STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745056	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern Oaks Therapy and Living Center	3350 Bonnie View Rd Dallas, TX 75216

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 1 of 5 (Resident #1) residents reviewed for resident rights. 1. The facility failed to ensure on 04/17/25, during the overnight shift, that Resident #1's room was without soiled linen placed on the floor and a brown smeared substance was on the wall directly above the soiled linen. 2. The facility failed to ensure on 04/17/25, during the overnight shift, that Resident #1's floor next to his bed was without dried up brown substances and yellow liquid stains. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept and clean environment. Findings included: Record review of Resident #1's Face Sheet dated 04/22/2025 indicated the [AGE] year-old male was admitted to the facility on [DATE] with diagnoses which included Colostomy Status (a surgical procedure where the end of the colon is brought out through an opening in the abdominal wall, allowing waste to be collected in a bag), Hepatic Encephalopathy (a brain disorder caused by the buildup of toxins in the blood due to liver failure or damage), Congestive Heart Failure (a chronic condition in which the heart does not pump blood as well as it should), and End-Stage Renal Disease (a severe condition where the kidneys have permanently lost their ability to function, requiring dialysis or a kidney transplant to maintain life). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15. Under Section H (Bladder and Bowel) revealed Resident #1 had an Ostomy (a surgically created opening on the abdominal wall that allows waste products (stool or urine) to exit the body). Resident #1 was continent of bowel and occasionally incontinent of urine. Resident #1's active diagnoses included heart failure (unable to pump enough blood to meet the body's need), end-stage renal disease, cerebrovascular accident (blood flow to the brain is disrupted), cirrhosis of liver (late-stage scarring of the liver, where healthy tissue is replaced with scar tissue), etc. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan, dated 04/23/25, indicated the resident had a behavior problem related to he removed his ostomy bag multiple times and said, I didn't remove it. Resident #1 removed his ostomy multiple times and said, I hate those bags. The goal was to have no evidence of behavior problems by the next target date of 05/15/2025. Some of the interventions included, administer medications as ordered, monitor/document for side effects and effectiveness; anticipate and meet the resident's needs, assist resident to develop more appropriate methods of coping and interacting; monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes, etc. Record review of Resident #1's Behavior Notes dated 03/23/25 at 7:53 PM the nurse documented, Note Text: NSG applied x3 separate times that the Nursing applied colostomy bags and gave colostomy care, RSDT (Resident) CONT (continue) to remove colostomy bags after care, RSDT denies that he's removing his colostomy bags, NSG attempts to redirect the RSDT with no success. Record review of Resident #1's Behavior Notes dated 04/20/25 at 8:04 PM the nurse documented, NSG applied x3 separate times that the Nursing applied colostomy bags and gave colostomy care, RSDT CONT to remove colostomy bags after care, RSDT denies that he's removing his colostomy bags, NSG attempts to redirect the RSDT with no success, NSG CONT to attempt to reeducate the RSDT on the Pros/Cons of leaving on the colostomy bags/Colostomy care as ordered, RSDT stated that he hates the bags, NSG verbalized understanding but no success on the RSDT leaving colostomy bags on, no change in status. Record review of the photo provided by an anonymous employee showed soiled linen placed on the floor against the wall and directly above the soiled linen was a brown smeared substance on 4/17/25. Record review of the video recording provided by anonymous employee showed dried up brown substances and yellow liquid stains on the floor next to Resident #1's bed on 4/17/25. In an observation and interview on 04/22/25 at 11:20 AM, Resident #1 was observed in his room sitting in his wheelchair eating and watching television. Resident #1's room was clean and organized. Surveyor observed Resident #1's wall and the floor on both sides of his bed as reflected in the photo to be clean without any stains. Resident #1's room did not have any foul odors. Resident #1 stated staff changed his colostomy bag with no issues, and he was unsure if his colostomy bag had ever broken. Resident #1 denied that he had ever attempted to remove his colostomy bag. In an interview on 04/22/25 at 2:00 PM CNA B stated Resident #1's mental status changed based on the days he had dialysis. CNA B stated she had never observed Resident #1's colostomy bag to burst. CNA B stated Resident #1 tended to take his colostomy bag apart on his own. CNA B stated she never asked Resident #1 about it, she just cleaned him up and informed the nurse. CNA B stated she had never had a nurse not go in to change his colostomy bag. CNA B stated they were supposed to place soiled linen in a plastic bag, take it to the soiled linen room, rinse the linen and then place it in the soiled linen barrel for the laundry staff to take to the laundry room. CNA B stated protocol must be followed to prevent contamination. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/22/25 at 2:25 PM CNA C stated she provided Resident #1 his showers and his colostomy bag had never busted. CNA C stated once Resident #1's shower was completed, the nurse changed his colostomy bag. CNA C stated all soiled linen must be placed in a plastic bag prior to transporting it through the facility. CNA C stated if there was any type of bodily fluids, they must rinse the items in the soiled linen closet prior to placing the items in the soiled linen barrel. CNA C stated soiled linen should not be left on the floor of a resident's room to prevent contamination. In an interview on 04/22/25 at 2:50 PM LVN C stated Resident #1's room was kept clean due to him receiving in-room dialysis. LVN C stated Resident #1's colostomy bag was to be changed every three days or as needed. LVN C stated she was trained by the ADON and LVN A. LVN C stated she also observed them work the floor. LVN C stated if linen had bodily fluids, it should be bagged up, rinsed, and placed in the appropriate barrel to be taken to the laundry. LVN C stated if the linen was badly soiled, it should be disposed. LVN C stated soiled linen should never be left out to avoid contamination. In an interview on 04/22/25 at 3:15 PM the ADON stated Resident #1 had instances where he attempted to remove his colostomy bag. The ADON stated they talked with Resident #1 and re-educated him and he denied doing it and would laugh. The ADON stated the content of the colostomy bag would drip on the floor, but she had never witnessed it all over the place. The ADON stated any soiled linen should not be placed on the floor. The ADON stated linen with bodily substances should be placed in a bag, taken to be rinsed in the soiled utility room and then placed inside of the soiled linen barrel for laundry to pick up. The ADON stated if a staff member entered any Resident's room and observed soiled linen on the floor, it could had been rectified with the CNA and the Nurse. The ADON stated not adhering to policy could create a potential contamination. In an interview on 04/22/25 at 3:40 PM the DON stated Resident #1 was impulsive and he was care-planned for removing his colostomy bag. The DON stated Resident #1 was provided a bed pan and he was educated on the importance of not removing his colostomy bag. The DON stated if the linen had bodily substances or blood on it, the linen would be rinsed out before sending it to the laundry. The DON stated staff should not leave soiled linen in a resident's room on the floor. In an interview on 4/23/25 at 09:20 AM HK A stated staff placed soiled linen in a plastic bag, rinsed it and then place it into the soiled linen barrel. HK A stated laundry staff transported the soiled linen barrel to the laundry room. HK A stated she did not handle soiled linen in a Resident's room. HK A stated after staff changed the linen, housekeeping would disinfect the mattresses only. In an interview on 4/23/25 at 9:45 AM LA A stated staff were supposed to bag heavily soiled linen, rinse it to the best of their ability in the soiled linen closet and then place it in the soiled linen barrel for her to transport and wash. LA A stated she had to wash Resident #1's red blanket (in the video) on Tuesday (4/15/25), Thursday (4/17/25) and again yesterday (4/22/25). LA A stated staff should not be placing soiled linen on a resident's floor to prevent contamination. In an interview on 4/23/25 at 10:20 AM LVN D stated all soiled linen should be placed inside of a plastic bag and transported to the soiled linen closet to be rinsed. LVN D stated staff should never leave soiled linen on the resident's floor. LVN D stated they had a soiled utility room where they rinsed the soiled linen and placed it in the soiled linen barrel for laundry to pick up. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/23/25 at 10:42 AM, an anonymous employee stated the room in the photo was Resident #1's room. The anonymous employee stated a nurse told her Resident #1 needed to be changed right before she took the photos on 4/17/25 at 2:11 AM. The anonymous employee stated she worked the 10PM to 6AM shift. The anonymous employee stated she assumed someone placed the sheets in the corner on the prior shift (2PM to 10PM). The anonymous employee stated she was unsure who removed the linen or cleaned the stain off the wall. The anonymous employee stated she did not show or tell anyone present at the facility about the soiled linen. The anonymous employee stated she texted the photos to the on-call phone number. The anonymous employee stated LVN A had the on-call phone and when she spoke to LVN A, LVN A provided her the phone number for the DON. The anonymous employee stated she called the DON, but she did not answer. The anonymous employee stated she only sent the photos to the on-call number. In a re-interview on 4/23/25 at 11:25 AM the DON stated no one had sent her any photos nor video. The DON stated she had not been made aware until the information was with her yesterday (4/22/25). The DON stated she had no clue who placed the items there, or who removed the items and cleaned the wall. In an interview on 4/23/25 at 12:25 PM, LVN B stated no one informed her of soiled linen being observed on Resident #1's floor. LVN B stated soiled linen should be placed in a bag, taken to the soiled linen closet, and rinsed out. LVN B stated bodily substances and vomit should be rinsed, placed in a yellow bag, and placed in the barrel for laundry. LVN B stated she usually did everything herself. LVN B stated she had never arrived to work and saw soiled linen with feces laid out on the floor. LVN B stated not handling soiled linen properly could lead to contamination. In an interview on 4/23/25 at 3:30 PM, the ADM stated he had only worked at the facility for two days. The ADM stated prior to his arrival, he had not been made aware of an issue regarding any photos or video prior to him starting on Monday (4/21/25). The ADM stated there was no knowledge of who placed or removed the sheets, or who cleaned the wall. The ADM stated if an allegation was made of Abuse or Neglect, the Abuse and Neglect Coordinator should be notified and an investigation would be initiated. The ADM stated he attempted to get a statement from the staff member that made the allegation, but she had not answered nor returned his call. The ADM stated if it involved a staff member, they followed the disciplinary process of suspending the staff member. The ADM stated once the investigation was completed, if it was substantiated, the staff member would be terminated. The ADM stated if it was unsubstantiated, the staff member would be allowed to return, coached, and issued a warning. The ADM stated all Resident Rights were to be honored. The ADM stated every resident deserved a clean environment. Record review of the facility's policy Laundry and Bedding, Soiled dated 3-1-2022, revealed . Handling 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Soiled laundry and bedding (e.g., personal clothing, uniforms, scrub suits, gowns, bed sheets, blankets, pillows, towels, etc.) contaminated with blood or other potentially infectious materials is handled as little as possible and with a minimum of agitation. b. Laundry that is contaminated with blood or body substances is placed in leak-proof bags or containers. c. Contaminated laundry is placed in a bag or container at the location where it is used and not sorted or rinsed at the location of use Record review of Residents' Rights Nursing Facilities issued by Health and Human Services and dated April 2019, revealed under Dignity and respect: You have the right to: Live in safe, decent, and clean conditions.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who needed colostomy care were provided such care, consistent with professional standards of practice for 1 of 5 (Resident #1) residents reviewed for ostomies (surgical opening from an area inside the body to the outside). 1. The facility failed to follow their Colostomy-Ileostomy policy as the nursing staff did not document each time colostomy/ileostomy care was provided for Resident #1. 2. The facility failed to ensure Resident #1's physician's order for changing of his ostomy bag (every 3 days), order for cleansing the area (every shift), or the order for emptying the bag (every shift) was reactivated on 04/01/25 when Resident #1 readmitted to the facility from the hospital. These findings placed resident at risk of complications related to a colostomy. Findings Included: Record review of Resident #1's Face Sheet dated 04/22/2025 indicated the [AGE] year-old male was admitted to the facility on [DATE] with diagnoses which included Colostomy Status (a surgical procedure where the end of the colon is brought out through an opening in the abdominal wall, allowing waste to be collected in a bag), Hepatic Encephalopathy (a brain disorder caused by the buildup of toxins in the blood due to liver failure or damage), Congestive Heart Failure (a chronic condition in which the heart does not pump blood as well as it should), and End-Stage Renal Disease (a severe condition where the kidneys have permanently lost their ability to function, requiring dialysis or a kidney transplant to maintain life). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated the resident was cognitively intact with a BIMS score of 15. Under Section H (Bladder and Bowel) revealed Resident #1 had an Ostomy. Resident #1 was continent of bowel and occasionally incontinent of urine. Resident #1's active diagnosis included heart failure, end-stage renal disease, cerebrovascular accident, cirrhosis of liver, etc. Resident #1 had no behaviors and no rejection of care. Record review of Resident #1's Care Plan, dated 04/23/25 indicated Resident #1 had an alteration in gastro-intestinal status r/t Colostomy. Under goals listed [Resident #1] would remain free from discomfort, complications or s/sx related to gastro-intestinal alterations through review date. Under interventions listed avoid activities that involve bending, lifting. Record review of Resident #1's Nurses Notes dated 03/29/25 at 12:36 PM the nurse documented, RSDT (Resident) with S/S of AMS, V/S 142/91 Resp increased to 22, HR (heart rate) at 47, RSDT with purse Lip breathing, Info given to NP [Name], Notified her of the RSDT being 2 hours into Dialysis, N/O (new order) received to send the RSDT to Hospital ER for Eval/Tx., Info applied to PCC and given to dialysis nursing. Record review of Resident #1's eMar (Medication Administration Record) Note dated 3/30/25 at 1:43 PM the nurse documented, Remains at the hospital. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nurses Notes dated 04/01/25 at 1:38 PM the nurse documented, Resident readmitted to the facility under the care of [Doctor]. Resident arrived via a stretcher accompanied by 2 EMS personnel and was transferred to the bed. Resident has a Hx of Alcoholic Cirrhosis of liver, A-fib, CHF, Hepatic Encephalopathy and HTN (Hypertension). Skin assessment was completed with the following issues noted: Permacath to the R-chest with intact dressing and Colostomy bag to the LLQ (left lower quadrant). Resident does not have open areas or redness observed. Respiration is even and unlabored with symmetrical rise and fall of chest, skin warm and dry. NP was notified and medication review was completed with her and agreed to continue with the discharge orders Record review of Resident #1's TAR (Treatment Administration Record) dated April 2025 revealed Resident #1's Ostomy care was discontinued on 04/01/2025. Further review of Resident #1's TAR revealed due to the Ostomy care being discontinued, there were no entries marked as Ostomy care being provided from 04/01/2025 until 04/23/2025. Record review of Resident #1's Order Summary printed on 04/22/2025 did not reveal any Orders related to Ostomy care. Record review of Resident #1's Order Summary printed on 04/23/2025 revealed the below Orders had been reactivated on 04/23/2025: OSTOMY: Change ostomy bag every 3 days every evening shift every 3 day(s) for Ostomy care Order Date: 04/23/2025 Start Date: 04/24/2025 OSTOMY: Clean area around the stoma with soap and water, pat dry, apply skin prep/stoma adhesive. Every 3 days. Every shift for ostomy care. Order Date: 04/23/2025 Start Date: 04/23/2025 OSTOMY: Empty bag q-shift every shift for Ostomy Care Order Date: 04/23/2025 Start Date: 04/23/2025 In an interview on 04/23/25 at 10:20 AM, LVN D stated she followed the Colostomy/Ileostomy Care Policy. LVN D stated they obtained a doctor's order for the necessary care to be provided. LVN D stated she was orientated to the facility's rules and policies by the ADON. LVN D stated the Orders were in PCC under Ostomy Care. LVN D stated they checked the bag, and if the bag needed to be flushed or cleansed, they addressed it. LVN D stated as a nurse, they should document what was addressed with the Resident. LVN D stated they should not leave the stoma exposed because feces may be everywhere. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/23/25 at 11:25 AM, the DON stated Resident #1 was sent out to the hospital on Saturday (3/29/25) and readmitted to the facility on Tuesday (4/1/25). The DON stated Resident #1's Ostomy treatment Orders should had been reactivated when he readmitted to the facility on [DATE]. The DON stated each time staff provided care to a Resident with an Ostomy, they should document the care provided. The DON stated if there were any concerns, staff should notify the NP. The DON stated if something were not documented, one could not confirm if the Nurse provided care or changed the Colostomy bag. The DON stated even though Nurses provided a verbal shift change report, if they were not documenting, her recommendation would be that every Nurse must document because documentation was part of the Resident's care. The DON stated if Nurses were not documenting in PCC when they changed the Colostomy bag or provided care, one would not know the status. In an interview on 04/23/25 at 12:00 PM, the ADON stated Nurses should document each time they changed and inspected the Colostomy bag. The ADON stated when a Resident returned from the hospital, they followed the Orders sent back from the hospital and informed the doctor and NP. The ADON stated the doctor would say resume previous Orders or he would make revisions. The ADON stated with Orders not being restarted, they needed to in-service staff on Orders being re-instated when a resident readmitted to the facility. The ADON stated moving forward, she would educate the nurses on making sure prior Orders were reinstated. In an interview on 04/23/25 at 12:25 PM, LVN B stated once it was reported to her that a resident needed their colostomy bag changed, she changed it. Resident #1 stated any time she was informed Resident #1 needed a colostomy bag, she changed it. LVN B stated Resident #1 had never been left without a colostomy bag especially when receiving Lactulose 3 times a day. LVN B stated sometimes she documented and sometimes she did not. LVN B stated it was a failure on her part for not adhering to policy. LVN B stated without proper documentation, someone coming on after her would not know the status of the resident if there had been any concerns. In an interview on 04/23/25 at 03:30 PM, the ADM stated nurses made sure the Colostomy bag was emptied and assessed the resident to ensure there was no irritation. The ADM stated moving forward, everything for a resident should be documented and there was no way around it. The ADM stated upon a resident's return to the facility, orders must be reinstated or modified. Record review of the facility's policy Colostomy/Ileostomy Care dated 5/11/2012, revealed, Purpose: The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the colostomy/ileostomy care was provided. 2. The name and title of the individual(s) who provided the colostomy/ileostomy care. 3. Any breaks in resident's skin, signs of infection (purulent discharge, pain, redness, swelling, temperature), or excoriation of skin. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The signature and title of the person recording the data. Record review of the facility's policy Charting and Documentation dated 3/1/2022, revealed, All services provided to the resident .shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 2. The following information is to be documented in the resident medical record: . c. Treatments or services performed .