

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Skyline Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3326 Burgoyne Dallas, TX 75233	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48235</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from Misappropriation of property for one (Resident #1) of 8 residents reviewed for misappropriation of property.</p> <p>The facility failed to protect Resident #1 from misappropriation of property by one of their employees AA. On 06/24/2024 the facility Business Office Manager and Administrator came to know that AA was using Resident#1's bank debit card for unauthorized transactions for the past several months. As a result, Resident #1 lost approximately \$25,000.00 from his personal bank account.</p> <p>This failure could place residents at risk of Exploitation/Misappropriation of Property and loss of lifelong earnings.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 12/11/2024 revealed Resident #1 was a [AGE] year-old male, with an original admitted [DATE]. Diagnosis included: Cognitive Communication Deficit (Difficulty in communication that arises from impairments in cognitive process), unspecified lack of coordination, Unsteadiness on feet, paranoid schizophrenia (A chronic mental health condition that affects the thought process).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #1 was independent with ADLs for toileting and personal hygiene.</p> <p>Record review of Resident #1's Care Plan dated 10/03/2024 reflected that he had a communication problem related to moderate hearing deficit, had delirium/ acute confusional episode related to malnutrition, he had impaired cognitive function/dementia, difficulty making decisions, knowledge deficit.</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455653
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Provider Investigation Report (PIR) (Form 3613-A of Texas Health and Human Services) dated 07/01/2024 reflected the incident date as 06/24/2024. The Provider Investigation Report Summary reflected the Business Office Manager requested Resident #1's bank statements to apply for Medicaid, BOM (Business Office Manager) reviewed the statements and reported her findings to the administrator that there were several unauthorized transactions over a period of several months. The resident informed that he had given his bank card to the activities to purchase food and cigarettes for him. The administrator noticed ATM withdrawals on the bank statement, the resident informed that he did not always give permission to the Activities Assistant to withdraw money. The Corrective Action Memo to AA reflected she violated facility policy or procedure, and Employers Statement Removing or borrowing company, employee, or resident property without prior authorization. After reviewing resident bank statements, AA has been accused of making unauthorized transactions on Resident #1. Action taken- Termination.</p> <p>In an observation and interview on 12/10/2024 at 01:08 PM with Resident #1 in his room revealed he was sitting in his bed and was hard of hearing. He stated one of the facility staff took around \$25,000 from his personal bank account using his bank debit card. Interview revealed he had given his debit card with PIN number to a facility staff member to purchase cigarettes and food from outside. Resident stated he asked the Business Office staff to check his bank balance and that is how he came to know about this incident. Resident stated the facility staff had come to speak to him about this. He stated he felt sorry for that employee and that the employee lost her job. Resident stated he was not afraid of any staff, and he was not giving his bank card to any employee anymore. Resident stated the Law Enforcement had come to talk to him about it after the ADM reported this incident to the police. Resident stated after 06/24/2024, he went to the business office to get money and gave that money to the Activity Department to buy his cigarettes. Resident stated he was not going without any of his immediate needs at that time.</p> <p>In a phone interview on 12/13/2024 at 02:11 PM AA revealed she used to work at the facility as an Activities Assistant, and she was no longer employed at the facility. AA refused to talk about the allegation of misappropriation of personal property.</p> <p>Record review of the AA's personnel file revealed her date of hiring as Activities Assistant was 09/23/2022, last day of work was 06/24/2024 and date of termination was 11/18/2024.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/11/2024 at 10:38 AM with Activity Director revealed she was working at the facility for [AGE] years. She had four activity assistants and AA worked as one of her Assistants. Interview revealed AA was no longer employed at the facility. She stated the Activity department was responsible to assist residents in purchasing food/cigarettes or anything they wanted from outside the facility or the vending machine. She stated AA was assisting Resident #1 in getting his cigarettes, coca cola, Twix chocolate candy from outside stores and she was supposed to put all receipts for review in a folder. AA was not doing it and later, after the AA was suspended, she found all the receipts from the business office while she was cleaning the shelves. She stated there were cash withdrawals made from stores as per some of the receipts and to do that, the AA had access to Resident #1's card PIN. She stated she did not review any of the receipts brought by AA since she trusted her with Resident #1's bank card and she should have checked them to prevent any misappropriation. She stated she now had a better system in place for all her assistants to document when they go to buy something for a resident, and she reviewed all the receipts. She stated if a facility employee had misappropriated resident funds by taking their money, it would put the resident at a risk of losing their savings and going without any money to buy the things they enjoyed. She stated all the employees received in service on abuse/neglect, and misappropriation of property after this incident. She stated she was not aware of any such exploitation/misappropriation allegations against any residents. She stated the facility administration terminated the employee who exploited the resident and there were no new concerns. She stated she learned about the financial exploitation by AA from the facility Administrator sometime in June 2024 and she heard AA took around \$23,000 from Resident #1's bank account via ATM withdrawals, using it to pay bills with Spectrum internet, at Footlocker footwear store and this happened within several months starting in 2023.</p> <p>An interview on 12/11/2024 at 12:14 PM with the Business Office Manager revealed she was the first to learn about the exploitation/Misappropriation of property by AA. She stated the resident came to her asking in June 2024, if she could find out how much money he had left in his bank account. She stated she requested his bank statement and received it after 5 days on 06/24/2024. She stated prior to that she had asked Resident #1 about getting his bank statements to apply for Medicaid, but Resident had refused. She stated she went through the bank statements and noticed several ATM withdrawals, charges to Metro PCS even though resident did not have the cell phone, Spectrum internet even though resident did not have internet service, and Foot Locker shoe stores. She stated she went and looked at Resident #1's room but did not find any new footwear/athletic gear. She stated she immediately notified the facility Abuse Coordinator, which was the administrator, and the administrator immediately called the police and reported this incident. Resident #1 was shocked to learn that he lost around \$25,000. Even though he disputed all the unauthorized charges, resident received only \$300.00 from the bank. According to the bank, the resident gave his bank card and PIN to the AA and for that reason they denied his dispute. She stated the alleged unauthorized transactions by AA took place for over a year from January 2023 until May/June 2024, and she had reviewed the bank statements. She stated the facility had not done anything for Resident #1 to compensate his financial damages. She stated the Activity Director was responsible to check the receipt each time the AA purchased things for Resident #1. She stated she recently learned from other employees that the AA got arrested from AA's residence for the misappropriation charges.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 12/11/24 at 01:40 PM with the DON revealed she was working at the facility for a year. She stated she was not involved in the investigation of the alleged misappropriation involving Resident #1 and AA, and she learned about it from the administrator. She stated she did not know the details about the unauthorized financial transactions the AA made using Resident #1's debit card. She stated the administrator notified the police, all the employees were in serviced on abuse/neglect, exploitation and misappropriation of property and there were no other such concerns. She stated to prevent such incidents, the administrator suggested the residents not to give their bank card to the employees but she did not agree to that suggestion since she felt it was restricting the resident's right to use their bank cards.</p> <p>Interview on 12/11/2024 at 02:03 PM with the Administrator revealed he was working at the facility since October 2023. He stated the Business Office Manager first learned about the exploitation/misappropriation of property of Resident #1 on 06/24/2024 and she reported to him immediately. He stated he called the police and reported the incident. The AA denied the allegations, she was suspended the same day pending investigation and later terminated. He stated he notified the psych services, Medical Director, Resident's responsible party and Ombudsman of this incident. He stated no negative outcomes were found from the trauma assessment completed on the resident. He stated he interviewed all the activities department staff, an in service was conducted for all the employees on abuse, neglect, exploitation or misappropriation of property. No negative outcomes were found on the safe survey conducted for residents and staff. During the resident council meeting they encouraged residents to report any abuse, neglect, exploitation or misappropriation of property and not to give their bank card to any of the employees. He stated he had reviewed the Resident #1's bank statement and noticed AA was using Resident #1's bank card for unauthorized transactions since April 2023.</p> <p>An observation of Resident #1 on 12/23/2024 at 12:14 PM in the hallway revealed he was interacting with the facility employees happily and noticed no concerns regarding his relationship with the facility employees.</p> <p>An interview with Resident #1 on 12/23/2024 at 12:20 PM revealed he was sitting in his bed in his room. Resident stated he was happy that the state agency was addressing his concern so that similar incidents will not happen to anybody. He stated he never gave permission to AA to withdraw cash from the ATM, or to pay any bills, or to buy any shoes/clothes. Resident stated he was able to smoke his cigarette and he had no other concerns at that time. Resident stated whenever he had to buy cigarette, he collected his money from the business office and used that money to buy cigarette through the activity department. Resident #1 stated he was not afraid of any employee at the facility and that he felt safe. He stated he no longer used his debit card and his check went to the facility trust fund account.</p> <p>Record Review of Resident #1's bank statements dated 10/17/2023 to 04/17/2024, reflected a recurring monthly deposit of \$3331.51 for Public Employees Nevada, several ATM withdrawals, an ATM fee, charges at Walmart, Footlocker, Amazon.com, Family Dollar, T Mobile, Spectrum, CVS and Walgreens pharmacies, vending machines, convenience stores.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the BOM on 12/23/2024 at 01:03 PM revealed BOM was responsible for resident's finances when they had a Trust Fund Account. BOM stated the resident had a Trust Fund Account starting 02/23/2024 and his social security check was deposited to the trust fund since March 2024. Resident #1's State of Nevada pension check started coming to that Trust fund Account on 07/26/2024. BOM stated Resident #1 did not keep any of his bank cards and that she was keeping his card in the business office safe box. She stated she was not aware of any resident who was giving their bank debit card to the Activity Department for any purchases/transactions at that time. BOM stated Resident #1 had no recurring deposits to his personal account anymore.</p> <p>An interview with the Activity Director on 12/23/2024 at 02:23 PM revealed the Activity Department still received Bank Debit cards and PINs from the residents who wanted to purchase outside items and the Activity Department staff used those resident's Debit Card to purchase outside food and other items as per those resident's requests. She stated at least one more resident, Resident #2 gave his debit card to the employees. She stated it was true that if an employee used a resident's debit card for ATM cash withdrawal, she or the resident will only know if they check the bank statements/transactions. She stated Resident #2 who gave his debit card and PIN to the employee was in his right mind and he regularly checked his bank statements. She stated there was no potential for misuse/exploitation at that time since only alert residents were giving their bank cards to the employees.</p> <p>An interview with the Administrator on 12/23/2024 at 03:28 PM revealed the residents who wanted to purchase outside items could still use their bank debit cards. He stated he was not aware of any resident who gave their debit card and PIN at that time, and that all the residents gave cash to the Activity Department for outside purchases. He stated there were no concerns about exploitation since the Activity Manager checked all the purchase receipts and verified the transaction was for the respective resident, and the resident had to sign on the copy of the receipt. He stated he could not punish all the residents by restricting them from giving their debit card to the Activity Department employees. He said he could not regulate that his employees did not buy anything for residents using their debit cards. He stated the system they had in place was adequate to ensure the safety of the resident bank accounts, and all the employees were in serviced and educated on Misappropriation of property. He stated his investigation of the Misappropriation incident involving Resident #1 revealed the AA was the only employee who had access to his debit card. He substantiated the allegation against the AA even though AA denied the allegation, and the AA was terminated from employment. He stated he learned from the detective who investigated the allegation that the AA got arrested for the same charges.</p> <p>An interview with the Administrator, Corporate Representative and Program Manager on 12/23/2024 at 03:55 PM revealed Administrator and Corporate Representative agreed they did not have any system in place to monitor ATM cash withdrawals or other transactions for an employee's personal benefit if they decided to misuse a resident's debit card. The administrator agreed that with the current transaction system, they will only be able to identify the misappropriation/unauthorized transactions once they took place. He agreed that the employees who misuse resident debit cards will not report if they used it for their personal needs. Administrator stated he will not give his personal debit card and PIN to anybody else due to misuse concerns. Both Administrator and Corporate Representative agreed that going forward, they can stop taking debit card from the residents, instead all residents will have to pay cash only for any outside purchases.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy titled, Abuse Prevention and Prohibition Program revised October 24,2022 reflected, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>On 12/27/2024 at 11:49 AM a telephone call was attempted to contact detective to request the copy of the police report and investigation report, but he did not answer.</p> <p>Record Review of General Progress note dated 06/24/2024 to 06/28/2024 reflected no signs of emotional distress or abnormal behavior noted on all shifts.</p> <p>Record Review of Resident #1's Psychiatric Subsequent assessment dated [DATE] revealed resident had not expressed any concerns regarding the Misappropriation incident, he told the mental health professional that I am good today, next visit was scheduled after 7 weeks.</p>