| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455996 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Renaissance at Kessler Park | 2428 Bahama Dr<br>Dallas, TX 75211 |

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) |
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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 3 residents reviewed for discharge or transfer.The facility failed to provide written notification to Resident #1's RP and Long-term care Ombudsmen. This failure could place residents at risk of improper transfer from the facility.Findings included:Findings included:Record review of Resident #1's face sheet, 05/12/26, reflected an [AGE] year old male, admitted [DATE], diagnosed with Schizophrenia, unspecified, (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations ,delusions and disorganized thinking), Unspecified Dementia, moderate with other behavioral disturbance (progressive decline in cognitive function affecting memory, thinking and behavior, without a clearly identified subtype). Record review of Resident #1's face sheet reflected Resident#1 had a RP.Record review of Resident #1's elopement assessment, 01/16/26, revealed Resident #1 was assessed on 01/16/26 and was determined to be at 0.0 score, indicated a elopement low risk, which meant no plan of care needed.Record review of Resident #1's admission MDS assessment, dated 01/23/26, reflected Resident #1 had a BIMS of 10, indicated moderate cognitive impairment. Record review of Resident #1 Discharge MDS, dated [DATE] reflected, Resident#1 wandering-presence and frequency has the resident wandered? coded at behavior not exhibited. Resident#1 had a BIMS of 10, indicated moderate cognitive impairment.Record review of Resident #1's progress notes, dated 03/26/26 and written by the DON, reflected, During the conversation on 3/25/26, writer informed resident's RP the resident was being transported to [local facility] with the MDS nurse and Wound care nurse present during the conversation. Record review of Resident #1's progress notes, dated 03/26/26 and written by the SW, reflected, On 02/12/2026, this SW and DON met with [RP] to discuss exit-seeking behavior. Pt attempted to go to doors and was easily redirected. Pt was moved to a room on hallway away from doors and did not make further attempts to go to doors for several weeks. Pt was previously in secure unit at [local facility], but pt was removed from unit seven years prior to d/c to this facility. Pt was moved, as behavior maybe be related to adjusting to new facility. RP was agreeable. When pt displayed exit seeking behaviors again, SW notified RP that pt attempted to exit and now pt will need to d/c to secure unit. RP confirmed understanding and requested a SNF close to RP, zip code .SW tried several facilities and RP not agreeable to any [specific locations. On 03/23/2026, pt requested this SW refer pt to [ local long term care facility].On morning of 03/25/2026, SW informed pt accepted by[local facility]. Liaison [from other facility] notified RP of acceptance and transfer, per SW request. SW f/u and confirmed liaison [from other facility] spoke with pt several times. DON spoke with pt as well, as this SW was out of office. Evening of 03/25/2026, SW informed by liaison that RP stating she was unaware of transfer and liaison was highly confused. Morning of 03/26/2026, SW informed RP wants pt transferred to [Another facility]. At 12:30 pm, this facility's liaison reports [RP] no longer wants to<br>(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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | transfer pt and wants pt to remain at [local facility] Nothing else to note.Record review of Resident #1's care plan, dated 03/27/26, reflected no record of history of elopement.Record review of Resident#1 census, undated, reflected on 1/16/26 Resident#1 obtained a room at the facility. On 02/12/26 Resident#1 was transferred rooms. On 3/25/26 Resident was had a stop billing. During a telephone interview on 05/12/26 at 8:35 AM, Resident#1's RP stated she did not receive a notification in writing about Resident #1 being discharged . Resident #1's RP stated she did not want the resident to be transferred until she looked at the other facility. Resident #1's RP stated she received a call on 03/25/26 from another facility that said Resident #1 was transferred. During an interview on 05/12/26 at 9:30 AM, the SW stated Resident #1 was exit seeking on 02/12/26. Resident #1 was moved to a room away from the door. The SW stated on 0321/26, the resident pushed on the exit door, the alarm sounded and Resident #1 attempted to leave. The SW stated Resident #1 was placed on 1:1 supervision (one staff member is assigned to provide constant and continuous oversight to one individual, ensuring their safety and well-being) The Social Worker stated she communicated with Resident #1's family member by phone. Resident #1 was denied by some local facilities because the facilities did not have a secure unit or space. The SW stated a local facility accepted Resident #1 on date 03/25/26 and he was transferred on 03/25/26. The SW stated she was confused why Resident #1's RP was upset about the transfer because initially she was ok with the transfer and planned to visit the new facility on before the resident transferred/ The SW could not recall if she told the facility ombudsmen and/or volunteer. The SW stated she was responsible for assisting with finding placements and discharges. During a telephone interview on 05/12/26 at 3:44 PM, the facility ombudsmen stated he was not notified of Resident #1's transfer to another facility.During a telephone interview on 05/12/26 at 4:14 PM, the facility ombudsmen stated the volunteer ombudsmen had not been notified of Resident #1's transfer to another facility.During an interview on 05/15/26 at 4:16 PM, the Administrator stated the SW would email the ombudsmen about the resident being discharged . The Administrator checked her emails, and she could not find a email from the SW to ombudsmen about Resident #1 transfer. The Administrator stated she expected the SW to follow the policy and procedures for proper discharge and transfers of the residents.Record review of the facility policy titled, Transfer and Discharge (including AMA) (Against Medical Advice), revised 09/01/23, reflected, non-emergency transfers or discharges initiated by the facility. Return not anticipated. Document the reasons for the transfer or discharge in the residence, Medical records and in the case of necessity for the residence. Welfare and the resident needs cannot be met in the facility document. The specific resident needs that cannot be met. Facility attempts to meet the residents needs in the service available at the receiving facility to meet the needs document. Any danger to the health or safety of the resident or other individuals that failure to transfer or discharges would pose. At least 30 days before the resident transferred or discharged , the social Services director will notify the resident and the residence representative and writing in a language and manner that they understand. This time frame does not apply if the resident was has not resided in the facility for 30 days.d. A copy of the notice shall be provided to a representative of the office of the State Long-Term Care Ombudsmen. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. for 1(Resident #1) of 3 residents reviewed.The facility failed to update Resident #1's care plan to reflect a history of exit seeking behaviors.This failure could place residents at risk of not receiving proper care.Findings included:Record review of Resident #1's face sheet, 05/12/26, reflected an [AGE] year old male, admitted [DATE], diagnosed with Schizophrenia, unspecified, (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations ,delusions and disorganized thinking), Unspecified Dementia, moderate with other behavioral disturbance (progressive decline in cognitive function affecting memory, thinking and behavior, without a clearly identified subtype). Record review of Resident #1's face sheet reflected Resident#1 had a RP.Record review of Resident #1's elopement assessment, 01/16/26, revealed Resident #1 was assessed on 01/16/26 and was determined to be at 0.0 score, indicated a elopement low risk, which meant no plan of care needed.Record review of Resident #1's admission MDS assessment, dated 01/23/26, reflected Resident #1 had a BIMS of 10, indicated moderate cognitive impairment.Record review of Resident #1 Discharge MDS, dated [DATE] reflected, Resident#1 wandering-presence and frequency has the resident wandered? coded at behavior not exhibited. Resident#1 had a BIMS of 10, indicated moderate cognitive impairment.Record review of Resident#1 progress notes, dated 03/26/26 reflected:Progress notes dated 03/26/26 reflected, On 02/12/2026, this SW and DON met with [RP] to discuss exit-seeking behavior. Pt attempted to go to doors and was easily redirected. Pt was moved to a room on hallway away from doors and did not make further attempts to go to doors for several weeks. Pt was previously in secure unit at [local facility], but pt was removed from unit seven years prior to d/c to this facility. Pt was moved, as behavior maybe be related to adjusting to new facility. Written by SW.Record review of Resident #1's care plan, dated 03/27/26, reflected no record of history of elopement. On 03/21/26 Resident was observed standing up and pushing an exit door open, causing the alarm to go off. An aide nearby observed all this and ran after the resident and re-directed the resident back into the facility. Resident was then placed on 1:1 supervision until secure unit placement. DON, family member have been notified written by LVN D During an interview on 05/12/26 at 3:40 PM, the DON stated the elopement assessment was done when a resident left the facility and not for exit seeking behaviors. The DON stated the facility was focused on getting the resident transferred from the facility and the care plan was not updated. The DON stated the care plan was important so that everyone who provided resident care would know level o f care the resident needed./ During an interview on 05/12/26 at 4:20 PM, the Administrator stated the care plan needed to be person centered specific to the resident's care. The Administrator stated it was important to update the care plan to make sure residents received the proper care. The Administrator stated the head of nursing was responsible for care plan updates. Record review of facility policy titled, Comprehensive Care Plan, dated 02/10/21, reflected, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.,,6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in 1 of 1 (Kitchen #1) reviewed for food safety in facility's only kitchen. The facility failed to ensure leftover food was labeled, dated, and stored properly in the refrigerator.The facility failed to ensure personal cups were kept in the designated area and not on the prep table. These failures place residents at risk of cross-contamination and foodborne illnesses.Findings included:During an observation on 05/12/26 at 7:30 AM, of the prep table, reflected meatloaf on a plate covered with saran wrap next to a disposable cup containing water and ice. During an interview on 05/12/26 at 8:50 AM, Dietary Aide A stated the plate on the table contained meatloaf. She stated the plate should have been thrown in the trash, but it was on the prep table all night. Dietary A stated staff were not allowed to work overtime, and she was not able to load any more dishes after 7:15 PM, to wash them after the previous night's meal. She stated she noticed the plate on the prep table when she left work the night before. Dietary A stated the person responsible for leaving the meatloaf on the prep table last night was one of the new cooks. Dietary A stated the intermediate person was not at work during the day of the interview on 05/12/26. Dietary Aide A stated the person responsible for not labeling, dating, and storing the meatloaf properly was the cook because they were supposed to put away all food at the end of the night, as well as turn in all food trays to her. Dietary Aide A stated her duties were to wash dishes, and sometimes she prepared drinks and served them to the residents. Dietary Aide A stated the risk of the meatloaf not being labeled, dated, and stored properly was that bacteria from insects and contamination could affect food served from the prep table. Dietary Aide A stated she did not notice the disposable cup on the prep table, but it should not have been there. She stated that if staff had personal drinks, they were supposed to carry them or place them in the area where their personal items belonged. Dietary Aide A stated all personal items were supposed to be placed in the office on the shelf in the corner. She stated the risk of staff leaving drinks on the prep table was cross-contamination, someone accidentally taking a sip, or the person having been sick, which could have led to spreading illness and affecting the resident's food. During an interview on 05/12/26 at 9:13 AM, [NAME] B stated she worked in the kitchen for 8 months. She stated her duties were to cook during the evening shift. [NAME] B stated she worked the night before and noticed the meatloaf on the prep table before she left. [NAME] B stated the meatloaf was an extra order for a resident, and the kitchen staff, who stayed later were supposed to deliver it, but she guessed they did not, because when she returned to work it was still on the prep table. [NAME] B stated the meatloaf was in the line for delivery, but she was not able to say why it was never delivered because she was not sure what happened after she left. She stated she was not sure which resident the meatloaf was intended for. [NAME] B stated it was not okay for the meatloaf to remain on the prep table all night and stated all leftover food was supposed to be discarded at the end of the night. She stated she had no way of knowing whether it had been left out on the prep table overnight. [NAME] B stated she was usually the person who cleaned up at the end of the night and ensured all food was put away or discarded. [NAME] B stated that if there was leftover food, she usually made sure it was labeled and dated with a use-by date and then placed in the refrigerator. [NAME] B stated the risk of the meatloaf not being labeled and dated with a use-by date was contamination if it was not properly contained. [NAME] B stated the person responsible for placing the disposable cup on the prep table was the new employee, [NAME] D, and that this was the second time she had placed her drinking cup on the prep table. [NAME] B stated she had tried explaining to [NAME] D where her drinking cup was supposed to go, but she did not think [NAME] D fully understood her because she did not speak English fluently and [NAME] B did not want to be harsh or rude to her. She stated the risk of the drinking cup being on the prep table was that it could contain bacteria and could spill onto food being prepared on the prep<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | table. [NAME] B stated personal drinks were supposed to be placed in the manager's office on the shelf where kitchen staff's personal belongings were supposed to go. During an interview on 05/12/26 at 9:37 AM, Dietary Aide C stated she worked in the kitchen for one week. Dietary Aide C stated she was not sure why the meatloaf was on the prep table. She stated she worked in the morning but was not there for the evening shift. Dietary Aide C stated she thought the meatloaf belonged to one of the kitchen staff. Dietary Aide C stated she did not see the meatloaf on the table when she came in that morning and thought one of the kitchen staff was going to eat it. She stated the meatloaf should have been labeled and dated with a use-by date. Dietary Aide C stated she was told that if there was leftover food, it was supposed to be discarded. She stated the risk of the meatloaf not being labeled, dated, and stored properly was contamination. Dietary Aide C stated she was not sure who placed the drinking cup on the prep table, and she stated it was not okay for the drinking cup to be on the prep table. Dietary Aide C stated she was not sure where personal drinking cups were supposed to be placed, but stated there was a designated place, and she was just unsure where it was. Dietary Aide C stated personal cups were not supposed to be on the prep table and the risk was contamination. During an interview on 05/12/26 at 9:55 AM, [NAME] D stated she worked in the kitchen since 05/07/26. [NAME] D stated the drinking cup on the prep table was hers. [NAME] D stated staff were not supposed to have personal cups on the prep table. [NAME] D stated she was not sure where personal cups were supposed to be placed. [NAME] D stated it was her third day, and the kitchen staff had not told. [NAME] D stated the risk of the drinking cup being placed on the prep table was that it could spill into a resident's food and cause contamination. [NAME] D stated she saw Dietary Aide C put the meatloaf on the prep table earlier that morning. [NAME] D stated there should have been a label and use-by date on the meatloaf. [NAME] D stated that if she had leftover food, she would usually place a label and use-by date on the food. [NAME] D stated with the meatloaf not being labeled or dated with a use-by date, staff would not know whether it was old. [NAME] D stated the risk of the meatloaf not being labeled or dated with a use-by date was that it could have been old or could have made a resident sick if consumed. [NAME] D stated she had not received any training prior to being hired. During an interview on 05/12/26 at 10:07 AM, the temporary Dietary Manager stated she was filling in for the Dietary Manager. She stated it was her first day filling in. The temporary Dietary Manager stated she could not say for sure why [NAME] D had her drinking cup on the prep table. The temporary Dietary Manager stated staff were told they had a designated area where all personal belongings were supposed to go. The temporary Dietary Manager stated the specific area where staff were supposed to place their drinks was near the office, and staff could also eat in that area, so they did not have to go all the way to the break room. The temporary Dietary Manager stated the risk of the drinking cup being placed on the prep table was that saliva from the cup could get into a resident's food. The temporary Dietary Manager stated if a staff member did not wash their hands prior to placing the cup on the prep table, another risk was contamination of food. The temporary Dietary Manager stated all items in the kitchen were supposed to be labeled and dated with a use-by date, regardless of whether the item had just come off the vendor truck. The temporary Dietary Manager stated she was not aware there was food on the prep table and once she went into the kitchen she did not see anything on the prep table but stated she just arrived at work. The temporary Dietary Manager stated the risk of the meatloaf not being labeled and dated with a use-by date was that staff would not know how long the food was there and it could have been in the temperature danger zone, creating bacterial growth. During an interview on 05/12/26 at 4:16 PM, the Administrator stated the expectation of kitchen staff was to discard all leftover food at the end of the night and the meatloaf should not have remained on the prep table all night and should have been refrigerated. The Administrator stated the meatloaf should also have had a label and use-by date on it. The Administrator stated the risk of the meatloaf not having a label and use-by date was that it could have caused foodborne illness if consumed by a resident. The Administrator stated staff were expected not to eat or drink on the food line while preparing food in the kitchen. The Administrator (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated if staff had food or drinks, they were supposed to be placed in the break room, and the risk of the drinking cup being placed on the prep table was that it could have caused illness in a resident. In an email on 05/21/2026 at 6:16 PM, the Administrator responded to an email regarding an email on how the kitchen staff are trained. The administrator emailed the permanent Dietary Manager regarding the trainings, and she forwarded his response reflected the following Aramark puts new employees with current employees for 4 days for training on menu, cooking instructions, ect. After 4 days they are then by themselves but still open for any questions they have. As well as they get training on for their food handler's certificate. Record Review of Dietary Aide C's employee record indicated she was hired on 08/14/25, a food handler's license, and a background check. Employee file did not have any training. Record Review of [NAME] D's employee record indicated she was hired on 05/05/26, an expired food handler's license, and a background check. [NAME] D's employee record did not have any trainings. Record review of the facility's policy titled, Food Safety and Sanitation Plan, dated 10/24/22, reflected, in part:11. Ready-to-Eat PHF Date MarkingReady-to-eat food would be clearly labeled using a calendar date to indicate the date the product was prepared and the date the product must be used or discarded.Commercially prepared PHF/TCS food products would be clearly labeled using a calendar date to indicate the date the product was opened and the date by which the product must be discarded. The use-by date must not have exceeded the manufacturer's established use-by date. During an interview on 05/12/26 at 4:30 PM, the DON stated there was not a policy for personal drinks or food for kitchen staff. |