

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

Printed: 07/18/2026
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 09/10/2025
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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure four out of six Residents the right to receive written notice, including the reason for the change, before the resident's room in the facility is changed. The facility did not provide evidence that four out of six Residents was given a written notice of a room change before the resident was moved. This failure could place all residents at risk for being displaced without notice and/or reason and decrease quality of life being in a new environment. Record review of Resident #1 revealed resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of acute congestive heart failure, emphysema, osteoarthritis, morbid (severe) obesity, type 2 diabetes, chronic obstructive pulmonary disease, and chronic respiratory failure. Her MDS dated [DATE] reflected a BIMS score of a 15 which indicated normal thinking and memory, meaning the individual's cognition was intact. Record review of Resident #1 census report dated September 8, 2025, revealed the resident was moved to another room on 06/04/2025. Record review of Resident #1 progress notes with an effective date range of 05/20/2025 to 09/10/2025, indicated no written notification to the resident or representative about why a room change was done. Record review of Resident #1 progress note dated 05/28/2025 social services noted, This writer along with Social Services spoke with the resident about her concerns regarding the room change. It was reiterated to the resident that she will have a roommate due to room consolidations and that she was properly notified beforehand that a room change was going to occur. It was explained to the resident that she must declutter some of the items in her room to ensure proper space for her roommate. The resident was unreceptive to this conversations. Unable to interview Resident #1 as she was discharged to the hospital. Record review of Resident #2 revealed resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, depression, asthma, morbid severe obesity with alveolar hypoventilation (excess body weight puts pressure on the diaphragm and lungs, reducing their ability to expand and take in oxygen), and kidney failure. Her MDS dated [DATE] reflected a BIMS score of a 14 which indicated the resident was cognitively intact and suggesting no or very minimal cognitive impairment. Record review of Resident #2's census report dated September 8, 2025, revealed the resident was moved to another room on 06/04/2025. In an interview on 9/8/2025 at 10:44 am with Resident #2, when asked if she's ever changed rooms, she said she has changed rooms but was never given a written notice. Record review of Resident #2's progress notes with a date Range of 06/01/2025 to 06/10/2025 indicate no documentation or written notification to the resident or representative about why a room change was done. Record review of Resident #3 revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of end stage renal disease, epilepsy, atrial fibrillation, toxic liver disease with fibrosis and cirrhosis of liver, congestive heart failure, and urinary tract infection. His MDS dated [DATE] reflected a BIMS score of a 15 which indicated the resident was cognitively intact and suggesting no or very minimal cognitive impairment. Record review of Resident #3's census report dated September 9, 2025, revealed the resident was moved to another room on (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/04/2025.Unable to interview Resident #3 as he was discharged to the hospital.Record review of Resident #3's progress notes with a date range of 06/03/2025 to 09/10/2025 indicated no documentation or written notification to the resident or the RP about why a room change was done. Record review of Resident #4 revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of transient visual loss, major depressive disorder, diverticular disease of intestine (a condition where small, bulging pouches form in the wall of the large intestine), cardiac arrest, anoxic brain damage (a condition where the brain is deprived of oxygen for a prolonged period, leading to brain cell death and damage), dysphagia, and end stage renal disease. Record review of Resident #4's MDS dated [DATE] reflected a BIMS score of a 12 which indicated the individual was likely experiencing difficulties with some aspects of cognitive function.Record review of Resident #4's census report dated 09/10/2025, revealed resident was moved to another room on 06/12/2025.In an interview with Resident #4 on 9/8/2025 at 11:01 am when asked if he's ever changed rooms, he said he has changed rooms but was only told that he was moving. When asked if he was given a written notice or told why, he said no.Record review of Resident #4's progress notes from 06/11/2025 to 09/10/2025 indicated no documentation or written notification to the resident or representative about why a room change was done. During an interview on 09/08/2025 at 2:45 PM with the LMSW, when asked what the procedures were when residents moved to a different rooms she said if residents needed to move rooms, the facility would try to find matching compatible roommates, and if the resident didn't like who they chose for their roommate, the resident had a right to refuse to move, and the facility would look for another roommate. She said, they told the residents verbally that they were going to move rooms. When asked if they provided written notices when residents moved to different rooms, she said, The building is so small we only provide a verbal notice.Record Review of the facility's Change of Room or Roommate policy dated 01/01/2023 revealed: 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required.7. The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interview and record review the facility failed to ensure residents had the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service for 6 of 6 confidential residents reviewed for weekend mail delivery. The facility failed to ensure residents promptly received their mail on the weekend. This failure could place residents at risk of not receiving mail in a timely manner and could result in a decline in residents' psychosocial well-being and quality of life. During a confidential resident group interview 6 of 6 residents stated that they never receive mail on Saturday. In an interview on 09/09/2025 at 10:15 AM with the AD, she said the BOM brings her the mail during the week to distribute to the resident, she said she brings it to the resident's rooms, if they are not in their rooms she leaves it on their bedside table. She stated that she comes in on Saturday to make sure Saturday activities are being completed, but she doesn't deliver the mail. In an interview on 09/09/2025 at 10:33 AM with the BOM, she stated that during the week when she receives the mail, she divides the facility mail (bill, invoices, and checks) and resident mail, she then gives it to the AD. She said if mail is delivered on Saturday, the mailman puts it in the facility mailbox at the front door. There is a code on the mailbox to get into it and she is the only one with the code. If there is mail delivered on Saturday, she'll get it on Monday and have the AD deliver it to the residents on Monday. Record review of the facility's, Mail policy revised January 2011 reflected: 4. Mail will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident and resident's representative(s) in writing of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 3 (Resident #1, Resident #2, and Resident #3) of 6 residents reviewed for discharge planning. - The facility failed to notify the resident/ residents representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understand. - The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #1, #2, and #3. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings Include: Record review of Resident #1 revealed resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of acute congestive heart failure, emphysema, osteoarthritis, morbid (severe) obesity, type 2 diabetes, chronic obstructive pulmonary disease, and chronic respiratory failure. Her MDS dated [DATE] reflected a BIMS score of a 15 which indicated normal thinking and memory, meaning the individual's cognition is intact. Record review of Resident #1's progress note dated 09/01/2025 revealed the resident was sent to the ER, the resident's family member was notified. There was no evidence of a discharge notice sent to the resident, the resident's representative or to the LTC Ombudsman. Record review of Resident #2 revealed resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of congestive heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, depression, asthma, morbid severe obesity with alveolar hypoventilation (excess body weight puts pressure on the diaphragm and lungs, reducing their ability to expand and take in oxygen), and kidney failure. Her MDS dated [DATE] reflected a BIMS score of a 14 which indicated the resident was cognitively intact and suggesting no or very minimal cognitive impairment. Record review of Resident #2's progress note dated 05/08/2025 at 10:48 am revealed the resident was sent to the ER. The note reflected, resident has critical hemoglobin level of 6.7. NP notified, order received to send resident out to ER. DON notified, unable to reach RP, left a message to call facility. There was no evidence of a discharge notice sent to the resident, the resident's representative or to the LTC Ombudsman. Record review of Resident #2's progress note dated 05/22/2025 at 5:00 pm, revealed, Resident request to be transferred to ER. transfer to ER per Family and Resident request. There was no evidence of a discharge notice sent to the resident, the resident's representative or to the LTC Ombudsman. Record review of Resident #3 revealed resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of end stage renal disease, epilepsy, atrial fibrillation, toxic liver disease with fibrosis and cirrhosis of liver, congestive heart failure, and urinary tract infection. His MDS dated [DATE] reflected a BIMS score of a 15 which indicated the resident was cognitively intact and suggesting no or very minimal cognitive impairment. Record review of Resident #3's progress notes dated 08/23/2025 at 2:31 pm revealed, (NP) instructed that the resident be sent to the ER for further evaluation. The resident's RP was called but could not be reached. A VM was left with the facility's callback number. There was no evidence of a discharge notice sent to the resident, the resident's representative or to the LTC Ombudsman. In an interview with the LMSW on 09/10/2025 at 11:45 am, when asked what notifications if any are given to the resident or the RP when a resident discharged to the hospital, she stated that the nurse who sent the resident to the hospital will call the family to let them know the resident was sent to the hospital. She added that the facility doesn't send written documentation to the family, resident, or local ombudsman. In an interview with the DON on 09/10/2025 at 1:38 pm when asked what notifications if any were given to the resident or the RP when a resident discharged to the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospital, she said, the nurse on duty would call the RP. When asked if anything in writing was provided to the resident or residents RP the DON stated no.A record review of the facilities Transfer and Discharge policy dated 01/01/2025 revealed: Policy Explanation and Compliance Guidelines:4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, web address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman.i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, web address and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations.5. Generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the resident's urgent medical needs; or d. A resident has not resided in the facility for 30 days. 6. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.7. The facility will maintain evidence that the notice was sent to the Ombudsman.12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).a. Obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis.b. Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements.c. For a transfer to another provider, ensure necessary information listed in #9 of this policy is provided along with, or as part of, the facility's transfer form. d. The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record.e. Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand.f. Document assessment findings and other relevant information regarding the transfer in the medical record.g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.		