

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455996	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER The Renaissance at Kessler Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2428 Bahama Dr 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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #10) of 4 residents reviewed for pharmaceutical services. The facility failed to ensure a package of Resident #10's Morphine Sulfate and MS Contin were immediately delivered to facility nursing staff by CNA A. This failure placed all 60 residents at the facility at risk of not receiving the therapy and/or care per provider orders to allow her to attain or maintain her highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #10's Face Sheet revealed she was an [AGE] year-old resident admitted to the facility on [DATE] for long term care. Relevant diagnoses included end stage heart disease (irreversible condition where the heart cannot pump effectively to meet the body's needs,) dementia (decline in cognitive abilities,) and major depressive disorder (persistent feelings of sadness.) Record review of Resident #10's MDS assessment1, dated 07/20/2025, revealed she was cognitively intact with a BIMS score of 14. Resident #10 required partial/moderate assistance from staff with personal hygiene and was fully dependent upon staff with shower/baths, toileting, and lower body dressing. Record review of Resident #10's Physician Orders on 09/25/2025 at 10:45 am revealed: Admit to [HOSPICE] for End Stage Heart Disease with a start date of 09/03/2025. Morphine Sulfate (Concentrate) Oral Solution 10 MG/5 ML . Give 0.25 ml by mouth every 3 hours as needed for shortness of breath . with a start date of 02/28/2023. MS Contin Oral Tablet Extended Release 15 MG . Give 1 tablet by mouth two times a day for pain . with a start date of 01/14/2025. Record review of Resident #10's Comprehensive Care Plan dated 10/31/2024 revealed Resident has a terminal illness and is receiving hospice care . Dignity will be maintained, and the resident will be kept comfortable and pain free . In an interview and observation with Resident #10 on 09/23/2025 at 12:14 PM, she was resting in her bed. She reported she was clean, dressed, and was in no distress. She reported sufficient care and that she was recently placed on hospice for her terminal illness. She stated she recently received a package of her pain medication in the mail and after she opened the package, she later gave a staff member the package and asked her to give it to her nurse . She did not recall if she informed the staff that the package was her medication. She denied any incidents of her experiencing unmanageable pain and denied the facility failed to provide her with pain medication upon her request. In an interview with the facility's ADON on 09/25/2025 at 10:00 AM, she stated medications at the facility were typically delivered via the pharmacy, and only a nurse or medication aide can sign for the medication upon receipt. The hospice company for Resident #10 delivered her medications separately via [PARCEL COMPANY] and did not inform the facility prior, so they were not able to anticipate the delivery. She stated this delivery was addressed to the resident directly and delivered after hours. She stated the package was not labeled as medication and was taken to the resident's room like a normal package or mail delivery. She stated that the resident opened the package and asked CNA A to bring it to her nurse at that time. She stated CNA A took the package not knowing what it contained, left the room, and placed it on a linen cart nearby. CNA A then (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted another resident with care and forgot about it. She stated this was the last time the package was seen . She stated the facility ceased working with the specific hospice company to prevent this from happening in the future. Additionally, she in-serviced all staff on misappropriation of property and did a verbal counseling for CNA A for her conduct. Attempts to interview CNA A on 09/25/2025 at 10:40 and 11:18 AM were unsuccessful. Attempts to interview Resident #10's hospice company at 09/25/2025 at 11:17 and 09/26/2025 at 11:03 AM were unsuccessful. In an interview with the facility's Administrator on 09/25/2025 at 12:28 PM, she revealed medications at the facility were typically delivered via the pharmacy and brought straight back to the nurse's station. The hospice company for Resident #10 delivered her medications separately via [PARCEL COMPANY] and did not inform the facility prior. She stated initially she was not even sure what was in the package. She stated it was not considered a diversion ; she considered it a resident package that went missing after it was delivered to the resident. She stated her expectations were for all medications to go through pharmacy delivery so the appropriate staff can respond accordingly per facility policy. She stated she has terminated the contract with Resident #10's previous hospice company, moving forward, to prevent this from occurring again. She stated once she discovered Resident #10's medications were missing; she filed a police report with local law enforcement and was able to re-order the medications promptly. She stated she had Resident #10's medications already on hand, so the resident did not go without or miss any of her medications due to this incident. Record review of CNA A's Associate Disciplinary Memorandum dated 08/25/2025 revealed verbal counseling, and Employee failed to deliver package to nurse resulting in missing package . with future directives of delivery to nurse immediately upon receiving a package. Record review of facility's In-Service Program Attendance Record dated 08/15/2025 revealed twenty-seven staff signatures from nursing, kitchen, and other support staff. Subject matter included Misappropriation of Property . Resident property should be handled with care and concern and placed appropriately for safekeeping. Record review of facility's policy, Drug Diversion Guidelines, rev. 10/24/2022, revealed:1. Do not sign for receipt of controlled substances until you have inspected the delivery from the pharmacy that all ordered medications have arrived.2. The narcotic count sheet should be signed and quantity received should be indicated.3. Medications should be put in storage areas immediately and not left at nurses station or on medication room counters.4. Controlled substances should be stored in a double locked compartment at times including discontinued and overstocked medications.5. A drug count must be done at each shift change and should be done whenever the keys to the narcotic storage areas are exchanged from one staff to another.6. ALL controlled substances should be counted including those in the lock box in the refrigerator and overstock narcotics in medication room.7. Access to refrigerator lock box and overstock narcotics in medication room should be limited.8. Signing the narcotic shift count sheet means you are accepting responsibility for the controlled substances. Therefore, do not sign unless you are certain that all of the controlled substances are present and have not been adulterated/tampered with or altered in any way. Record review of facility's policy, Policy and Procedures . Receiving Controlled Substances rev. 08/2020, 11. Only licensed personnel may receive controlled substances from the pharmacy courier. Procedures for receiving controlled substances include: a. A nurse signs for the medications, including the controlled substances, on the pharmacy delivery ticket and inspects the medications.b. If a discrepancy or dispensing error is identified for a controlled substance, the nurse must notify the pharmacy at point of delivery. The nurse should document description of discrepancy/error on delivery packing slip/manifest and refuse/reject delivery of the affected medication(s).c. The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication) or in accordance with facility policy.d. Two nurses, and/or in accordance with facility policy, witness placement of the controlled substances in the secured compartment of the medication cart.e. Controlled substance inventory sheets are filed appropriately. A hard-bound log book, or in accordance with facility policy, is utilized to track the controlled substance from delivery to (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disposition. All discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. Policies developed by the facility in accordance with local/state regulations may supersede the procedures outlined in this policy . II. Loss of Supply of Medication:1. The DON investigates the suspected loss and research all the records related to medication receipt, its use since receipt, and all persons involved with medication administration and the supply of medication and identifies the last known point in time that the medication was available. The pharmacy should be notified, and the pharmacy should verify that the medication was dispensed. A thorough search is conducted in all drug storage areas, the residents' room, and any other locations where medications may have been used/placed during medication administration in an attempt to locate any missing container or medication supply.2. If the supply cannot be found after a thorough investigation has been completed, a supply must be obtained for the resident.3. Document the loss and the investigation process. Notify the prescriber and family if doses have been missed and/or follow facility policy.4. If the loss involves a controlled substance, all the controlled drug accountability procedures and documentation should be reviewed and audited. If the audit reveals a particular individual or individuals who might be suspected of involvement with the loss, appropriate disciplinary actions are taken and deferred to human resource policies.5. Appropriate agencies, required by state and federal law, will be notified.		