STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. Building B. Wing	04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32227

Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent neglect for one (09/12/23) of one incident reviewed for reporting according to facility policy.

The facility failed to follow their policy to report to the State Survey Agency when Resident #1 was missing for approximately 15 hours after leaving the hospital where he went for a doctor's appointment.

This failure could place the residents in the facility at risk of lacking timely reporting of incidents.

Findings included:

Review of the facility's policy titled Abuse/Neglect dated 03/29/18 reflected the following:

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.

.3 Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19.

a. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's MDS dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypotension (low blood pressure), and muscle weakness. The resident was cognitively intact with a BIMS score of 15, and he had the ability to express his ideas and wants. Resident #1 did not have upper or lower extremity impairment but used a wheelchair for mobility. The MDS further reflected the resident did not wish to be asked about returning to the community. Review of Resident #1's care plan initiated on 05/15/23 reflected he required an antipsychotic for the diagnosis of schizoaffective disorder. The care plan further reflected Resident #1 was at risk for falls due to balance problems during transition and gait. He refused to use a standard walker and preferred to use a wheelchair only for ambulation (walks behind the wheelchair). Interventions included to educate the resident on fall prevention and ensure the resident was wearing appropriate footwear when transferring or mobilizing in the wheelchair. Review of Resident #1's nurses noted dated 03/28/24 documented by the DON revealed the following: writer received a call from van driver regarding patient pick up. stated patient was not in designated area he looked around facility and was informed by ER patient was in er. patient told ER he needed to speak with psych dr he having suicidal thoughts. writer asked van driver to allow writer to speak with [hospital] staff. writer was greeted by rude staff member when i advised writer of needed inform on patient current condition and updated address. she refused to accept my information over phone by text or email. I asked if we can bring paper work for resident current med list etc stated no we know him. She told both van driver and myself they would keep him. Writer asked van driver to come back to facility and get his med list and take to [hospital]. Review of Resident #1's clinical records revealed the resident had signed the Discharge Against Medical Advice on 03/29/24 and witnessed by the DON. Interview on 04/13/24 at 9:18 AM with Resident #1's family revealed the facility sent the resident to the hospital for an appointment. While at the ER the resident told hospital staff he was hearing voices and had suicidal ideations. Resident #1 told his family he said those things for attention. While at the ER, the hospital staff gave the resident a bus pass so he could go to the homeless shelter. Resident #1's family said the nursing facility should have never allowed the resident to go to his appointment unattended because he was not right in his mind. Resident #1 was also given a piece of paper and the resident did not know what he was signing but signed it anyways. The family also said the resident had spent the night under an overpass. Interview on 04/13/24 at 11:00 AM with Resident #1 he was currently in a hospital after having some type of surgery, and he was not able to explain the type of surgery. He said he was taken to the hospital for an appointment, and while he was there, he asked to be seen by psych services, but did not give details why. The resident said he wanted to go to the homeless shelter so the hospital gave him a bus pass because he did not want to return to the nursing facility and wanted to try something new. Resident #1 said the nursing facility found him at the homeless shelter the following day and asked him to return to the facility, but he declined. The facility staff gave him piece a paper and explained to him he chose to be discharged from the facility, and he was also told he could return to the nursing facility when he felt good and ready. Resident #1 further stated the nursing facility treated him very well, and he never had any problems while he was living there. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Treemont Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5550 Harvest Hill Rd Dallas, TX 75230	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 04/13/24 at 1:54 PM with the Van Driver revealed he took Resident #1 to the hospital for a dr appointment some time after 1:00 PM. The resident did not require a staff to accompany him because he was alert and oriented X4 and did not need physical assistance. The resident was checked in at the front office of the appointment and he Van Driver gave the hospital staff his phone number to call him when the resident was out of his appointment. Around 4:00 PM, the Van Driver got a phone call from the hospital saying the resident was ready. When he got there, he did not see the resident and began to look for him. He finally asked where they checked in, where the resident was and he was told Resident #1 had checked himself into he ER. The Van Driver went to the ER but the staff there would not give him an information on the resident claiming it was confidential information even after he explained the resident lived at the nursing facility. The DON asked the Van Driver to return to the facility to get Resident #1's paperwork to give to the ER and when he returned to the hospital, he was told the resident had been evaluated, released, and given a bus pass after they did not find the resident with mental problems. The Van Driver said he and other facility staff began to look for the resident at the homeless shelter and other locations where homeless people are known to gather and Resident #1 was not found so the police was contacted. The following day, 03/29/24, he received a phone call from the homeless shelter around 9AM saying Resident #1 was there so the facility staff went to the shelter to meet with the resident. The Van Driver further stated the resident was not demented and safe to go to his dr appointments on his own and he was using his walker at the time of his appointment. Interview on 04/13/24 at 11:29 AM with LVN A revealed Resident #1 was a younger resident and during his stay at the facility he was very quiet and kept to himself and only left his room to smoke. LVN A said the resident was alert and oriented, able to make his own decisions and was very compliant with his medications and care. The resident used a walker or wheelchair for mobility and during the resident's stay he had never mentioned he wanted to leave the facility. Interview on 04/13/24 at 11:35 AM with CNA B revealed Resident #1 was alert and oriented and very nice. The resident was independent with most ADLs and used both a wheelchair and walker for mobility. CNA B said the resident was very quiet and stayed to himself and he never mentioned he wanted to leave the facility. Interview on 04/13/24 at 11:13 AM with the ADON revealed an appointment had been made for Resident #1 at the hospital to have his ear checked out. She said the resident was quiet and kept to himself and he was also compliant with care and medications. Resident #1 was mostly independent and he was able to make his own decisions and was his own responsible party. The facility was made aware by the Van Driver that he was not able to locate the resident when he returned to pick him up after his appointment. They all began to search for the resident and the police was contacted when Resident #1 was not located. Resident #1 was found the following day, 03/29/24, at the homeless shelter and the resident told them he did not want to return to the facility because he was not happy there. Resident #1 was assessed and there were no concerns or injuries noted. The resident also told them his family had been promising him they would take him out of the facility and he got tired of waiting. Resident #1 was presented with the AMA paperwork and he agreed to sign it. The ADON further stated the resident had never mentioned he wanted to leave the facility and was compliant with care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/13/24 at 12:13 PM with the DON revealed Resident #1 had been taken to the hospital for a dr appointment on 03/28/24. She said the resident was independent for the most part, his own responsible party and able to make his own decisions. The resident did not need a staff member to accompany him because he was alert and oriented and independent for the most part. After the appointment the Van Driver was not able to find the resident where he was left and he had been told the resident had checked himself to the ER. The DON said she tried to talk to the hospital staff but they were very rude, and would not take her information or listen when she tried to tell them Resident #1 lived at the nursing facility. She asked the Van Driver to return to the facility so he could take the resident's paperwork back to the hospital and when the Van Driver returned, the hospital let him know Resident #1 had been released an given a bus pass. The DON said they began to look for the resident at different places the family had told them where homeless people gathered but he was not located so the police was called. The homeless shelter was contacted and said the resident was not there. The following morning, 03/29/24, they were contacted by the homeless shelter to let him know Resident #1 was there. When they arrived at the homeless shelter he told the nursing facility staff he was happy to see them but he did not want to return to the nursing facility because he was in his right mind and he always thought himself as a drifter. The DON assessed the resident and there were no visible concerns or injuries noted. Resident #1 went on to say his family kept promising him they would all get a house together and he would leave the nursing facility but the family never did. They asked the resident again if he wanted to return to the nursing facility and he again said no so the resident was given the AMA paperwork to sign and it was all explained and he was agreeable. The family was contacted to let them know he had been found. During the resident's stay at the nursing facility he had never mentioned he wanted to leave the facility. The incident was not called because the DON said the resident was really never missing because he had been taken to an appointment and the hospital had released him without their knowledge. Interview on 04/13/24 at 12:37 PM with the Administrator revealed the Van Driver had made them aware Resident #1 had been released from the hospital and given a bus pass. The administrator said they began to look for the resident for several hours and called the police when he was not located. Resident #1 was very pleasant, alert and oriented, able to make his own decision and never expressed he wanted to leave the nursing facility. The following morning, 03/29/24, they were notified by the homeless shelter the resident was there so they went to try and get him. The resident expressed he did not wish to return to the nursing facility so he was given the AMA paperwork to sign explaining he was leaving against medical advice and the resident was agreeable. The Administrator further stated she had not reported the incident to the State Survey Agency because Resident #1 was alert and oriented, the resident had been homeless in the past and he had been used to that lifestyle. They did not feel like he had been in danger and she also believed she had 24 hours to report the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse and neglect were reported immediately but not later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency for 1 of 1 incidents reviewed for reporting. The facility failed to report to the State Survey Agency when Resident #1 was missing for about 15 hours after leaving the hospital where he went for a doctor's appointment. This failure could affect residents by resulting in a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment. Findings included: Review of Resident #1's MDS dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypotension (low blood pressure), and muscle weakness. The resident was cognitively intact with a BIMS score of 15, and he had the ability to express his ideas and wants. Resident #1 did not have upper or lower extremity impairment but used a wheelchair for mobility. The MDS further reflected the resident did not wish to be asked about returning to the community. Review of Resident #1's care plan initiated on 05/15/23 reflected he required an antipsychotic for the diagnosis of schizoaffective disorder. The care plan further reflected Resident #1 was at risk for falls due to balance problems during transition and gait. He refused to use a standard walker and preferred to use a wheelchair only for ambulation (walks behind the wheelchair). Interventions included to educate the resident on fall prevention and ensure the resident was wearing appropriate footwear when transferring or mobilizing in the wheelchair. Review of Resident #1's nurses noted dated 03/28/24 documented by the DON revealed the following: writer received a call from van driver regarding patient pick up. stated patient was not in designated area he looked around facility and was informed by ER patient was in er. patient told ER he needed to speak with psych dr he having suicidal thoughts. writer asked van driver to allow writer to speak with [hospital] staff. writer was greeted by rude staff member when i advised writer of needed inform on patient current condition and updated address. she refused to accept my information over phone by text or email. I asked if we can bring paper work for resident current med list etc stated no we know him. She told both van driver and myself they would keep him. Writer asked van driver to come back to facility and get his med list and take to [hospital]. Review of Resident #1's clinical records revealed the resident had signed the Discharge Against Medical Advice on 03/29/24 and witnessed by the DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/13/24 at 9:18 AM with Resident #1's family revealed the facility sent the resident to the hospital for an appointment. While at the ER the resident told hospital staff he was hearing voices and had suicidal ideations. Resident #1 told his family he said those things for attention. While at the ER, the hospital staff gave the resident a bus pass so he could go to the homeless shelter. Resident #1's family said the nursing facility should have never allowed the resident to go to his appointment unattended because he was not right in his mind. Resident #1 was also given a piece of paper and the resident did not know what he was signing but signed it anyways. The family also said the resident had spent the night under an overpass. Interview on 04/13/24 at 11:00 AM with Resident #1 he was currently in a hospital after having some type of surgery , not able to explain the type of surgery. He said he was taken to the hospital for an appointment and while he was there, he asked to be seen by psych services, but did not give details why. The resident said he wanted to go to the homeless shelter so the hospital gave him a bus pass because he did not want to return to the nursing facility and wanted to try something new. Resident #1 said the nursing facility found him at the homeless shelter the following day, asked him to return to the facility but he declined. The facility staff gave him piece a paper and explained to him he chose to be discharged from the facility and he was also told he could return to the nursing facility when he felt good and ready. Resident #1 further stated the nursing facility treated him very well and he never had any problems while he was living there. Interview on 04/13/24 at 1:54 PM with the Van Driver revealed he took Resident #1 to the hospital for a dr appointment some time after 1:00 PM. The resident did require a staff to accompany him because he was alert and oriented x 4 and did not need physical assistance. The resident was checked in at the front office of the appointment and he Van Driver gave the hospital staff his phone number to call him when the resident was out of his appointment. Around 4:00 PM, the Van Driver got a phone call from the hospital saying the resident was ready. When he got there, he did not see the resident and began to look for him. He finally asked where they checked in, where the resident was and he was told Resident #1 had checked himself into he ER. The Van Driver went to the ER but the staff there would not give him an information on the resident claiming it was confidential information even after he explained the resident lived at the nursing facility. The DON asked the Van Driver to return to the facility to get Resident #1's paperwork to give to the ER and when he returned to the hospital, he was told the resident had been evaluated, released, and given a bus pass after they did not find the resident with mental problems. The Van Driver said he and other facility staff began to look for the resident at the homeless shelter and other locations where homeless people are known to gather and Resident #1 was not found so the police was contacted. The following day, 03/29/24, he received a phone call from the homeless shelter around 9AM saying Resident #1 was there so the facility staff went to the shelter to meet with the resident. The Van Driver further stated the resident was not demented and safe to go to his dr appointments on his own and he was using his walker at the time of his appointment. Interview on 04/13/24 at 11:29 AM with LVN A revealed Resident #1 was a younger resident and during his stay at the facility he was very quiet and kept to himself and only left his room to smoke. LVN A said the resident was alert and oriented, able to make his own decisions and was very compliant with his medications and care. The resident used a walker or wheelchair for mobility and during the resident's stay he had never mentioned he wanted to leave the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/13/24 at 11:35 AM with CNA B revealed Resident #1 was alert and oriented and very nice. The resident was independent with most ADLs and used both a wheelchair and walker for mobility. CNA B said the resident was very quiet and stayed to himself and he never mentioned he wanted to leave the facility. Interview on 04/13/24 at 11:13 AM with the ADON revealed an appointment had been made for Resident #1 at the hospital to have his ear checked out. She said the resident was quiet and kept to himself and he was also compliant with care and medications. Resident #1 was mostly independent and he was able to make his own decisions and was his own responsible party. The facility was made aware by the Van Driver that he was not able to locate the resident when he returned to pick him up after his appointment. They all began to search for the resident and the police was contacted when Resident #1 was not located. Resident #1 was found the following day, 03/29/24, at the homeless shelter and the resident told them he did not want to return to the facility because he was not happy there. Resident #1 was assessed and there were no concerns or injuries noted. The resident also told them his family had been promising him they would take him out of the facility and he got tired of waiting. Resident #1 was presented with the AMA paperwork and he agreed to sign it. The ADON further stated the resident had never mentioned he wanted to leave the facility and was compliant with care. Interview on 04/13/24 at 12:13 PM with the DON revealed Resident #1 had been taken to the hospital for a dr appointment on 03/28/24. She said the resident was independent for the most part, his own responsible party and able to make his own decisions. The resident did not need a staff member to accompany him because he was alert and oriented and independent for the most part. After the appointment the Van Driver was not able to find the resident where he was left and he had been told the resident had checked himself to the ER. The DON said she tried to talk to the hospital staff, but they were very rude and would not take her information or listen when she tried to tell them Resident #1 lived at the nursing facility. She asked the Van Driver to return to the facility so he could take the resident's paperwork back to the hospital and when the Van Driver returned, the hospital let him know Resident #1 had been released and given a bus pass. The DON said they began to look for the resident at different places the family had told them where homeless people gathered but he was not located so the police was called. The homeless shelter was contacted and said the resident was not there. The following morning, 03/29/24, they were contacted by the homeless shelter to let him know Resident #1 was there. When they arrived at the homeless shelter he told the nursing facility staff he was happy to see them but he did not want to return to the nursing facility because he was in his right mind and he always thought himself as a drifter. The DON assessed the resident and there were no visible concerns or injuries noted. Resident #1 went on to say his family kept promising him they would all get a house together and he would leave the nursing facility but the family never did. They asked the resident again if he wanted to return to the nursing facility and he again said no so the resident was given the AMA paperwork to sign and it was all explained and he was agreeable. The family was contacted to let them know he had been found. During the resident's stay at the nursing facility he had never mentioned he wanted to leave the facility. The incident was not called because the DON said the resident was really never missing because he had been taken to an appointment and the hospital had released him without their knowledge. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/13/24 at 12:37 PM with the Administrator revealed the Van Driver had made them aware Resident #1 had been released from the hospital and given a bus pass. The administrator said they began to look for the resident for several hours and called the police when he was not located. Resident #1 was very pleasant, alert and oriented, able to make his own decision and never expressed he wanted to leave the nursing facility. The following morning, 03/29/24, they were notified by the homeless shelter the resident was there so they went to try and get him. The resident expressed he did not wish to return to the nursing facility so he was given the AMA paperwork to sign explaining he was leaving against medical advice and the resident was agreeable. The Administrator further stated she had not reported the incident to the State Survey Agency because Resident #1 was alert and oriented, the resident had been homeless in the past and he had been used to that lifestyle. They did not feel like he had been in danger and she also believed she had 24 hours to report the incident. Review of the facility's policy titled Abuse/Neglect dated 03/29/18 reflected the following: .The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. .3 Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation