

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 04/21/2026
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 3 residents (Residents #1 and #2) reviewed for infection control practices.1. CNA B and CNA C failed to perform hand hygiene before contact, between care, and change of gloves while providing incontinence care to Resident #1 and Resident #2.2. CNA B and CNA C failed to put on PPE while providing incontinence care to Resident#1, who was on enhanced barrier precautions due to having a feeding tube.These failures could place residents at risk of exposure to infectious agents and could lead to the development of infection. Findings included:1. Record review of Resident #1's Comprehensive MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with a readmission of 07/16/24. Resident #1 was cognitively intact with a BIMS score of 15. He had diagnoses which included hypertension (abnormally high arterial blood pressure) and aphasia (a disorder that results from damage (usually from a stroke or traumatic brain injury) to areas of the brain that are responsible for language). He also had a feeding tube.Record review of Resident #1's care plan, dated 01/27/26, reflected: Focus: [Resident #1] Has functional bladder incontinence rule out Confusion, Disease Process, Impaired Mobility. Goal: [Resident #1] will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Check and change Resident#1 every 2-4 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes.Resident#1's care plan dated 01/27/26 reflected: Focus: [Resident#1] on enhanced barrier precaution due to gastronomy tube and wound. Goal: [Resident#1] will remain in Enhanced barrier precautions without complications thru next review. Interventions: Proper signage to be clearly indicated, PPE, including gowns and gloves available outside room, alcohol-based hand rub available at rooms, proper trash can inside residents' room and near exit for discarding PPE prior to exit of the room. Proper use of PPE to be observed, use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi-drug-resistant organism. 2. Record review of Resident #2's Quarterly MDS Assessment, dated 02/26/26, reflected the resident was a [AGE] year-old female, who admitted on [DATE]. Resident#2 was cognitively intact with a BIMS score of 15, and her diagnoses included contractures of the right and the left knee (the permanent, abnormal shortening or tightening of muscles, tendons, skin, or tissues, which causes joint stiffness and restricts movement).Record review of Resident #2's care plan, dated 04/16/26, reflected: Focus: [Resident #2] has bladder incontinence rule out decreased mobility and weakness. Goal: [Resident #2] will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Check the residents during rounds and as required for incontinence. Wash, rinse and dry perineum [the area between the anus and vulva]. Change clothing as needed after incontinence episodes.Observation on 04/21/26 at 12:28 PM revealed CNA B and CNA C went to Resident #1's room to provide the resident incontinence care. CNA B first knocked on the resident's door and then entered the room. Without washing her hands, CNA B put on gloves and put her supplies together. CNA (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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C also entered the room to help, and she also put on gloves without washing her hands. Observation revealed Resident #1 had a gastronomy tube and had an enhanced barrier precaution sign outside the door and PPE was outside the room. CNA B and CNA C did not put on a gown upon entering the room. CNA B proceeded to use wet wipes to cleanse Resident #1's abdominal folds and perineal area (the anatomical region located between the thighs). Her technique was one wipe, one swipe. She wiped down the peri area from inner area towards the outer area. Resident #1 then was turned on his right side, and CNA B wiped the resident's buttocks and thighs from inner area towards the outer area. Resident #1 was wet and had bowel movement. CNA B then removed the soiled brief and discarded it. Without performing hand hygiene or changing her gloves, CNA B took a clean brief and put the clean brief on Resident #1. They then positioned the resident in bed with the call light in reach. They removed their gloves, took the trash, and left the resident's room without washing hands. CNA B took the trash to the soiled closet and without washing her hands she went to Resident #2 room. Observation on 04/21/26 at 12:39 PM revealed CNA B and CNA C went to Resident #2's room to provide the resident incontinence care. CNA B first knocked on the resident's door and then entered the room. She explained the procedure and went to wash her hands and before she could wash her hands, she left the room and went back to Resident#1's room. She came back with another bag of trash she put on the soiled closet and came back to Resident#2 room. Without washing her hands, she put on gloves and put her supplies together. CNA C also put on gloves without washing her hands. CNA B used wet wipes to cleanse Resident #2's abdominal folds and perineal area (the anatomical region located between the thighs). Her technique was one wipe, one swipe. She wiped down the peri area from inner area towards the outer area. Resident #2 then was turned on her right side, and CNA B wiped the resident's buttocks and thighs from inner area towards the outer area. Resident #2 was heavily wet with urine, and CNA B removed the soiled brief and discarded it. Without performing hand hygiene or changing her gloves, CNA B took a clean brief and put the clean brief on Resident #2. CNA B and CNA C then positioned the resident in bed with the call light in reach. Lastly, they removed their gloves, took the trash, and left the resident's room without washing their hands. Interview with CNA C on 04/21/26 at 12:47 PM revealed she knew she was supposed to perform hand hygiene before contact with Residents #1 and #2, between the care, and with each removal of gloves. She also stated they were supposed to wear gowns with Resident #1 who was on enhanced barrier due to gastronomy tube, but she forgot. She stated failure to perform hand hygiene before contact, between care, and after removal of gloves and wearing PPE could lead to contamination and spread of infection. She stated she had done training on hand washing and PPE, but she could not remember when. Interview with CNA B on 04/21/26 at 1:50 PM revealed she was supposed to perform hand hygiene before contact and after care and with each change of gloves, but she did not know she was supposed to change gloves between care since she came from another state and things were different. She stated she was also supposed to wear PPE with Resident#1, who was on enhanced barrier. CNA B confirmed there was an enhanced barrier sign on the door to the room, and PPE was located by the door due to the resident having a feeding tube. CNA B stated she forgot. She revealed she did not change her gloves or wash her hands between the residents. She also revealed she did not change her gloves or wash her hands while moving from handling soiled briefs and then clean briefs. She stated she did not have reason for not doing it. She stated that failure to perform hand hygiene during incontinence care, between residents and wearing of PPE on resident with enhanced barrier signs could lead to cross contamination and infection. She stated she usually forget to wear PPE because she was always in a hurry to get care done. She stated she had not received in-service training on hand washing and infection control in the facility because she was newly hired. Interview with ADON on 04/21/26 at 3:15 PM revealed her expectation was for staff to perform hand hygiene before contact with residents, between care, and when they changed their gloves. The ADON stated she also expected staff to wear PPE before entering resident rooms with signs of enhanced barrier by the door. She stated failure to perform hand hygiene before contact, between care, and change of (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>gloves while soiled could lead to cross contamination and spread of infection. She stated failure to wear PPE before contact with residents on enhanced barrier could also lead to cross contamination. She stated CNA B had been in the facility for three weeks, and she had not received training on infection control. She stated the facility had offered training on hand washing and wearing PPE, and she was not sure whether the two staff were in attendance. Record review of the facility's current Hand Hygiene policy, dated 03/01/22, reflected the following: This facility considers hand hygiene the primary means to prevent the spread of infections.1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.3. Hand-hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) should be readily accessible and convenient for staff use to encourage compliance with hand-hygiene policies 7. Use an alcohol-based hand rub containing at least 62% alcohol: or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents.j. After contact with blood or bodily fluids; A Resident contact .m. After removing gloves.n. Before and after entering isolation precaution settings. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment.9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.Record review of the facility's current Infection Prevention and Control Program policy, dated 1/1/ 24, reflected the following: c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.</p>		