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 02/15/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for four (Resident #1, #2, #3, and #4) of fifteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #1, #2, #3, and #4's rooms was in a position that was accessible to the residents on 02/015/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #1 Record review of Resident #1's Face Sheet, dated 02/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included contracture (tightening or shortening of the muscles), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body).Record review of Resident #1's Quarterly MDS Assessment (tool used to assess health status), dated 01/01/2026, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS (tool used to assess cognitive status) of 09. The Quarterly MDS Assessment indicated the resident was dependent on staff for eating, hygiene, dressing, bed mobility, and transfer.Record review of Resident #1's Comprehensive Care Plan, dated 01/22/2026, reflected the resident had alteration in musculoskeletal (having to do with muscles, bones, joint, ligaments, and tendons of the body) status r/t contracture and intervention included to be sure call light was within reach. During an observation and interview on 02/15/2026 at 9:29 AM, revealed Resident #1 was observed in her bed, awake. Resident #1's call light was observed lying on the floor. The resident stated she used the call light if she needed to call the staff. She said she did not have the call light and could not find it. She said it was not the first time that she could not find her call light. Resident #2 Record review of Resident #2's Face Sheet, dated 02/15/2026, reflected a [AGE] year-old female admitted on [DATE]. Diagnoses included epilepsy (brain disorder caused by abnormal electrical signals in the brain), muscle wasting, lack of coordination, and unsteadiness of the feet.Record review of Resident #2's Quarterly MDS Assessment, dated 12/21/2025, reflected the resident had severe impairment (resident required significant assistance and support in daily life) cognitively with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident needed assistance for transfer, bed mobility, toileting hygiene, shower, dressing, and personal hygiene.Record review of Resident #2's Comprehensive Care Plan, dated 12/30/2025, reflected the resident had alteration in musculoskeletal status r/t contractures and interventions included to be sure call light was within reach. The care plan reflected the resident was at risk for falls.During an observation and interview on 02/15/2026 at 9:31 AM, Resident #2 was observed in her bed, awake. Her call light was observed coiled on the lowest bed frame and was not within reach. When asked where her call light was, the resident did not reply.During an observation and interview on 02/15/2026 at 9:35 AM, LVN A stated call lights should always be within reach of the residents in case the residents needed to call the staff for assistance. (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: 745056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2026
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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. LVN A was observed going inside Residents' #1 and #2's room. LVN A was observed picking up Resident #'s call light off the floor, she then placed the call light where Resident #1 could reach it. LVN A then went to Resident #2's side of the room removed Resident #2's call light from the frame of the bed and placed the call light within Resident #2 reach. She said staff should make sure that the residents' call lights were within resident before living the room.Resident #3 Record review of Resident #3's Face Sheet, dated 02/15/2026, reflected a [AGE] year-old male admitted on [DATE]. Diagnoses included difficulty in walking, epilepsy, repeated falls, and fracture (broken bone).Record review of Resident #2's Quarterly MDS Assessment, dated 12/10/2025, reflected resident had a severe impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated the resident needed assistance for transfer, bed mobility, toileting, hygiene, shower, and dressing.Record review of Resident #3's Comprehensive Care Plan, dated 01/13/2025, reflected resident had an actual fall on 10/30/2025 and interventions included to be sure call light was within reach. During an observation and interview on 02/15/2026 at 9:34 AM, Resident #3 was observed in his bed, awake. Resident #3 ‘s call light was observed on the floor. The resident stated his call light had been on the floor since morning, and staff had not placed it back to his bed.During an observation and interview on 02/15/2026 at 9:40 AM, CNA C stated she did not notice that Resident #3's call lights was on the floor when she brought the resident's breakfast. She said she should have made sure the call light was within the resident's reach when she left the resident's room. She said the residents used call lights to call the nurse if they needed something. CNA C picked up the call light and placed it within reach of the resident. She said she would also check the call lights of the residents assigned to her if they were within reach of the residents.Resident #4 Record review of Resident #4's Face Sheet, dated 02/15/2026, reflected a [AGE] year-old female admitted on [DATE]. Diagnoses included obesity (excessive accumulation of body fats) and polyneuropathy (damage of multiple nerves).Record review of Resident #4's Quarterly MDS Assessment, dated 12/12/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident needed assistance for dressing, transfer, bed mobility, hygiene, and shower.Record review of Resident #4's Comprehensive Care Plan, dated 01/11/2026, reflected the resident was at risk for fall and interventions included be sure call light was within reach. During an observation and interview on 02/15/2026 at 9:44 AM, Resident #4 was observed in her bed, awake. The resident's call light was observed hanging on the repositioning bar. The resident said the staff would always hang her call light on the repositioning bar, but it was difficult for her to turn just to get the call light. She said she hoped the staff would put it somewhere that would be easier for her to reach it.During an observation and interview on 02/15/2026 at 9:55 AM, CNA D stated call lights were important for the residents because the residents used the call lights to call the staff if they needed something. She went inside Resident #4's room and saw the call light dangling from the bed and that was not within reach of the resident. CNA D took the call light from the railings and asked the resident where she wanted the call light. The resident said to clip it to her side.During an interview on 02/15/2026 at 10:28 AM, LVN B stated she did not notice that Resident #4's call light was not within the reach of the resident. She said if the call lights were not with the residents, then there was no way the residents would be able to make their needs known. She said the residents would use their call lights to call the staff if they needed to be changed, needed a pain pills, or even to refill their pitcher. During an interview on 02/15/2026 at 11:58 AM, the ADON stated call lights were important for the residents because the residents used them to call (continued on next page)

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 02/15/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff when they needed something or needed assistance. She said all the staff were responsible in making sure the call lights were with the residents. She said residents might fall trying to get the call light or trying to go to the bathroom by themselves. She said the call lights were for all the residents, whether dependent or independent. She said the expectation for the staff was to make sure the call lights of the residents were with the residents at all times. She said she would start an in-service regarding the call lights.In an interview on 02/03/2026 at 12:48 PM, the Administrator stated staff should make sure the call lights were within reach of residents in case they needed help. He said sometimes residents would knock the call lights down when they move so the staff should make sure the call lights were secured that even when the residents moved, they would not fall. He said the call lights were for both the dependent and independent residents. He said independent residents might be having a distress and would not be able to call the staff because their call lights were not with them. She said the call lights should be monitored throughout the day by the CNAs and the nurses. He said the ADON already started an in-service for call lights. Record review of the facility's policy, Call Lights: Accessibility and Timely Response revised 01/01/2024 reflected Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance . Policy Explanation and Compliance Guidelines . 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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 02/15/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one (Residents #1) of ten residents reviewed for medication storage. The facility failed to ensure that Resident #1's barrier cream was stored properly and not left on the resident's side table visible and accessible to the resident and other residents on 02/15/2026.These failures could place the residents at risk of misuse of medications and possible adverse reactions.Findings included: Record review of Resident #1's Face Sheet, dated 02/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia (a condition characterized by loss of memory and ability to reason), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body).Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected the resident had a BIMS of 09 which indicated her cognition was moderately impaired. The Quarterly MDS Assessment indicated the resident was incontinent for bladder and bowel.Record review of Resident #1's Comprehensive Care Plan, dated 01/22/2026, reflected the resident was incontinence and goals included the resident would be free from skin breakdown. During an observation and interview on 02/15/2026 at 9:32 AM, Resident #1 was observed in her bed, awake. A tube of barrier cream was observed on top of the resident's side table and was accessible to the resident and others. The resident stated the staff would use the cream when they clean and changed. She said, sometimes, some staff would put it on her side table.During an observation and interview on 02/03/2026 at 10:38 AM, LVN A stated she did not know who left the barrier cream in Resident #1's room. She said the tube should be inside the cart or where the resident could not reach it. She said the residents might use them more than the recommended and could result in skin redness or dryness. She said confused residents might consume cream as well that could result to upset stomach and nausea. LVN A was observed removing the medication and she said she would put it inside the treatment cart. During an interview on 02/15/2026 at 11:58 AM, the ADON stated medications should not be stored inside the residents' rooms because residents might use the medication inappropriately and could result in adverse reactions. She said the tube of wound dressing cream should have been inside the nurse's cart and not within reach of any resident. She said the expectation was for the staff to always scan the rooms of the residents to see if there were medications inside the rooms of the residents. She said she would start an in-service about not leaving any form of medication inside the residents' rooms.In an interview on 02/03/2026 at 12:48 PM, the Administrator stated the expectation was for the staff to be mindful to look around the residents' rooms for any medication for resident's safety. He said residents could consume or use medications inappropriately left at bedside that could result to harm. He said the ADON already started an in-service about medication storage.Record review of the facility's policy, Medication Labeling and Storage 2001 MED-PASS, Inc., no revision date, reflected Policy Statement: The facility stores all medications and biologicals in locked compartments.