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	05/21/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #1) reviewed for medication errors. The facility failed to administer Resident #1's thyroid medication since she was admitted on [DATE]. This failure could place residents at risk of their medical conditions worsening from lack of treatment. Findings included:Record review of Resident #1's admission MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting the left side of her body and her ability to speak, diabetes, kidney failure, and hypothyroidism (thyroid not producing enough hormones, slowing their metabolism). Her BIMS score was 15, indicating she was cognitively intact. Her Functional Abilities assessment indicated she required assistance with her ADLs. Her Medication assessment reflected that she used insulin daily, and no drug issues were found during review of her medication regimen.Record review of Resident #1's care plan, dated 04/24/26, reflected her need for dialysis but did not reflect her hypothyroidism. Hypothyroidism was listed in her diagnoses on the care plan. Record review of Resident #1's discharge record from her previous nursing home, dated 03/06/26, listed hypothyroidism as one of her diagnoses. The physician's History and Physical reflected she was on Levothyroxine 112 mcg daily for thyroid disorder. Her discharge instructions listed Hypothyroidism, continue levothyroxine, monitor for acute needs, labs per primary care provider. Her medication administration record listed Levothyroxine 112 mcg 1 tablet in the morning for low thyroid. Her physician discharge notes listed hypothyroidism as one of her diagnoses, her medications included levothyroxine 112 mcg in the morning.Record review of Resident #1's CAA worksheet, uploaded to her EHR from the facility's previous EHR program, reflected a date range from 11/01/25 to 05/01/26. Thyroid problem was listed under Other diseases and conditions that can affect appetite of nutritional needs. Under Analysis of Findings, thyroid disease is listed Under Medical Problems that can affect cognition, thyroid disorder is listed. Her care plan, dated 03/24/26, reflected she had hypothyroidism with interventions of give thyroid replacement therapy as ordered, obtain and monitor lab work as ordered. Record review of Resident #1's Admit Assessment for her current facility, dated 03/19/26, did not mention the resident's hypothyroidism. Record review or Resident #1's current medication administration record did not list levothyroxine as one of her medications. In an interview on 05/21/26 at 9:20 AM, the Administrator stated the facility did not have a DON currently and the ADON was not working on this date. In a phone interview on 05/21/26 at 12:35 PM, Resident #1's family member stated when the resident was admitted to the hospital (unrelated to her hypothyroidism), they were asked if the resident had been taking her thyroid medication because her lab work was very elevated, as if she had not been taking it. The family member stated he asked Resident #1 if the facility had been giving her thyroid medication, and she stated she had not had it. In an interview on 05/21/26 at 12:42 PM, the NP stated he was unaware of Resident #1 having hypothyroidism. He stated she exhibited no symptoms of hypothyroidism that would have clued him in. He stated his medical group had assumed care on 05/01/26 when the facility had a change in ownership, and there was no indication of hypothyroidism in her EHR, or that she had been taking levothyroxine. He stated the attending physician must not have reviewed all her records (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	since hypothyroidism was listed as one of her diagnoses. The NP stated he had no explanation of how Resident #1 was not on her thyroid medication. He stated going without her medication could cause several problems, but the resident had not exhibited any symptoms of low thyroid. Phone interview attempt on 05/21/26 at 1:00 PM with Resident #1's physician was unsuccessful, message left. In an interview on 05/21/26 at 1:20 PM, LVN-A stated he was unaware Resident #1 was supposed to be on thyroid medications. He was unaware the resident had hypothyroidism. He stated neither the resident nor the resident's family had mentioned it to him. He stated he did not review the residents' history from the previous facility. LVN-A stated the ADON usually reviews new admissions to ensure all orders were in place. In an interview on 05/21/26 at 1:50 PM, Hospital RN C stated Resident #1's TSH (Thyroid Stimulating Hormone) level was very high. RN C stated he had to administer twice the normal dose of levothyroxine as normal to the resident. He was unable to share what her level was. In an interview on 05/21/26 at 3:30 PM, MA C stated she did not recall ever administering levothyroxine to Resident #1. She stated she did not recall seeing that order at any time . Phone interview attempt on 05/21/25 at 3:45 PM with Resident #1's physician was unsuccessful. Message left. Record review of the facility's Medication Administration policy, dated July 2020, reflected: It is the policy of this facility that medications shall be administered as prescribed by the attending physician