makes breathing difficult), Parkinsonism (a set of neurological movement disorders characterized by slowness of movement, muscle stiffness, tremors, and balance issues), laceration of right toe. Resident #7's skin and ulcer treatments were noted as pressure reducing device for chair, pressure reducing device for bed, turning/repositioning, and applications of ointments/medications. Record review of Resident 7's Care Plan 08/17/2025 revealed Resident #7 had a non-pressure ulcer to her sacrum. The care plan was not revised to reflect a laceration to her right toe. She received treatment per wound care physician orders. 2. Record review of Resident #8's Comprehensive MDS assessment, dated 03/12/2026, reflected a [AGE] year-old male admitted [DATE]. His BIMS score was a 14, which implied his cognition was intact. His diagnoses included non-pressure ulcer of the right thigh. Resident #8's skin and ulcer treatments were noted as pressure reducing device for chair, pressure reducing device for bed, turning/repositioning and applications of ointments/medications. Record review of Resident #8's Care Plan undated reflected no care plan or interventions addressing his non-pressure ulcer to the right thigh. He received treatment per wound care physician orders. During an observation and interview on 05/12/2026 11:00 a.m., Resident #7 was sitting in a wheelchair in her room. Resident #7 was wearing nonslip slippers. Resident #7 had an air mattress and cushion in her wheelchair. Resident #7 stated that she saw the wound care nurse once a week for her toe and it was healing. During an observation and interview, on 05/12/2026 1:50 p.m., Resident #8 was sitting up in a wheelchair in his room at his computer with a dressing noted near his knee. Resident #8 stated that he was admitted with the wound and that the wound care physician changed his dressing once per week. During an interview on 05/13/2026 at 10:02 a.m., the MDS Nurse stated that during the morning meeting, the nurse staff provided her updates to residents, which would trigger updates to the residents' Care Plan and MDS. The information that would provide a change was new diagnoses, new orders, any change to resident care needs. The MDS nurse stated the DON and the two nurses were always present during morning meetings. The MDS nurse stated that a new skin tear or wound should be placed on resident MDS and Care Plan. She stated that the risk to the resident if their MDS or care plan was not updated would be that they would not be provided the necessary care they require or worse with wound could lead to infection.During an observation on 05/13/2026 at 11:18 a.m., of wound care of resident #8 toe. No concerns with wound (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. During an interview on 05/13/2026 at 11:39 a.m., LVN C stated that if there was a change in resident care, new diagnosis, new orders, or anything that happened with a resident it was discussed in the morning meeting. She stated the reason they informed the MDS nurse was so she could update the resident's care plan. She stated the risk to the residents not having their MDS or Care Plan updated was proper care wouldn't be followed for the residents. During an interview on 05/13/26 at 1049 AM, DON B stated she expected any changes in a resident to be shared with the team during the morning meeting, and for the MDS and Care Plans to be accurate and person centered. She stated that the MDS Coordinator was present for the morning meetings. She stated the ADM was working on getting every department head access so that other disciplines, such as dietary and social services, could contribute to making the care plans. The DON stated if care plans were not accurate, residents may not receive the appropriate care. During an interview on 05/13/2026 at 1:54 p.m., the ADM stated she expected MDS and Care Plans were completed accurately and updated timely with care that was up to date with the resident's conditions. Record review of the facility's Care Planning - Interdisciplinary Team policy dated 09/2013 reflected Our facility's Care Planning/ Interdisiplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 1. A comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review record, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #9) reviewed for personal hygiene. The facility failed to provide Resident #9 with scheduled showers between 12/22/2025 and 03/04/2026. This failure could place residents, who require assistance from staff for personal hygiene, at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections.The findings included: Record review of Resident #9's Discharge MDS assessment, dated 03/04/2026, reflected a [AGE] year-old male admitted [DATE]. His BIMS was not completed, unable to determine his cognition. His diagnoses included Sequelae of Cerebral Infraction, (long-term neurological and physical deficits that persist after an ischemic stroke) Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) affecting left non-dominate side, muscle weakness, lack of coordination, cognitive communication deficit. He was dependent on staff for showering/bathing, upper body dressing, lower body dressing. Record review of Resident #9's Comprehensive Person-Centered Care Plan, 12/24/2025, reflected, Resident #9 had an ADL performance deficit shower days are Tuesday, Thursday and Saturday with the intervention that Resident #9 was totally dependent on staff to provide bed bath/shower as necessary. Record review of the facility's shower sheet book from December 2025 through March 2026 reflect no staff had provided Residents #9 with a shower/bed bath. Record review of facility's grievance log dated February 2026 revealed Resident #9's family member stated no shower had been provided since admission. Record review of facility grievance log dated March 2026 revealed Resident #9's family member stated resident #9 had not received a shower since admission. During an interview on 05/11/2026 at 11:46 a.m., Resident #9's family member stated that Resident #9 passed away while in the hospital, and she revealed she had concerns with the facility. She stated that she had to provide Resident #9 with bed baths since he was admitted to the facility, because the staff would not provide him with a bed bath or shower. She stated that she filed a grievance with the facility in February and March to inform leadership of how the staff was treating Resident #9. She stated that the SW asked her whether it was her personal preference to provide Resident #9 with bed baths and Resident #9 family member stated no that it was not her preference to have to provide Resident #9 with a bath, but it needed to be done. During an interview on 05/12/2026 at 1:25 p.m., CNA D stated that they were assigned to Resident #9's hallway, and Resident #9's shower days were Tuesday, Thursday, and Saturday. CNA D stated bed bound residents received bed baths. She stated that she could not recall if she had provided Resident #9 with a bed bath. She stated that if a resident received a shower or bed bath they documented it on a shower sheet and turned the shower sheet into the nurse. She stated that even if a resident refused a shower or bed bath, they documented the resident refused. CNA D stated that if a sheet was not provided either the aide had forgotten to document on the sheet, may have forgotten to turn the shower sheet in or did not provide shower to the resident. She stated if a resident was not provided with a shower, they would become dirty and they had the right to be clean. During an interview on 05/12/2026 at 2:41 p.m., the SW revealed that Resident #9's family member did place a grievance that stated that the facility had not provided a shower or bed bath to Resident #9. The SW stated that she informed the previous administrator and (previous) DON A, and they conducted an impromptu meeting where the family member stated that she provided Resident #9 with showers. The SW stated, during that meeting, she asked was the family member's preference to provide showers and was told by Resident #9's family member that it needed to be done. During an interview on 05/13/2026 at 12:09 p.m., DON B stated her expectation was for residents to be on a shower schedule upon admission. Showers would be provided either Monday, Wednesday, and Friday or Tuesday, Thursday, and Saturday. DON B stated that it was not the responsibly of family members (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to provide shower or bed bath. DON B stated her expectation was for showers to have occurred on the scheduled days, and the risk to residents who did not receive a shower would be skin breakdown and dignity issues. An unsuccessful attempt to call the previous administrator was made on 05/12/2026 at 3:00 pm; left voicemail. No returned call received prior to exit.An unsuccessful attempt to call DON A on 05/12/2026 at 3:05 p.m. left voicemail. No returned call received prior to exit.Record review of the facility's policy, dated February 2018, titled, Bath, Shower/Tub, reflected, the purposes of this procedure are to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that were accurately documented for 1 (Resident #2) of 6 residents reviewed for administration. The facility failed to document, at least once per shift, that the task turn/reposition for Resident #2 was completed. This failure could place residents at risk of developing skin breakdowns.Findings included: Record review of Resident #2's Quarterly MDS assessment, dated 04/27/2026, reflected a [AGE] year-old male admitted [DATE] and readmitted [DATE]. His BIMS score was a 03 which indicated severe cognitive impairment. His diagnoses included Osteomyelitis of Vertebra (serious spinal infection where bacteria or fungi invade the bones of the spine (vertebrae) and often adjacent discs), Sacral and Sacrococcygeal (the sacral region refers to the triangular bone at the base of the spine, formed by five fused vertebrae. The sacrococcygeal region involves the joint connecting the bottom of the sacrum to the tailbone) region, Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) following cerebral infarction (stroke) affecting the right dominant side, non-pressure chronic ulcer of the buttocks with necrosis irreversible death of cells and living tissue) of muscle, pressure ulcer of left buttock, pressure ulcer of right buttock. The resident had two stage four pressure ulcers listed on admission. Resident #2 was dependent on staff for all functional abilities. Record review of Resident #2's care plan, undated reflected, Resident #2 had an ADL self-care performance deficit. Interventions with bed mobility revealed Resident #2 was totally dependent on staff for repositioning in bed as necessary. Record Review of Resident #2's task Turn/Reposition located in Resident #2's EHR for 04/16/26 through 05/13/2026 reflected missing documentation of the task being completed on the following days/ shifts: 04/16/26 - Second and Third shift04/17/26 - Second and Third shift04/20/26 -Third shift04/21/26 - Third shift04/22/26 - Third shift04/23/26 - Third shift04/24/26 - Third shift04/25/26 - Third shift04/26/26 - Third shift04/27/26 - Third shift04/28/26 - Third shift04/29/26 - Third shift04/30/26 - Third shift05/01/26 - Third shift05/02/26 - Third shift05/05/26 - Third shift05/07/26 - Second and Third shift05/08/26 - Second and Third shift05/11/26 - Second and Third shift05/13/26 - Second and Third shift During an interview on 05/12/2026 at 1:25 p.m., CNA D revealed that residents were required to be checked and changed every two hours and, during that time they were turned and repositioned. CNA D stated that they were to chart once per shift in electronic health record CNA D stated that if staff did not chart at least once per shift that they had did turn/reposition that would mean the staff member forgot to document the task or that they had not completed the task. She stated the risk to the resident if task was not documented would potentially lead to skin breakdowns. During an observation and interview on 05/13/2026 at 9:04 a.m., Resident #2 was in bed laying on his left side sleep. Resident #2's family member was at his bedside and stated that the facility did not turn him every two hours as required. She stated they may staff turned him twice per shift, but not every two hours like they were supposed to. During an interview on 05/13/2026 at 13:39 a.m., LVN C revealed the facility policy was to check/change and turn/reposition residents every two hours. She stated that the aides were required to chart in the EHR system at least once per shift. LVN B stated that if it was not charted it did not happen. LVN B stated the risk of staff not documenting residents being checked/changed and turned/repositioned at least once per shift meant that the task wasn't completed and that could cause skin to break down. During an interview on 05/13/2026 at 12:09 p.m., DON B stated that it was her expectation for staff to check/change and turn/reposition every two hours. She stated that staff were required to chart once per shift. She stated if EHR did not show they charted it meant the task was not performed. The DON stated that if the care provided was not documented, the risk to the resident was skin breakdowns or prevention of wounds healing. During an interview on 05/13/2026 at 1:54 p.m., the ADM stated that her expectations were to document for check and change/repositioning (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and turning was once per shift. She stated if it was not documented, it did not happen. The ADM stated that if it was not documented, the risk to the resident would be skin breakdowns and prevent healing of resident who had wounds. Record review of the facility's policy titled Charting and Documentation dated 07/2017 reflected All services provided to the resident, progress toward the care plan goal, or changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record.