

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 3 residents (Resident #1) reviewed for resident rights. -The facility failed to accommodate Resident #1's needs by not ensuring that his call light was within reach for him to call for assistance when needed. -The facility failed to accommodate Resident #1's needs by not providing a functional and properly fitted wheelchair to maintain the resident's independence. These failures could place residents at risk of a decline in their dignity and well-being. Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 06/01/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident's BIMS score was 4, which indicated severe cognitive impairment. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 used a manual wheelchair and was totally dependent on staff for most self-care ADLs and mobility. The MDS Assessment under Section I-Active Diagnoses, reflected Resident #1's active diagnoses included: cerebrovascular diseases (disorder that affects blood flow to brain), body mass index of 23.0-23.9, adult (within healthy weight category), seizure disorder (brain disorder that causes involuntary movement), traumatic brain injury (brain injury caused by outside trauma), hemiplegia and hemiparesis (weakness and paralysis that affects one side of the body), and depression (mood disorder). The MDS Assessment under Section K-Nutritional Status reflected Resident #1 was 5 feet 11 inches tall and weighed 166 lbs. Record review of Resident 1's care plan, dated 05/29/26, reflected the resident had an ADL self-care performance deficit r/t physical limitation secondary to Parkinson's Disease, hemiplegia, history of CVA (stroke), and traumatic brain injury. Interventions included: conversing with resident while providing care, explaining all procedures and tasks before starting, praising all efforts at self-care, promoting dignity by ensuring privacy, providing the appropriate level of physical assistance with ADLs, encouraging resident to discuss feelings about self-care deficits, encouraging resident to participate to the fullest extent possible with each interaction, encouraging use of call light for assistance, monitoring, documenting and reporting to MD any potential for improvement and declines in function, and completing skin assessments. Further review of this document reflected Resident #1 had potential for nutritional problems r/t decrease in appetite, protein calorie malnutrition, diabetes mellitus and hyperlipidemia, with a current weight of 166.2 lbs. and a weight 30 days back of 191.9 lbs. Interventions included: a diet as ordered by the MD, honoring resident's rights to make personal dietary choices with education as needed, house supplements as needed, providing meals in dining rooms if resident agrees, monitoring, documenting, and reporting s/sx of malnutrition to MD, obtaining and monitoring labs as ordered, dietitian to evaluate and make diet changes, and weekly weights for four weeks. Record review of Resident #1's therapy evaluation, dated 9/10/25, reflected in part the following: Power (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Chair Eligibility Assessment: Subjective: Pt is [AGE] year-old male with primary diagnosis of encephalopathy and history of brain injury more than 10 years ago. Pt with history of owning power chair, however, denied and removed from facility due to behavioral concerns. Preliminary evaluation completed this date to see if Pt is appropriate for power wheelchair. Pt educated regarding purpose of preliminary evaluation and evaluation videotaped with verbal permission from patient. VII. Assessment Conclusions: Pt presents to skilled preliminary power chair evaluation with noted decreased head control, poor trunk control, decreased motor control of L side of body, decreased functional strength in RUE, decreased bilateral coordination, decreased gross and fine motor coordination, and decreased activity tolerance. In addition, Pt with moderate cognitive impairment with decreased orientation and memory recall. Through observation, Pt with multiple behaviors which impact judgement and impulse control. Due to these observations, Pt is no appropriate for power w/c due to being a safety hazard to self and others with poor judgement, poor safety awareness, poor impulse control, poor insight into deficits, limited motor control, and impaired executive functioning. In addition, Pt currently in custom manual w/c with [brand] cushion that provides appropriate supports meeting all seating and positioning needs. In an observation and interview on 07/08/26 at 10:00 a.m., Resident #1 was observed lying flat in bed with limited ROM of left arm and fingers. Resident #1 had to ask for assistance with zipping his bag. Resident #1 became upset and stated, They do me bad in here! He proceeded to state that he stayed in bed most of the time because he was uncomfortable sitting in his wheelchair. Resident #1 stated the wheelchair was too wide and he was unable to propel himself due to the weakness in his arms. Resident #1 stated staff would push him to one spot and leave him, and the Administrator would not allow his friends to help him, so he was unable to move around like he wanted to. Resident #1 stated he asked for a motorized wheelchair and the facility kept lying to him about getting one. The manual wheelchair was observed in Resident #1's room and was wider and more heavy-duty than an average sized wheelchair. Resident #1 asked for a drink, and when told to use his call light, the resident stated he did not know where it was. The state surveyor searched and found Resident #1's call light clipped to the back of the bed, out of Resident #1's reach. RN A was called into the room, and she observed Resident #1's call light clipped behind his bed. In an interview on 07/08/26 at 10:15 a.m., RN A stated the expectation was for call lights to be always clipped within reach so the residents could call for assistance as needed. RN A stated she did not know why Resident #1's call light was clipped behind his bed and out of reach. She stated she would speak with the aides on her hall to ensure that they understood where the call lights should be placed. In further interview on 07/08/26 at 12:53 p.m., RN A stated she worked at the facility since October 2025 and worked on the 500 hall with Resident #1. She stated Resident #1 required a 2-person assist with care due to behaviors and mobility issues, which was also why it was important for his call light to remain within reach. RN A stated staff were expected to check for call light placement during rounds and anytime they entered resident rooms. RN A stated Resident #1 was transferred out of bed per his request; however, he chooses to remain in bed often. In an interview on 07/08/26 at 1:16 p.m., the DOR stated he worked at the facility since May 2025. He stated Resident #1 was receiving rehab services when he started, and was discharged on 06/22/26, after he exhausted all his Medicare Part A benefits. The DOR stated Resident #1 had a customized manual wheelchair that he refused to use because it was too big for the resident since he had lost weight. The DOR stated Resident #1 requested a motorized wheelchair that he felt might benefit the resident, but he had to be re-evaluated for it. The DOR stated Resident #1 was on the list to be evaluated, but it was taking a while because he was working through the list alone. The DOR stated Resident #1 also needed to be switched to Medicare Part B to get back in therapy. The DOR stated he could help Resident #1 get a (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smaller manual wheelchair, in the meantime if he wanted. In an interview on 07/08/26 at 1:54 p.m., CNA B stated she worked at the facility for 8 years. She stated she worked on 500 hall with Resident #1; however, she was not the only staff who went into his room. CNA B stated she was unaware that Resident #1's call light was clipped to the back of his bed. She stated she checked the placement of call lights during her rounds and ensured that they were within reach of the residents. In an interview on 07/08/26 at 2:21 p.m., CNA C stated he worked at the facility for 2 years. He stated he worked on 500 hall with Resident #1 and described the resident as non-compliant with care and would refuse to get out of bed. CNA C stated when Resident #1 would ask to be transferred out of bed, he would yell to get right back in bed. CNA C stated Resident #1 never told him that the wheelchair was uncomfortable. CNA C stated Resident #1 just had a behavior of yelling and being aggressive towards staff. In an interview on 07/08/26 at 2:32 p.m., the DON stated the expectation was for staff to ensure that call lights were always placed within reach of the residents. The DON stated call light placement was checked during rounds, at least every 2 hours. The DON stated not keeping the call light within reach could place residents at risk of not getting help when needed. The DON stated Resident #1 never reported any concerns about his manual wheelchair to her, and he remained in bed by choice. The DON stated Resident #1 was usually non-compliant with ADLs and did not like to participate in any activities. In an interview on 07/08/26 at 3:28 p.m., the NP stated he visited with Resident #1 yesterday, and there were no reported issues. The NP stated he was not aware that Resident #1's manual wheelchair was not suitable or that it prevented him from wanting to get out of bed. The NP stated it was previously reported that Resident #1 often refused therapy and other activities, but he never attributed it to the wheelchair. The NP stated if the wheelchair was uncomfortable, it would make sense why Resident #1 stayed in bed. The NP stated he would look into this issue during next visit. In an interview on 07/08/26 at 3:51 p.m., the Administrator stated Resident #1 was evaluated for a motorized wheelchair in September 2025 and did not qualify due to physical condition and behaviors. The Administrator stated Resident #1 had a motorized wheelchair previously, and he was a danger to himself and other residents. The Administrator stated the facility recently received new wheelchairs and Resident #1 received one. The Administrator stated he was unaware that the manual wheelchair in Resident 1's room was not suitable for him. The Administrator stated it was possible that the wheelchairs got mixed up when staff were cleaning them because the resident's wheelchair should not be too wide. He stated the resident recently went into the community with family in his wheelchair with no reported issues. The Administrator stated Resident #1 could not propel himself in the manual wheelchair, but it was mostly due to him not wanting to put in the effort. The Administrator stated although Resident #1 did not qualify for the motorized wheelchair in September 2025, it was his right to be re-evaluated if he requested it. The Administrator stated Resident #1 needed Medicare Part B to start therapy again; however, he would follow up with the DOR. Review of the facility's policy titled Resident Rights and Responsibilities, notice of revised February 2025, reflected in part the following: Policy: It is the policy of this facility to inform the resident both orally and in writing of his/her rights as a resident, as well as, the rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility. Further review of this document reflected it did not address call lights. The facility's policies on resident rights (call lights) and quality of care (assistive devices) were requested from the Administrator on 07/08/26 at 2:50 PM and an accessible copy was not provided prior to exit.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the bed rails, mattress, and bed frame were compatible for 2 of 6 residents (Resident #2 and Resident #3) reviewed for physical environment. -The facility failed to provide Resident #2 and Resident #3 with a mattress that was functional, comfortable, and appropriate to their needs. This failure could place residents at risk of not having appropriate furniture to accommodate special needs, which could affect their health, comfort, and safety. Findings included: 1. Record review of Resident #2's Quarterly MDS Assessment, dated 06/16/26, 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 her cognition was intact. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 was totally dependent on staff for most self-care ADLs and mobility. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: cerebrovascular diseases (disorder that affects blood flow to brain), body mass index of 50.0-59.9, adult (severe obesity weight category), and lack of coordination. The MDS Assessment under Section K-Nutritional Status reflected Resident #2 was 5 feet tall and weighed 298 lbs. Record review of Resident 2's care plan, dated 06/30/26, reflected the resident had limited physical mobility and was at risk for falls r/t obesity and lack of coordination. Interventions included: providing supportive care and assistance with mobility as needed, providing appropriate level physical assistance with ADLs as needed, and a therapy referral. Further review of this document reflected there was no focus or interventions r/t bed mobility, safety, or comfort. Record review of Resident #2's physician orders, dated 07/08/26, reflected in part the following: -Pressure-reducing mattress to bed for pressure injury prevention; Start date: 06/30/26. Further review of this document did not reflect an active order for a bariatric mattress or bedrails. In an observation and interview on 07/08/26 at 11:30 a.m., Resident #2 was observed lying in bed. Resident #2 was a bariatric resident. Resident #2 stated she felt unsafe in her bed and had asked multiple times for bedrails, but they were never provided. Resident #2 stated she had not had any falls or other accidents, but she still felt unsafe and uncomfortable. Observation of the bed revealed it was a bariatric bedframe with a mattress that was too large and did not fit properly. The mattress extended approximately 4-6 inches beyond the frame of the bed. Resident #1 stated she was unaware that the mattress was too big for the frame, but that could be why she felt a need for bedrails to keep her from rolling off the side of the bed. Further observation revealed the bed was in the lowest position for a fall intervention and there were no other hazards in the room. 2. Record review of Resident #3's Quarterly MDS Assessment, dated 06/22/26, 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 maximal assistance with most self-care ADLs and supervision assistance for mobility with use of a motorized wheelchair. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: heart failure, respiratory failure, morbid obesity, and muscle wasting and atrophy (loss of muscle tissue). The MDS Assessment under Section K-Nutritional Status reflected Resident #2 was 5 feet 11 inches tall and weighed 355 lbs. Record review of Resident #3's care plan, dated 05/06/26, reflected the resident was at risk for planned or expected weight gain r/t edema (swelling caused by excessive fluid). Interventions included: notifying the MD of increased shortness of breath, escalating edema, increased anxiety, (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inability to lie flat, and change in alertness. Further review of this document reflected there was no focus or interventions r/t bed mobility, safety, or comfort. Record review of Resident #3's physician orders, dated 07/08/26, reflected there was no active order for any type of therapeutic mattress. In an observation and interview on 07/08/26 at 11:48 a.m., Resident #3 was observed sitting in her motorized wheelchair in the room. Resident #3 stated her motorized wheelchair was functional and comfortable; however, she was uncomfortable in her bed. Resident #3 stated the bed was large enough, but the mattress was old and lumpy, which caused increased pain in her back. Resident #3 stated this also disturbed her sleep because she had to constantly toss and turn to find a comfortable spot. Resident #3 stated she had not had any falls or other accidents. Resident #3 stated the mattress was worn down due to her size and she reported this to Administrator, but nothing was done. Observation of Resident #3's bed revealed it was a bariatric bedframe with a properly fitted mattress; however, the mattress was lumpy with an uneven structure. In an interview on 07/08/26 at 12:58 p.m., RN A stated she worked on the 500 hall with Resident #2 and Resident #3. RN A stated both residents were considered bariatric and required a bariatric bed and at least 2-person assist with care. RN A stated she was not aware of any issues with the residents' beds and there were no reported changes in condition. In an interview on 07/08/26 at 2:36 p.m., the DON stated all residents in the facility were considered a fall risk; however, Resident #2 was not a high fall risk. The DON stated Resident #2's bed was kept in the lowest position to prevent any risk of falls with harm. The DON stated she was not aware that Resident #2 had concerns about her safety in bed, and there were no reported issues with her condition. The DON stated she was also unaware of any issues with Resident #3's mattress. The DON stated she made Resident #3's bed because she liked her sheets tucked tightly, but the resident never complained to her about the mattress being lumpy or uncomfortable. The DON stated there were also no reported changes in Resident #3's condition. In an interview on 07/08/26 at 3:35 p.m., the NP stated he was not aware that Resident #2 wanted bedrails on her bed to feel safer, but he was open to assessing her for them. The NP stated he was also unaware that Resident #2 and Resident #3 had issues with their bariatric mattresses. The NP stated concerns for changes in condition and safety would be on his radar if the mattresses were inappropriate due to both residents being bariatric but none had been reported. The NP stated any changes in condition would be specific and possibly different for each resident; however, increased pain and discomfort could be a risk based on the residents' comorbidities. In an interview on 07/08/26 at 4:00 p.m. with the DON and Administrator, the Administrator stated the facility had gotten rid of all rental beds about two weeks ago and this included Resident #2's bed. The Administrator stated Resident #2 received another bariatric bed, but he was unaware that the mattress did not fit properly. He stated the former maintenance director assembled the bed, but failed to inform him that the mattress was too large. The Administrator stated the facility used 42-inch mattresses for the bariatric beds, but somehow Resident #2 had a 48-inch mattress. The Administrator stated he did not know where the 48-inch mattress came from. The Administrator provided the state surveyor with an order form as proof that a new mattress had just been ordered for Resident #2. He also stated the facility had assist rails delivered for Resident #2's bed; however, they were still in the box because they did not fit her bedframe. Regarding Resident #3, The Administrator stated she only reported needing a new mattress after she found that another resident received one. The Administrator stated he checked Resident #3's mattress and did not find any issues. The Administrator stated the facility's management system informed them when it was time to check the beds; however, there was no policy on how often the mattresses had to be changed and it was done as needed. The Administrator stated Resident #3 had the same mattress for years and just recently started complaining. The (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated it was his expectation for all residents to have functional furniture to maintain their safety and well-being. The DON stated being bariatric could place residents at risk for many things, but she refused to provide clinical insight regarding potential risks associated with having an inappropriate bed. Review of the facility's policy titled Safe, Comfortable, Homelike Environment revised 1/2022, reflected in part the following: Policy: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongingsto the extent possible.Procedure1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs andpreferences.2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect apersonalized, homelike setting. These characteristics include:.Personalized furniture and room arrangements;.		