

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  05/04/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47161</p> <p>Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 of 4 residents (Resident #1 and #2) reviewed for neglect reporting.</p> <p>The facility failed to report an allegation of neglect to the State Agency when Resident #1 was physically abused by Resident #2, sustaining an injury, on 05/02/25.</p> <p>This failure could place residents at risk for not having allegations of neglect reported which could lead to injury or worsening of condition and ongoing abuse/neglect.</p> <p>Findings included:</p> <p>Review of Resident #1 MDS assessment, dated April 12, 2025, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was moderately impaired. His diagnoses included Alzheimer's Disease and Dementia.</p> <p>Review of Resident #1's Care Plan, dated 03/13/2025, reflected:</p> <ul style="list-style-type: none"> <li>o Resident has an ADL self-care performance deficit related to dementia.</li> <li>o Resident is at a high risk for falls related to gait/balance problems, confusion</li> <li>o Resident is a risk for falls, has had an actual fall with no injury related to poor balance</li> <li>o Resident is at risk for harm related to physical aggression from another resident</li> </ul> <p>Review of Resident #1's Nurse Note, dated 05/02/2025 at 11:04 AM, reflected:</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse received a call about the resident's injury. The nurse arrived to work and went to assess the resident he was noted in his wheelchair in the dining room sleeping. Resident's head and ears appeared to be swollen and face was red. MD called to get orders. A stat skull series was ordered, and DON was made aware. Awaiting arrival of the x-ray, MD was called again, and new orders were given to send resident out 911 for evaluation and treatment.</p> <p>Review of Resident #1's Nurse Note, dated 05/02/2025 at 12:46 PM, reflected:</p> <p>Resident was seen coming to the dinning/nurse's station with a raised and red area to right side of forehead. Resident was assessed and asked what happened, but resident could not give a description as to what happened to him. Resident was then given Tylenol for pain. Cold compress was applied to the raised area. Skull series ordered. Physician notified of incident.</p> <p>Review of the facility's Physical Agression Recieved for Resident #1 dated 05/02/25 at 05:30 reflected Incident Description: Resident ws seen coming to the dining/nurses station wiht a raised red area to the right side of forehead. Resident was assessed and asked what happened, but resident could not give a description as to what happend to him. Resident was then given tylenol for pain. Cold compress were applied to the raised area. Skull serious ordered. NP, DON and Family have been notified . Immediate Action Taken: Head to toe assessment, skull series ordered [Confirmation Number], NP, DON and Family have been notified .Injury Observed at Time of Incident: Skin tear to right elbow, unable to deteremine to face . Level of Pain: Numerical: 5, Level of Consciousness: Alert Mobility: Wheelchair bound . Mental Status: Oriented to person, impulsiveness, forgetful, lack of safety awareness</p> <p>During an observation on 05/04/25 at 9:45 AM revealed Resident #2's right hand was swollen and bruised. Resident #2 was observed sleeping.</p> <p>An interview on 05/04/2025 at 11:40 AM with the DON revealed she was informed that Resident #1 had a facial injury by staff but could not state who. The DON said that there were no witnesses to the incident, where Resident #1 had sustained a facial injury. The DON said it was determined Resident #1 was hit in the head by roommate.</p> <p>An interview on 05/04/2025 at 12:00 PM with the Administrator revealed the incident involving Resident #1 was not self-reported. Administrator stated Resident #2 had abused Resident #1. Administrator stated he did not report the incident to Texas Health and Human Services Commissions because it was resident on resident altercation without intent to harm, since both residents BIMS score are 3 and they resided on the memory care unit.</p> <p>Review of the facility policy Abuse Prevention and Prohibition reflected: The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents immediately, but no later than 2 hours after if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman.</p>		