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	05/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on interview and record review, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status which had the potential for requiring physician intervention for one (Resident #1) of five residents reviewed for changes in condition. The facility failed to notify Resident #1's physician when she displayed signs and symptoms of being short of breath, which ultimately caused her to miss her scheduled dialysis appointment. This failure could place residents at risk of not receiving timely interventions and care. Findings included: Review of Resident #1's Face Sheet, dated 05/03/25, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses including acute respiratory failure (a sudden inability of the lungs to adequately provide oxygen to the blood or remove carbon dioxide, leading to a buildup of carbon dioxide and low oxygen levels in the blood), chronic diastolic (congestive) heart failure (a condition where the heart's left ventricle becomes stiff and can't relax properly, preventing it from filling with enough blood during the resting period between heartbeats), end stage renal disease (a condition where the kidneys are no longer able to adequately filter waste and excess fluid from the body), and dependence on renal dialysis (when a person relies on artificial kidney machines (dialysis) to filter their blood and remove waste products, because their kidneys are no longer functioning properly to do this naturally). Review of Resident #1's MDS Assessment, dated 03/12/25, reflected she received oxygen therapy both prior to and during admission to the facility. Review of Resident #1's Physician's Orders, dated 05/03/25, reflected she was ordered O2 at 2-4lpm via NC to keep O2 sat above 92% every shift for SOB. The start date for this order was 04/02/25. Review of Resident #1's Care Plan, dated 03/29/25, reflected Resident #1 received oxygen therapy. An intervention included for the facility to monitor for signs/symptoms of respiratory distress and report to the Medical Director as needed. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's electronic medical record on 05/03/25 reflected no evidence that a Change in Condition Assessment had been completed for Resident #1 following her reported episode of shortness of breath on 05/01/25. There was also no evidence that Resident #1's physician (also the facility's Medical Director) had been notified of the episode on 05/01/25. There was a Late Entry documented in the Nurse's Notes, by the ADON, on 05/03/25 which reflected that on 05/01/25, .The resident has been noted with respiratory distress, requiring transportation to the dialysis facility. The nurse noted that respirations are even and unlabored, with O2 at 97% and O2 noted at 4LPM/NC. The MD called and notified of C.O.C. with current vitals . Review of Resident #1's electronic medical records on 05/03/25 reflected her vital signs were documented as follows: 05/01/25 7:29AM - O2 was at 96% 05/01/25 10:44AM - O2 was at 94% 05/01/25 3:05PM - O2 was at 95% During a telephone interview with Resident #1's family member on 05/03/25 at 10:51AM, they voiced a concern that Resident #1 missed her scheduled dialysis appointment on 05/02/25 due to shortness of breath. The family member was not sure if Resident #1's physician was made aware of this change in condition. During a telephone interview with Resident #1's physician (also the facility's Medical Director) on 05/03/25 at 11:02AM, he stated he was not made aware of Resident #1's episode of shortness of breath on 05/01/25. He stated he did not receive any messages regarding this change in condition. He stated he would not need to be notified of a missed dialysis appointment, as there was no risk to a resident unless several dialysis appointments were missed in a row. He stated due to Resident #1's comorbidities, her shortness of breath could have been caused by any number of things. He stated he would expect to be notified of this change in condition. During a telephone interview with Resident #1's Nurse Practitioner on 05/03/25 at 11:23AM, she stated she was not made aware of Resident #1's episode of shortness of breath on 05/01/25. She stated due to Resident #1's comorbidities, she was on continuous oxygen therapy. The Nurse Practitioner stated she would not need to be notified of a missed dialysis appointment, but shortness of breath was considered a change in condition in which she would expect to be notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 05/03/25 at 11:59AM, she stated Resident #1's most recent dialysis appointment was on 04/29/25. She stated Resident #1 was scheduled for a dialysis appointment on 05/01/25; while Resident #1 was in the facility's transport vehicle, it was reported by a staff member that she became short of breath. The ADON stated she utilized Facetime with Resident #1 to observe her during the transport, and she confirmed Resident #1 appeared to be short of breath. The ADON explained that this was not uncommon for Resident #1 when she was in an upright position, and it was the reason why the facility had an extra staff member ride in the transport van with her on the way to dialysis (to provide extra monitoring). Resident #1 was brought back to the facility; she missed her dialysis appointment that day. The ADON stated she observed and assessed Resident #1 upon her arrival back to the facility. She stated Resident #1 was alert, oriented, and able to easily answer questions. Her vitals and oxygen stats were within normal limits. The ADON stated Resident #1 reported feeling fine upon her return to the facility. She stated she advised LVN A to notify Resident #1's physician of her change in condition; this should have been completed along with a Change in Condition Assessment. The ADON stated the risk of a resident's physician not being notified of a change in condition, as well as the risk of a Change in Condition Assessment not being completed, was the potential for no interventions and/or follow-up monitoring being completed. She stated again, it was not uncommon for Resident #1 to have shortness of breath due to her comorbidities. During an interview with LVN A on 05/03/25 at 12:12PM, she stated she last worked with Resident #1 on 05/01/25. She stated Resident #1 attempted to refuse to go to her scheduled dialysis appointment three times, because she stated she was waiting for a specific piece of mail to be delivered in which she needed to sign for receipt. LVN A stated she was finally able to convince Resident #1 to go to her dialysis appointment. She stated when Resident #1 left for her appointment, she observed her to be alert, oriented, and in stable condition (no shortness of breath). While Resident #1 was in route to the dialysis appointment via the facility's transportation vehicle, she was noted to have shortness of breath by facility staff. LVN A explained that it was not uncommon for Resident #1 to become short of breath due to her comorbidities. Resident #1 was brought back to the facility at that time. LVN A stated when Resident #1 arrived back at the facility, she was alert, oriented, and in stable condition. Her vital signs were within normal limits. She displayed no signs or symptoms of being in respiratory distress. LVN A stated she was advised by the ADON to notify Resident #1's physician of her episode of shortness of breath; she stated she left a voice message for the physician. She stated she did not document leaving this message. She stated she did not complete the documentation for a Change in Condition Assessment for Resident #1, because when she arrived back at the facility, it was right before change of shift. She thought the oncoming nurse would complete the assessment. LVN A stated the risk of not documenting was that, if you don't document, it didn't happen. Voice messages were left for CNA B (who was present when Resident #1 became short of breath on the transport vehicle) on 05/03/25 at 12:52PM and 05/03/25 at 1:57PM. CNA B did not return the telephone calls prior to survey exit. Voice messages were left for CNA C (who was present when Resident #1 became short of breath on the transport vehicle) on 05/03/25 at 12:55PM and 05/03/25 at 1:38PM. CNA C did not return the telephone calls prior to survey exit. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Notifying the Physician of Change in Status policy, dated 03/11/13, reflected, .The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. This facility utilizes the INTERACT tool, Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Work day notification of the physician . The policy also reflected, .The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record .