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	10/29/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and to ensure each resident receives adequate supervision to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents, hazards, and adequate supervision. 1. The facility failed to ensure Resident #1 did not exit the facility without supervision and walk for two miles to a family member's residence on 10/25/2025. An IJ was identified on 10/28/2025. The IJ template was provided to the facility on [DATE] at 04:38 PM. While the IJ was removed on 10/29/2025 at 4:57 PM, the facility remained out of compliance at a scope of Isolated and a severity level of no actual harm because the facility needed to evaluate and monitor the effectiveness of their corrective actions that were put into place. This failure could place facility residents at risk of elopement resulting in acute injury, serious impairment, or death.Findings included:Record review of Resident #1's admission care plan dated 10/28/2025 reflected, [AGE] year-old female admitted to the facility 10/18/2025. Resident #1's primary diagnosis was cerebral infarction due to embolism of right middle cerebral artery (a stroke that occurs when a blood clot blocks the right MCA, cutting off blood flow to a large portion of the brain). Secondary diagnoses of type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), acute respiratory failure with hypoxia (a life-threating condition where the body's lungs fail to adequately provide oxygen to the bloodstream, leading to low oxygen levels). Resident #1 had a UTI (urinary tract infection) that could cause altered mental status, loss of appetite, and behavioral changes.Record review of Resident #1's MDS dated [DATE] reflected, she had a BIMS score of 12 (Moderately Impaired cognition) and the care area assessment summary reflected cognitive loss, and falls.Record review of the elopement risk assessment for Resident #1 dated 10/18/25 reflected for physical capability she required assistance for transfer, adjustment to facility/statement and/or threats to leave facility reflected she understood and verbalized acceptance of need for nursing home care. Resident #1's cognitive skills for daily decision making reflected modified independence with some difficulty in new situations only. She had no previous attempts to leave own residence/facility, no restlessness or anxiety. Resident #1 recognized stop lights and signs, she knew precautions when crossing streets, could state her name, and she knew the location of her current residence.Record review of LVN-E documentation dated 10/25/2025 reflected: [6:45 AM Answered call light, [Resident #1] stated she needed assistance getting dressed. Vital sign assessment done and co-nurse assisted [Resident #1] with getting dressed. Resident alert and oriented x4 to person, place, time, and DOB. [Resident #1] denies pain. VS: BG-199, BP-160/89, HR-93, Temp.97, RR20, O2sats97%RA. Staff escorted [Resident #1] to dining room via walker. [7:15 AM] [Resident #1] sat down at table and started working puzzle. [Resident #1] stated she wanted to go back to her room, left dining room ambulating via walker and returned to her room.[8:09 AM] Co-nurse reported to this nurse [LVN-E] that she assisted [Resident #1] to sit on the side of bed and served breakfast in her room.[8:30 AM] During routine med pass resident was not in assigned room. This nurse [LVN-E] looked down middle, east, and west hallways, in the foyer and outside by front entrance, then asked co-nurse and other staff members if they see resident. [8:36 AM] Weekend supervisor notified. Notified MOD who stated she will go to 2nd floor, inform staff, and look for [Resident #1]. Co-nurse left facility in her car to search for resident. This nurse [LVN-E] and 3rd nurse searched 1st floor in all rooms, toilets, closets, stairwell, shower rooms, and other miscellaneous rooms. 2nd floor ADON-B and multiple staff searched facility parameters and [Next Door].[8:40 AM] This nurse called [Resident #1] cell phone multiple times, no answer, left voicemail requesting call back. [8:44 AM] Notified DON who stated she will be in communication with weekend supervisor and administrator and update staff accordingly.[8:55 AM] This nurse [LVN-E] called [Family] who stated resident was not with her and possibly left with her friends. [Family] stated she will call her friends to confirm.[9:05 AM] Called administrator left voice mail requesting call back.[9:21AM] Received call back from administrator who instructed this nurse [LVN-E] to continue to search rooms, including 2nd floor. [9:25 AM] Received message from weekend supervisor who informed this nurse [LVN-E] that resident was with her [Family]. [9:27 AM] Overhead page from ADON-A to cancel search. Record review of World Weather for October 25, 2025, reflected, the weather was 64 degrees Fahrenheit in the city with southeast winds at a speed of 3.6 Record review of Google Maps revealed Resident #1 would have traveled through