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No. 0938-0391

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 03/17/2026
NAME OF PROVIDER OR SUPPLIER Treemont Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and follow a written policy on permitting residents to return to the facility after being hospitalized for 1 resident (Resident #2) of 2 residents reviewed for transfer/discharge.The facility failed to ensure Resident #2 was allowed to return to the facility after hospitalization and not discharged from the facility. This failure could place residents at risk of being discharged while being hospitalized and not allowed to return to the facility, causing a disruption in their care and services and potential decline in health.Findings included:Record review of admission Record for Resident #2 revealed [AGE] year-old female admitted on [DATE] with a primary diagnosis of CEREBRAL INFARCTION, UNSPECIFIED (-stroke.)and secondary diagnosis of Hemiplegia (one-sided paralysis or weakness of the face, arm or leg.)and Hemiparesis following cerebral infraction affecting right dominant side, Unspecified dementia (Brain disease that alters brain function and causes a cognitive decline) unspecified severity, without behavioral disturbance, Psychotic Disturbance, mood Disturbance, and anxiety. Record review of Minimum Data Set Nursing Home and Swing Bed Tracking dated 02/23/2026 revealed Section A- F. Entry tracking record. A1900 admission Date (Date of this episode of care in this facility began) 02/23/2026.Record review of Minimum Data Set Nursing Home discharge date d 02/24/2026 revealed Section A-Identification Information- Unplanned. Discharge Status- Short Term General Hospital. Record review of Discharge-Summary dated 02/24/2026 revealed reason for discharge send hospital for evaluation. Brief history resident sent hospital for evaluation has a G-tube possible aspiration slightly coarse sound upper RT lobe(a serious finding that suggests fluid, mucus, or foreign material has entered the airways). Denied any cyanosis(a bluish or purplish discoloration of the skin, lips, or mucous membranes caused by insufficient oxygen in the blood or poor circulation) or respiratory distress. During an interview on 03/17/2026 at 12:15 p.m., with DON stated Resident #2 was admitted on [DATE] and transferred to the hospital on [DATE] for treatment she did not return to the facility from the hospital as she was not financially approved. During an interview on 03/17/2026 at 12:46 with Marketer/Admissions stated Resident #2 she was not funded. Resident #2 She was not approved for admission based on funding. Resident #2 She did not have an identification card, only a green card. He stated Resident #2 she was screened for admission but was not funded for admission . During an interview on 03/17/2026 at 1:54 PM, the Administrator stated residents are accepted when the facility can meet medical necessity. If the facility cannot meet Medical Necessity then there would be arrangements made for safe discharge. He stated they do not want to drop them in the hospital. During an interview on 03/17/2026 at 2:07 p.m., the ADON stated Resident #2 was approved clinically for admission but was not approved financially for admission. Resident #2 was admitted into the facility on [DATE] by confusion ; the facility was waiting for another resident from the same transferring facility. Management was not in the building during the admission process, and Resident #2 was admitted . During an interview on 03/17/2026 at 2:20 p.m., the BOM revealed Resident #2 was clinically approved but not financially approved for admission . Resdident #2 She was never approved for financial reasons. Transportation was set up or the wrong person , the facility was expecting two (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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents. The facility failed to ensure Resident #1,was provided adequate supervision on 03/04/2026 when he eloped from the facility without staff knowing and was found by the local police off the facility grounds. The noncompliance was identified as past noncompliance (PNC). Immediate Jeopardy began on 03/04/26 and ended on 03/04/26. The facility had corrected the noncompliance before the survey began. This failure could place residents who require supervision at risk of harm, severe injury, and possible death. Findings included:Record review of Resident #1's admission Record reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included in part dementia (loss of mental functioning), cerebral infarction (stroke), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), generalized muscle weakness, and atherosclerotic heart disease (hardening of the arteries).Record review of Resident #1's admission Comprehensive MDS Assessment, dated 03/03/26, reflected a BIMS score of 1, indicating severe cognitive impairment. The MDS reflected Resident #1 did not have wandering behaviors.Record review of Resident #1's Elopement Risk Assessment, dated 02/28/26, reflected that the resident was at a high risk of elopement with a score of 16. Record review of Resident #1's Care Plan dated 03/02/26 did not identify elopement risk as a focus with goals or interventions. Record review of Resident #1's Progress Notes from 02/28/26 to 03/04/26 reflected no documentation of prior elopement attempts or exit seeking behaviors. Record review of Nursing Progress Note for Resident #1 dated 03/04/26 at 01:00 a.m. by the DON reflected: At approximately 01:00, exit door alarm sounded. Staff immediately initiated facility elopement/missing resident protocol. Resident was noted to be absent from the unit. Immediate search of building and surrounding premises conducted. Local law enforcement was notified. Within minutes, facility received a call from police department reporting resident was wandering around. Resident was transported by law enforcement to. Hospital for medical evaluation. Writer contacted hospital at approximately 02:00. Hospital staff reported resident undergoing laboratory testing and evaluation. At approximately 02:30, hospital notified writer that resident is medically stable, no acute issues identified, and awaiting transportation for return to facility. Administrator and responsible party and MD notified. Care plan to be updated upon resident's return. Close monitoring to be initiated. Review of hospital discharge record dated 03/04/26 reflected Resident #1 was discharged back to the facility with no injuries or acute findings. Review of Weekly Skin assessment dated [DATE] at 05:05 a.m. conducted by RN A, reflected Resident #1 had no signs of injuries upon return to the facility. Review of incident report dated 03/04/26 by the DON reflected in part: Upon return, the resident was placed on 1:1 supervision for safety. Ongoing close monitoring initiated. Social Services notified and will submit referral for evaluation and possible placement in a secured unit to prevent recurrence. Review of Progress Note dated 03/04/26 at 02:10 p.m. by SW B reflected Resident #1 could not provide meaningful details during a follow-up interview of the elopement. SW B recommended that Resident #1 be placed in a secure unit and would place referral to memory units in the area. Review of admission Record reflected Resident #1 was discharged to another facility on 03/04/26 at 05:02 p.m. In an interview with Resident #1's family member on 03/13/26 at 07:15 p.m., the family member stated that she received a phone message on 03/04/26 during the night notifying her that Resident #1 had eloped from the facility around 01:00 a.m. and the police had brought him back to the facility around 02:00 a.m. She stated following the incident she saw Resident #1 that afternoon on 03/04/26 and she did not note any injuries or changes in his behavior and he did not remember the incident and could not provide any details. She stated that Resident #1 did not have any prior exit seeking behaviors or (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	history of trying to elope. She stated that Resident #1 could walk but he was not very coordinated and was at risk of falls. She stated the facility told her he needed to be on a locked unit, and he was transferred to another facility. She stated she was concerned about the incident because the street outside the facility was very busy and he could have been hit. She stated Resident #1 walked slowly, and she did not understand why the facility did not quickly find him. In an interview on 3/17/26 at 06:50 a.m., the DON stated she was notified on 03/04/26 by RN A, the nurse on duty, that at approximately 01:00 a.m. a facility door alarm had sounded. She stated that RN A told her that she had gone to the door and looked but did not see the resident. RN A stated she then did a head count, and Resident #1 was not found in the facility or on the facility grounds. RN A stated that within 20 minutes she had received a call from the police that Resident #1 was found wandering in the community and was transported to the local hospital by the police. The DON stated that Resident #1 returned to the facility on [DATE] at 05:00 a.m. with no injuries, and he was placed on 1:1 observation until he was transferred to a sister-facility with a locked unit on the same day. The DON stated that Resident #1 typically used a wheelchair, and he did not have any prior elopement history or behaviors. She stated the ADM had access to the cameras and that RN A had not gone outside the building to look for Resident #1 when the exit door had alarmed, but staff searched the facility and the property once it was identified that Resident #1 was missing. She stated there were currently no residents at the facility with a score of 10 or more who were considered a high risk for elopement. She stated that since the elopement, elopement drills are being conducted 3 times a week (one on each shift), and each day she checked all resident's elopement assessment scores and monitoring for any changes and scores over 10 indicating high elopement risk. She stated that maintenance checked all doors daily to make sure that locks and alarms worked properly. She stated that since the elopement all staff were provided with abuse and neglect and elopement response training. She stated that only staff had access to the door codes and these are changed monthly and as needed. She stated there were no known mechanical issues with the doors. She stated that Elopement Risks Assessments were completed on all patients immediately following the incident. In an interview on 03/17/26 at 08:10 a.m., the ADM stated that he was notified on 03/04/26 that staff could not find Resident #1 and a code orange was initiated (facility code to initiate elopement protocol). He stated the police called the facility when they located Resident #1 within an hour. He stated that the police took Resident #1 to the local hospital for evaluation and Resident #1 did not have any injuries and returned to the facility around 05:00 a.m. the same morning. He stated he was unsure if Resident #1 was previously identified as being at risk for elopement. He stated he was told that RN A had looked outside when the exit door alarmed, but he could not confirm that she had walked around the facility. He stated this was the reason the nurse no longer worked at the facility. He stated it was the nurse's responsibility to have gone around the building at the time that the door alarmed. He stated that CNA D was outside and had seen Resident #1, but CNA D had not realized he was a resident, and instead thought Resident #1 was a homeless person. He stated that CNA D worked on the 2nd floor, whereas Resident #1 was a new admit to the 1st floor. The ADM stated that the police found Resident #1 near the hospital or the crossing bridge near the hospital. He stated that Resident #1 had gone at least as far as the main road, and he was not near the facility when found by the police. He stated that the area where Resident #1 was found was approximately a 5-to-10-minute walk, and perhaps longer for Resident #1. He stated following the elopement of Resident #1, elopement drills were done 3 times a week (1 per shift), elopement assessment risks were monitored daily, and all residents were reassessed for their elopement risks. He stated that following the incident, the maintenance department checked all the doors and alarms and no issues or malfunctions were found, and that the maintenance department now made daily checks on all door magnetic locks. He stated that Resident #1 was placed on 1:1 monitoring immediately upon return to the facility, and he was transferred to a sister-facility with a locked unit within 24 hours. He stated since the incident abuse and neglect training and elopement response training were conducted with CNA D and RN A. He stated that CNA D (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	behaviors. The facility took the following actions to correct the noncompliance prior to the start of the survey: All staff received training on abuse and neglect as well as training on elopement response with emphasis on the need to check outside the building in response to door alarms. In interviews on 03/17/24 between 05:20 a.m. and 12:38 p.m., a total of eight staff members from the day shift, evening shift, and night shift were interviewed. They included CNA's, RN, an LVN, and Physical Therapist. These staff interviews revealed that staff had received abuse and neglect training as well as elopement training since Resident #1's elopement. These interviews reflected that staff were knowledgeable of elopement response protocol including the need to check outside the building following a door alarm. Review of records on 3/17/26 reflected staff in-service training dated 03-04-26 on the facility Abuse and Neglect policy were reviewed with staff signatures present. Staff in-service training dated 03-04-26 on the facility Elopement Response and Elopement Prevention policies were reviewed with staff signatures present. All residents were reassessed for elopement risks. Review of records on 3/17/26 of a list of Elopement Assessments for all residents was reviewed and reflected that all resident elopement assessments were updated on 03/04/26. An AD Hoc QAPI meeting was conducted to review the elopement. Review records on 3/17/26 of a facility document dated 03/04/26 included AD Hoc QAPI Contributors reflected the signatures of the administrator, the DON, an assistant director of nurses, the medical director, social services, dietary, activity director and maintenance. Door locks and alarms were checked on 03/04/26 and daily. Record review on 3/17/26 of maintenance response reflected the door locks and alarms were checked on 03/04/26 and daily. Review of facility documents titled, Door Alarm Monitoring and Missing Resident/Elopement Monitoring reflected that this was done daily. Door alarm codes were to continue to be changed monthly. Record review on 3/17/26 of the facility document titled Door Alarm Code Change reflected that the door alarm codes were changed each month. Elopement drills were conducted with staff three times per week (one on each shift). Record review on 03/17/26 of facility documents titled, Elopement Drill of Actual Elopement Guide reflected elopement drills were conducted with staff three times per week beginning on 03/04/26 and staff evaluation reflected no issues were identified. The DON monitors all residents' elopement scores daily. In an interview and observation on 03/17/26 at 09:48 a.m., the DON stated that she is now monitoring a report of all Resident's elopement scores by generating a report daily. The daily report of resident's elopement scores was reviewed. The DON stated that she monitors this report for any changes in residents' scores and for any scores over 10 which might indicate a need for interventions. Record review on 3/17/26 of the facility policy (undated) titled, Elopement Prevention reflected, Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement.The resident's care plan will be modified to indicate the resident is at risk for elopement episodes.interventions into elopement episodes will be entered on the resident's care plan and medical record.