

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  745056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2026
NAME OF PROVIDER OR SUPPLIER  Southern Oaks Therapy and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for 1 of 3 residents (Resident #1) reviewed for discharge. The facility failed to ensure that Resident #1's responsible party was notified of the resident's discharge, following (or at the time of) the issuance of a NOMNC notifying the resident of the end of his Medicare-covered services, before Resident #1, who did not fully understand the contents, signed the notice. This failure could place residents at risk of not having access to available advocacy services, discharge options, and appeal processes, which could result in an unsafe discharge. Findings included: Record review of Resident #1's face sheet, dated 02/06/26, reflected a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included: malignant neoplasm of prostate (prostate cancer) and cognitive communication deficit (difficulty in communication related to cognitive impairments-such as memory and attention). Record review of Resident 1's admission MDS assessment, dated 01/15/26, reflected the resident's BIMS score was 14, which indicated intact cognitive. The MDS Assessment under Section B-Hearing, Speech, and Vision, reflected Resident #1 was usually understood and usually understood others, and had adequate vision. Section GG-Functional Abilities reflected Resident #1 required supervision or touch assistance with most ADLs. Record review of Resident 1's care plan, dated 01/09/26, did not address the resident's need for a representative's involvement in decision making. Record review of Resident #1's EHR on 02/06/26, reflected the facility had a family member listed as the resident's RP. Record review of Resident #1's admission agreement documents, dated 01/14/26, reflected that the documents were signed for Resident #1 by his designated RP. Record review of Resident #1's NOMNC notice, dated 02/02/26, reflected the Administrator notified Resident #1 of the notice on 02/03/26 at 12:44 PM, and the last covered day would be on 02/05/26. The notice reflected that if Resident #1 disagreed with the notice he could appeal the decision. Record review of Resident #1's progress notes, dated 02/03/26 at 12:46 PM by the Administrator, reflected the following: admin, in the presence of the receptionist presented [Resident #1] with a copy of the NOMNC. Last cover day is 2.25.2026 with discharge date as 2.6.2026. [Resident #1] was asked about home health and discharge location. Admin will speak to rehab manager on DME needed. Record review of Resident #1's progress notes, dated 02/04/26 at 3:48 PM by the Administrator, reflected the following: [Resident #1] called his [family/RP] who came to my office while on the phone with the police. [Resident #1] called his [family/RP] and informed her that I threatened to put him out. That never happened. [Resident #1] kept on saying that we were evicting him to which I replied, no sir, you were admitted on a short-term stay, the insurance issued a NOMNC which you signed and didn't appeal, there has been no application for Medicaid submitted and thus you are expected to discharge home on Friday. I had HR manager and Dietary manager with me as witnesses to the conversation. [Family/RP] stated that we</p> <p>(continued on next page)</p>		

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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>cannot put [Resident #1] out, that we must give him 30 days. [Family/RP] was informed that his LCD is tomorrow and that we were able to verify that he has not submitted a Medicaid application for long term stay. [Family/RP] provided my description to the police and then walked away when I informed her that [Resident #1] is expected to discharge on Friday. [Family/RP] replied, No sir, and walked away. Police arrived at the facility. [Family/RP] proceeded to point admin out to th [sic] police. Officers listened to explanation of discharge process. [Family/RP] responded that [Resident #1] was under the influence and not able to make informed decisions. Administrtaor [sic] informed [family/RP] that [Resident #1] is his own responsible party and thus we must speak directly to him. Officers responded that [NAME] [sic] is a civil matter and asked about [Resident #1's] admission and his plans for discharge upon admission. [Family/RP] insisted that officers lay eyes on [Resident #1] which they did. [Resident #1] was awake, alert and oriented when visited earlier. In an interview on 02/05/26 at 2:45 PM, Resident #1's family/RP stated Resident #1 was initially admitted to the facility for rehabilitation and she was told that he could transition to LTC. The family/RP stated she spoke with the BOM about documents needed for LTC, and she was still working on gathering Resident #1's social security card and identification card. The family/RP stated she handled all of Resident #1's business with the facility and signed all documents because the resident was not coherent enough due to being heavily medicated and unable to read well; however, when it came to Resident #1's discharge notice, she was not notified or provided with the document to sign. She stated the facility provided Resident #1 the document to sign without her being present. The family/RP stated Resident #1 called and told her that he had to sign some papers and was being kicked out of the facility. The family/RP stated she went to the facility and was told that she needed to take Resident #1 home with her. The family/RP stated the Administrator was short-tempered and did not explain the discharge process or offer any assistance. The family/RP stated she was still under the impression that Resident #1 could do LTC at the facility. She stated the facility's BOM was previously helping her with the LTC process, but she had not seen her at the facility for several days. In an interview on 02/06/26 at 9:27 AM, the Administrator stated Resident #1 admitted to the facility in January under an HMO policy (a type of health insurance plan that typically requires members to use a specific network of doctors, hospitals, and other healthcare providers), and the facility had to report updates on the resident's condition every 6-7 days until Resident #1 received a NOMNC on 02/02/26. The Administrator stated the discharge plan from the beginning was for Resident #1 to discharge home with family; however, it was never specified which family member. The Administrator stated he called Resident #1 into his office with the receptionist as a witness and explained the NOMNC and appeal process to the resident. The Administrator stated Resident #1's family, who was listed as the resident's RP in the EHR, was not present. The Administrator stated Resident #1 was his own RP and was able to comprehend what was being explained to him regarding the NOMNC when he signed it. He stated he was not sure why Resident #1 was not listed as his own RP in the EHR or why he did not sign his own admission documents. The Administrator stated he knew that Resident #1 understood the NOMNC process because he called and told his family that he was being discharged. The Administrator stated Resident #1's family came to the facility, and he explained the NOMNC process to her, but she tried to bully her way through any conversations about the discharge. The Administrator stated since Resident #1 did not appeal the NOMNC, his last cover date was on 02/05/26, and he needed to either discharge home or switch to private pay because there was no Medicaid application pending. The Administrator stated corporate had already issued Resident #1 a letter notifying him that he was now considered private pay, and Resident #1 tossed the letter aside and stated he did not want it. The Administrator stated Resident #1's family/RP</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for his or her stay at the facility. Nonpayment applies if the resident doesnot submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.f. The facility ceases to operate.4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. Review of the Centers for Medicare and Medicaid Services (CMS) website, <a href="https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/nomncinstructions.pdf">https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/nomncinstructions.pdf</a> reflected in part the following: Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10095.The notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative .</p>		