| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 745056 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern Oaks Therapy and Living Center | 3350 Bonnie View Rd<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to notify the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status or need to alter treatment for 1 resident (Resident #1) of 6 residents reviewed for resident rights. The facility failed to notify Resident #1's delegated representative of a change in treatment on 05/13/26 when the physician ordered an antipsychotic medication, Risperidone 1 mg, to be administered twice daily. This failure could place residents at risk of not being able to exercise their rights regarding care, which could lead to harm or decreased quality of life.Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 03/30/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident's BIMS score was 15, which indicated cognition was intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required moderate assistance with most self-care ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident #1's active diagnoses included: bipolar disorder (mental condition that causes extreme mood swings) and schizophrenia (severe mental illness that causes delusions and disorganized thinking). Record review of Resident 1's care plan, dated 05/04/26, did not reflect the resident's need for a representative's involvement in decision making. Record review of a consent for treatment form provided by the DON, dated 05/14/26, reflected Resident #1 signed for consent to be administered risperidone for treatment of schizophrenia/psychosis. Further review reflected the document was not signed by Resident #1's POA/RP. Record review of Resident #1's progress notes, dated 05/15/26 at 7:55 p.m. by PA, reflected the following: History includes:1.On 5/11/26, [Resident #1] exhibited verbal and physical aggression. Nursing staff contacted 911, and responding officers recommended a transfer to [psych hospital] for further evaluation. [Resident #1] was subsequently transported via EMS. [Resident #1] returned to the facility on 5/13/26. While medical records from the hospital visit are currently limited, please note that the following medications were initiated upon her return: amlodipine, cetirizine, risperidone, and proctofoam HC foam. Additionally, guaifenesin, topical hydrocortisone, hydroxyzine, and ondansetron were added on a PRN basis. On 5/14, [Resident #1] also began a lactobacillus probiotic regimen.Subjective: [Resident #1] was observed seated on her rollator walker in the dining room listening to music. [Resident #1] stated that she is doing ?fine' today. When asked regarding her recent hospitalization, [Resident #1] indicated that she was unsure of the reason for her stay. [Resident #1] reports that her chronic pain remains stable. [Resident #1] denied experiencing chest pain, fever, chills, or shortness of breath. Per medical record review, she has not had a bowel movement today. [Resident #1's] plan and progress was discussed with nursing staff and therapy. Record review of Resident #1's progress notes, dated 05/16/26 at 7:36 p.m. by RN A, reflected the following: [Resident #1's POA/RP] has some concerns about [Resident #1] having a reaction to medication and requested to place psych risperidone on hold until she was able to speak to Psych Dr. On call [NP]. was notified and NP request and ordered for education to be provided to [Resident #1's POA/RP] about safety and if [Resident #1] was to have a behavior it could result in resident being transferred out to psych. [Resident #1's POA/RP] stated she understands and<br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medication was placed on hold for 8 days. will continue to monitor for any acute changes. [sic] Record review of Resident #1's active physician orders, dated 06/04/26, reflected in part the following: - risperidone oral tablet 1 mg-give 1 tablet by mouth two times a day for bipolar disorder. Start Date: 05/13/26 Record review of Resident #1's EHR on 06/04/26, reflected the resident had a delegated medical POA and resident representative. Further review of this document did not reflect that a judge deemed Resident #1 incompetent. Record review of Resident #1's MAR, dated 05/2026, reflected the resident's risperidone oral tablet 1 mg was started on 05/13/26 at 9:00 p.m. and held on the following dates and times: -05/16/26 at 9:00 p.m.-05/17/26 at 9:00 a.m. and 9:00 p.m.-05/18/26 at 9:00 a.m. and 9:00 p.m.-05/19/26 at 9:00 a.m. and 9:00 p.m.-05/20/26 at 9:00 a.m. and 9:00 p.m.-05/21/26 at 9:00 a.m. and 9:00 p.m.-05/22/26 at 9:00 a.m. and 9:00 p.m.-05/23/26 at 9:00 a.m. and 9:00 p.m.-05/24/26 at 9:00 a.m. Further review of the document reflected Resident #1's risperidone oral tablet 1 mg was resumed on the following date:-05/24/26 at 9:00 p.m. In an interview on 06/04/26/26 at 9:35 a.m., Resident #1's POA/RP revealed the facility transported Resident #1 to a local psychiatric hospital without notifying her first after the resident had a behavioral crisis. The POA/RP stated Resident #1 was given risperidone which caused her to drool and have slurred speech that. The POA/RP stated the symptoms continued after Resident #1 returned to the facility so she told the nurse to stop the medication until she could find a different doctor because she did not trust the facility's MD. The POA/RP stated it was reported to her that Resident #1 was taken off the medication. She stated she was not aware that it was resumed on 05/24/26 because she had not found a different doctor or spoken with the facility's psych doctor. The POA/RP stated the facility usually notified her regarding Resident #1's care but they failed to inform her that the risperidone was being administered again. The POA/RP stated she never signed a consent form for Resident #1 to start the medication, and she was upset that the resident was taking it without her knowledge. In an observation and interview on 06/04/26/26 at 10:15 a.m., Resident #1 stated she felt okay and denied having any bad symptoms from the medications she took. Resident #1 was not drooling, and her speech did not sound slurred. Resident #1 recalled going to the local hospital but did not know why she went or what medications she was given. Resident #1 also could not recall what new medication she was taking at the facility. Resident #1 stated her family helped her make decisions regarding her care. In an interview on 06/04/26/26 at 2:58 p.m., the MD stated he ordered risperidone 1 mg bid for Resident #1 on 05/13/26 after discharge recommendation from the local psychiatric hospital. The MD stated Resident #1 had a positive response to the medication as she was calmer and able to communicate clearly when he visited her. The MD stated a signed consent form was required before risperidone could be administered and it was the facility's responsibility to ensure that it was completed. The MD stated the former interim DON was very good and he trusted that she had gotten it signed by the appropriate party. In an interview on 06/04/26/26 at 3:16 p.m., the DON stated she has worked at the facility for one week. She stated risperidone was a medication that was required to have a signed consent by the resident or the family if they were listed as representative before it was administered. The DON stated if the resident was able to sign the consent form themselves the family would still be notified with permission from the resident. The DON stated she did not work at the facility when Resident #1 was ordered the risperidone and did not know who was responsible for getting the consent form signed at that time. The DON stated it was important for appropriate consent to be given for psychoactive medications due to the class of medication and black box warnings (serious, life-threatening, or permanently disabling adverse effects) that could come from taking it. In an interview on 06/04/26/26 at 5:06 p.m., the Administrator initially stated Resident #1's family was only listed as the resident's POA for care; however, Resident #1 had a BIMS of 15 and had the capacity to make her own decisions. After checking the chart, the Administrator stated Resident #1's family was also listed as the resident representative. He stated the facility notified the resident representative regarding a resident's care, but they did not have to consent to medical treatment if the resident could do so. Review of the facility's policy titled Psychoactive Medications revised May<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2025, reflected in part the following: POLICY:It is the policy of this facility to maintain every resident's right to be free from use of psychoactive medication. Other alternative measures to manage target behavior will be tried prior to the use of psychoactive medications. PROCEDURES: The use of psychoactive medication must first be explained to the resident, family member, or legal representative. A consent is to be obtained either from the resident or responsible party if resident unable to give. A verbal consent may be obtained if no responsible person is available. The person obtaining the consent is to sign the consent once obtained. The facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. Explain the potential negative outcomes of psychoactive medication, show symptoms of withdrawal, depression, or reduced social contact. |