STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675754	A. Building B. Wing	05/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traymore Nursing Center	4315 Hopkins Ave Dallas, TX 75209

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 (Resident #1) of 1 resident's reviewed for CPR. 1. LVN A failed to initiate and perform CPR immediately after finding Resident #1 unresponsive on 05/29/25. 2. LVN A, LVN B and LVN C failed to perform any life saving measures on Resident #1 per his Care Plan, Physician Orders and Advanced Directives. Resident #1 expired in the facility on 05/29/25. The noncompliance was identified as PNC. The IJ began on 05/29/25 and ended on 05/30/25. The facility had corrected the noncompliance before the survey began on 05/31/25. These failures could affect the Full Code residents at the facility by placing them at risk for not receiving CPR and further life-saving treatments as desired, which could result in death. Findings included: Record review of Resident 1's face sheet, dated 05/31/25, revealed Resident #1 was an [AGE] year-old male admitted to the facility on [DATE], readmitted to the facility on [DATE] and 05/15/25. Resident #1's diagnoses included: encephalopathy (a group of brain disorders that cause brain dysfunction or damage, potentially affecting thinking, behavior, and consciousness), heart failure, acute respiratory failure with hypoxia (occurs when the lungs cannot adequately provide oxygen to the blood), acute chronic kidney failure and disease (stage 4), and end stage renal disease. Record review of Resident #1's Quarterly MDS assessment, dated 04/10/25, revealed the resident had severe cognitive impairment with a BIMS score of 7. Resident #1 was diagnosed with ESRD (end-stage renal disease), which required dialysis treatments three times per week. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Discharge MDS assessment, dated 05/29/25, revealed in Section X0600 - Type of Assessment in Subsection F. - Entry/Discharge reporting revealed a Code of 12 for Death in facility. Record review of Resident #1's care plan dated 05/15/25 revealed the following: Focus: [Resident #1] request to be Full Code Status or Full Code . Date Initiated: 07/11/2022 Cancelled Date: 05/30/2025 Goal: Comply with resident and family wishes . Date Initiated: 07/11/2022 Cancelled Date: 05/30/2025 Interventions/Tasks: Call for emergency personnel and initiate CPR. Date Initiated: 07/11/2022 Cancelled Date: 05/30/2025 Communicate residents choice. Date Initiated: 09/12/2022 Cancelled Date: 05/30/2025 Inform physician and family of any changes in condition. Date Initiated: 09/12/2022 Cancelled Date: 05/30/2025 Residents code status reviewed with family and RP with each care plan review/care plan meeting. Date Initiated: 07/11/2022 Cancelled Date: 05/30/2025 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respect residents end of life decisions. Date Initiated: 07/11/2022 Cancelled Date: 05/30/2025 Record review of Resident #1's order summary report dated, 05/31/2025 reflected: Full Code Communication Method: Phone Order Status: Active Order Date: 11/01/2023. Record review of the facility's staffing schedule for the 6:00 PM - 6:00 AM shift on 05/29/25 revealed: LVN A, LVN B, LVN C, CNA D and CNA E were all on duty when Resident #1 expired at the facility. Record review of Resident #1's skin assessment on 05/20/25 at 2:02 PM by LVN J revealed no concerns. Record review of Resident #1's skin assessment on 05/29/25 at 9:30 AM by LVN J revealed no concerns. Record review of Resident #1's nurse progress notes from LVN L on 05/29/25 at 7:13 PM, revealed: Res went for unclogging of av shunt, not successful. Res has new permcath [sic] to rt upper chest wall, drsg dry and intact. Res went to dialysis after permcath inserted and rec'd dialysis. Return to facility, cond stable. Res c/o pain to at rt neck, hydrocodone given, and then res layed down in bed. Will cont to monitor. v/s 154/67, 18, 97.9, 70. Record review of Resident #1's Nurse Progress Notes from LVN L on 05/29/25 at 5:00 PM, revealed: Norco Oral Tablet 5-325 mg, give 1 tablet by mouth every 6 hours as needed for PAIN MANAGEMENT, Res c/o pain to rt neck. NORCO 1 TAB PO GIVEN. Record review of Resident #1's nurse progress notes from LVN L on 05/29/25 at 7:20 PM, revealed: PRN Administration was: Effective, Follow-Up Pain Scale was: 0 Record review of Resident #1's nurse progress notes from LVN A on 05/30/25 at 12:10 AM, revealed: This nurse made initial round at 7:35 pm, resident was lying in bed with no distress, awake and alert, verbally responsive. He denied any pain/discomfort, new dialysis port to right neck IJ when asked with dressing intact. V/s at this was 131/63, 20, 97.4, 97% and blood sugar was 124mg/dL. At 21:40, this nurse did the 2nd round and noted resident sitting on his electric w/c unresponsive with a large amount of blood on his clothing and on the floor, unable to obtain v/s and 911 call was placed. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's record for residents who expired in the facility reflected, [Resident #1] expired at the facility on 05/29/25. On 05/31/25 at 7:05 PM an attempted telephone call to Resident #1's RP was unsuccessful. On 05/31/25 at 4:16 PM a telephone call was made to the police department. The dispatcher stated that a police report would need to be ordered from the records department. The records department was open Monday - Friday from 8:00 AM - 5:00. The dispatcher provided the website information to submit a Records Request for a Police Report about the incident regards to Resident #1 at the facility on 05/29/25. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with LVN A on 05/31/25 at 1:04 PM, revealed she had been employed at the facility for 9 months. LVN A stated on 05/29/25 she worked the 6:00 PM - 6:00 AM shift with Resident #1. LVN A stated that Resident #1 went to dialysis earlier during the day and his dialysis port was clogged. Resident #1 was sent to the vascular center and had the dialysis port in his hand capped. LVN A stated that Resident #1 received a new dialysis port in his neck at the vascular center and was returned to the facility around 5 PM according to the progress notes in EMR. LVN stated that Resident #1 was complaining of pain and discomfort in his neck and received some pain medication (Norco) from [LVN L] prior to her shift. LVN A stated that at the beginning of her shift, she was doing her rounds on the floor and arrived at [Resident #1's] room and opened the door and she spoke with him, and everything appeared to be fine. LVN A stated that Resident #1 did not complain of anymore discomfort from the new inserted dialysis pump in his neck. LVN A stated that she returned to Resident #1's room a couple of hours later to check in with him and observed that he was sitting in his wheelchair and his head was pushed back, and his eyes were opened. LVN A stated that she spoke to Resident #1, but he did not respond. LVN stated that she checked Resident #1 for vital signs, and he did not have any pulse, blood pressure and no respiration. LVN A stated that it appeared that Resident #1 had pulled out the dialysis port from his neck and she observed the port in his hand and there were large amounts of blood throughout Resident #1's room. LVN A stated that she exited Resident #1's room and screamed down the hallway for [LVN C] but did not hear a response. LVN A stated that she told CNA D to try and located LVN C. LVN C could not be located, therefore LVN A asked for CNA D to call LVN C, who did not answer her phone. LVN A stated that she directed CNA D to go upstairs to get LVN B to have her come downstairs to assist her. LVN A stated that she telephoned 911 while CNA D went upstairs to get LVN B. LVN B, CNA D and CNA E returned downstairs, and she informed LVN B and CNA E about finding Resident #1 dead. LVN A stated that the 911 dispatcher was asking her questions about her observation of Resident #1. LVN A stated that the 911 dispatcher asked her to perform CPR on Resident #1, but she did not. LVN A stated that she was CPR Certified but did not know why she did not perform life saving measures on Resident #1 who was a full code, which meant he should have received CPR. LVN A stated that she sent a text message to the ADON, DON and Administrator informing them about her observation of Resident #1 in his room and what happened. LVN A stated that the DON asked her if there was an RN or the floor and she said, I don't know. LVN A stated that LVN B and LVN C did not perform CPR on Resident #1. LVN A stated that staff were getting the crash cart to take it to Resident #1's room when the ambulance and paramedics arrived at the facility. LVN A stated that the paramedics stated that CPR was not needed because Resident #1 had already passed away upon their arrival to the facility. LVN A stated that the ADON, DON and Administrator arrived at the facility sometime while the police were at the facility. LVN A stated that the police spoke with her and took her statement about the incident and then left because there was nothing suspicious. LVN A stated that Management told her to write in the nurses' notes in Resident #1's chart about the incident and she was suspended pending the facility's investigation. She stated that someone from corporate told her that she had been terminated from the facility due to not performing CPR on Resident #1 effective 05/29/25. LVN A stated that she has not worked at the facility since her shift on 05/29/25. LVN A stated that she did not want to provide the surveyor any risk or harm associated with a who was full code and CPR was not performed. On 05/31/25 at 2:34 PM an attempted follow-up interview with LVN A via telephone was unsuccessful. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CNA D on 05/31/25 at 1:57 PM, revealed she had been employed at the facility for 5 months. CNA D stated that she was on duty on 05/29/25 and worked the 6:00 PM - 6:00 AM shift at the facility. CNA D stated that on 05/29/25, she was assigned to work the first floor. CNA D stated that she arrived to work prior to the beginning of her shift. CNA D stated that when she arrived, she began to gather and pick up the residents' food trays from their rooms. CNA D stated that she arrived at Resident #1's room door and knocked on the door, entered the room, and said hello to the resident. CNA D stated that Resident #1 appeared to be in no distress, and she entered his room and picked up his food tray and exited the room. CNA D stated that a few hours later, LVN A was running down the hall and calling for help. LVN A told CNA D that [Resident #1] was dead. CNA D stated that she telephoned the Nurse [LVN C] who was on break, but LVN C did not answer. CNA D stated that she called upstairs and spoke with the Nurse [LVN B] and told her that one of their patient's downstairs was dead. CNA D stated that she telephone [LVN C] again and she told her that [Resident #1] was deceased and LVN C stated that she would return to the facility. CNA D stated that LVN B and CNA E from upstairs arrived downstairs and LVN A was on the telephone with 911. CNA D stated that LVN C then arrived at the facility from her break. CNA E stated that she did not observe LVN A, LVN B, and LVN perform CPR on Resident #1. CNA D stated that the paramedics arrived at the building and took over the situation. CNA D stated that the police would not allow anyone into Resident #1's room. CNA D stated that the police took statements from everyone, the ADON, DON and Administrator arrived at the facility. CNA D stated that after everything was clear, she and CNA E cleaned Resident #1's room, which was very bloody. CNA D stated that she was in shock about the situation, and she had never seen that type of scenario occur and it was devastating. In a telephone interview with CNA E on 05/31/25 at 2:08 PM, revealed she had been employed at the facility for 1 year. CNA E stated that she was on duty on 05/29/25 and worked the 6:00 PM - 6:00 AM shift at the facility. CNA E stated that on 05/29/25, she was at the Nurses Station upstairs and LVN B received a telephone call from CNA D, who works downstairs. CNA E stated that LVN B told her that CNA D said that a resident downstairs was found unresponsive in his room and passed away. CNA E stated that she and LVN B went downstairs and observed CNA D and LVN A at the Nurses Station. CNA E stated that LVN A was on the telephone with 911. CNA E stated that LVN B asked CNA D what room the resident was in and LVN B and CNA E went to the resident's room and observed the resident. CNA E stated that Resident #1 was observed in his wheelchair, and he was leaning on his right side. CNA E stated that she did not remember Resident #1 having anything in his hand(s), but remembered that there was a large amount of blood throughout the room including on Resident #1's lap, pants, shoes, hands, floor, trashcan, nightstand and underneath Resident #1's bed near the A/C. CNA E stated that she and LVN B were both in shock and disbelief after viewing Resident #1 in his room and returned to the Nurses Station. CNA E stated that LVN B asked LVN A if Resident #1 was Full Code and if anyone started CPR on Resident #1 and LVN A replied, No, he was already deceased . CNA E stated that LVN A was on the phone with 911 and the dispatcher said that they were going to send a police officer to the facility, and it was a signal 87, whatever that meant. CNA E stated that she nor LVN B did CPR on Resident #1. CNA E stated that the paramedics arrived and took over the situation and then the police came, and she gave a statement to the police officers. CNA E stated that she returned upstairs to her assigned area and continued her work duties. CNA E stated that after the police left the facility, CNA D telephoned her to assist with cleaning up Resident #1's room. On 05/31/25 at 2:20 PM an attempt to interview LVN B via telephone was unsuccessful. On 05/31/25 at 2:22 PM an attempt to interview LVN L via telephone was unsuccessful. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with LVN C on 05/31/25 at 2:26 PM, she stated that she had been employed at the facility for 1 year. On 05/29/25, she stated that she worked the 6:00 PM - 6:00 AM shift at the facility. She stated that CNA D telephoned her and told her that she was out of the facility on break. CNA D told her that [Resident #1] was found by LVN A in his room unresponsive and he was possibly deceased . LVN C stated that she told CNA D that she would return to the facility. LVN C stated that she returned to the facility about 10 minutes after receiving the telephone call from CNA D. LVN C stated that when she returned to the facility, no staff members were in Resident #1's room and LVN A, LVN B and CNA D and CNA E were at the Nurses Station. LVN C stated that she observed LVN A on the telephone with 911 and asked her if she performed CPR on Resident #1. LVN C stated that LVN A replied, No, because he is dead. LVN C stated, there was too much going on and she decided to mind her business and go back to her work because a patient requested pain medication. LVN C stated that she was CPR Certified but did not perform CPR on Resident #1 who was full code. LVN C stated that if she were on duty and observed a resident in his room or anywhere unconscious, she would call a code blue. LVN C stated that a code blue, meant she would alert staff that there was an unresponsive resident, she would check for vitals, get the crash cart, and look and the binder on the crash cart to ensure the code status of the Resident. If the resident were a full code, such as Resident #1, she would place the resident on a hard surface and begin CPR until paramedics would arrive and take over the life saving measures on the resident. LVN C stated that she did not know why she did not perform CPR on Resident #1 per his advanced directive, physician's orders, and the facility's CPR Policy. LVN C stated that LVN A had not returned to work at the facility after 05/29/25. LVN C stated that the risk of not performing CPR on a resident that had a Full Code status was that if CPR was not performed, the resident can die. In an interview with LVN G on 05/31/25 at 5:30 PM, she stated that she had been employed at the facility for 3 months. LVN G stated that she was not on duty when the incident occurred at the facility involving Resident #1 being found unconscious by LVN A. LVN G stated that she was in shock when she heard from other staff members that LVN A, LVN B and LVN C did not perform CPR on Resident #1, who was Full Code. LVN G stated that if she walked into a resident's room and observed that the resident was unconscious and/or unresponsive, she would immediately call for help from other staff, check the resident for a pulse, if there was no pulse, immediately place the resident on a hard flat surface, and immediately start CPR. LVN G stated that she would immediately start delegating tasks for other staff to assist her while she was performing CPR on the unresponsive resident, such as calling 911 and getting the Crash Cart. LVN G stated that she was CPR Certified. LVN G stated that there were many risks that occurred involving the incident with Resident #1. LVN G stated that Resident #1 was not removed from his w/c and placed on a flat surface. LVN G stated that LVN A did not get the Crash Cart, which would have revealed that Resident #1 was a Full Code. LVN G stated that LVN did not check for v/s on Resident #1. LVN G stated that LVN could have applied pressure to the area that was bleeding on Resident #1. LVN G stated that the harm of not performing CPR on a resident, such as Resident #1, who was Full Code, was that the resident could have bled out and died because no CPR measures were taken. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA H on 05/31/25 at 5:46 PM, he stated that he had been employed at the facility for 3 months. CNA H stated that he was not on duty when the incident occurred at the facility involving Resident #1 being found unconscious by LVN A. CNA H stated that if he found a resident unconscious, he would immediately contact other staff, including a Nurse and then obtain v/s and then get the Crash Cart to obtain the Advance Directive Binder on the Cart to check the Code Status of the resident. CNA H stated that he would ensure that someone has called 911, let them know that they had a Code Status for the resident and that CPR was being administered if the Code Status was Full Code and if there was a DNR, let them know that CPR would not be administered to the resident. CNA H stated that if the resident was Full Code, he would make sure that the resident was on a flat surface, such as if they were in a chair, place them on the floor in the right position to make sure that they were underneath something hard prior to doing the CPR compressions. In an interview with RN I on 05/31/25 at 6:01 PM, she stated that she had been employed at the facility for one ½ years. RN I stated that she was not on duty when the incident occurred at the facility involving Resident #1 being found unconscious by LVN A. RN I stated that she works the 6:00 AM - 6:00 PM shift. RN I stated that if she observed a resident in their room unconscious, she would call for help and then check for vitals and then give tasks for staff to do, such as getting the Crash Cart to check the book to see if the resident was a Full Code or DNR. She stated that Resident #1 was a Full Code, therefore she would have checked for v/s, removed him from his w/c and placed him on the floor, which was a hard flat surface and then began life saving measures and perform CPR until the paramedics arrived. RN I stated that LVN A should have begun performing CPR on Resident #1 due to his advanced directive being a Full Code. RN I stated that LVN A should have performed CPR on Resident #1 until the paramedics arrived at the facility to take over the attempted life saving measure on Resident #1. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with ADON F on 05/31/25 at 6:07 PM, she stated that she had been employed at the facility for 3 years. ADON F stated that she was not on duty when the incident occurred at the facility involving Resident #1 being found unconscious by LVN A. ADON F stated that on 05/29/25 at 10:04 PM, she received a text message from LVN A stating that she observed [Resident #1] in his room unresponsive and without any vital signs. ADON F stated that she sent a reply text message to LVN A to start CPR immediately on Resident #1 and call 911. ADON F stated that LVN A sent a reply text message stating, No, he's dead without any vital signs. ADON F again directed LVN A to immediately start CPR on Resident #1 and to call 911. LVN A later sent a reply text message stating that 911 was already at the facility. ADON F sent a reply text message to LVN A to let her know what was happening. ADON F stated that she received a telephone call from the DON, who advised her that she and the Administrator were on their way to the facility, and she needed to meet them at the facility. ADON F stated that around 10:15 PM, she and the DON arrived at the facility at the same time. ADON F stated that when they arrived at the facility, law enforcement was outside of the facility, and they introduced themselves and asked them for some information about what was going on. ADON F stated that law enforcement would not provide them any information and advised both parties that they were not able to enter the facility because of the ongoing law enforcement investigation and they were awaiting the arrival of detectives from the Homicide Department. Both parties asked law enforcement if they could know where [Resident #1] was bleeding from and were advised that the resident was bleeding from two possible areas. ADON F stated that they were eventually allowed to enter the facility, but law enforcement would not allow them into [Resident #1's] room. ADON F stated that eventually they were allowed to investigate [Resident #1's] room and they observed the resident slumped over and there were large amounts of blood throughout the room including his pants, shirt and the floor. ADON F stated that she observed something in [Resident #1's] hand, but she did not know what it was at that time. ADON F stated that she later realized that it was the cap from the shunt cap in [Resident #1's] hand. ADON F stated that herself, DON, and Administrator then spoke with LVN A and asked her what happened. ADON F stated that LVN A stated that she did not perform CPR on Resident #1 because he was in a sitting position. ADON F stated that she told LVN A that she should have placed Resident #1 on a flat surface, such as the floor and began CPR on him. LVN A told ADON F that Resident #1 was lifeless and did not have any vital signs, therefore she did not perform CPR on Resident #1. ADON F stated that law enforcement was still waiting for their Homicide detectives to arrive and in the meantime, they spoke with LVN A and CNA D to get their statements. ADON F stated that law enforcement cleared the scene and stated that they did not have any concerns regarding foul play after speaking to the Medical Examiner. ADON F stated she called the Medical Examiner and he reported that he did not have any suspicions and asked him what will be on [Resident #1's] Death Certificate. The Medical Examiner stated that [Resident #1's] PCP will complete the Death Certificate. The DON then directed LVN A to write nurses' notes in [Resident #1's] Chart in EMR, she was given a Corrective Action and Terminated from the facility. LVN K replaced LVN A for the duration of the shift. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 05/31/25 at 4:32 PM, she stated that on 05/29/25 around 10:00 PM, LVN A sent her a text message that [Resident #1] had a Change of Condition and bled out and was unresponsive. The DON told LVN A to initiate CPR to Resident #1 immediately because his Code Status was Full Code and 911. The DON stated that she told LVN A that she was on her way to the facility. The DON stated after she ended the call with LVN A, she notified the ADON, Administrator and Corporate Nurse and they all arrived at the facility within a few minutes of each other. The DON stated that when all parties arrived at the facility, they noticed that there were some policemen outside and introduced themselves to them and were directed not to enter the facility until the Medical Examiner had been notified. The DON stated that this was normal protocol for law enforcement to come to the facility after a death in the facility. The DON stated that when the Administrator arrived, there were two police officers outside and they stated that they were waiting for their homicide detectives to arrive to the scene. The homicide detectives arrived on the scene and spoke with the Medical Examiner who cleared the scene and allowed the staff that were outside in the building. The DON stated that Resident #1 was observed in his room sitting in his wheelchair with a large amount of blood throughout the room. The DON stated that it appeared that Resident #1 had pulled out the cap (which was clinched in between Resident #1's thumb and index) on his dialysis port and bled out prior to being found by LVN A. The DON stated that Resident #1 had never pulled out or attempted to pull out the cap on his dialysis port prior to this date. The DON stated that she received statements from all staff that were present during the incident. The DON stated that LVN B never mentioned anything to Management about LVN A stating that she was not going to perform CPR on Resident #1 because he was dead. The DON stated that she spoke with the Medical Examiner prior to him releasing Resident #1's body to the Funeral Home. The Medical Examiner told her that he did not find anything suspicious about Resident #1's death and suspected that Resident #1 bled out due to pulling off the cap on his dialysis port. The DON stated that LVN A, after finding Resident #1 unresponsive was to check to see if he was breathing, if he was not breathing, check his pulse for v/s and then yell out for help. LVN A was not supposed to leave [Resident #1] unattended, and another staff member should have come to Resident #1's room with a Crash Cart and assist him with CPR, next someone was to call 911 and then notify Management. The DON stated that staff know that they are never supposed to text Management about anything, especially an unresponsive resident. The DON stated that staff have been In-serviced on Communication and how to report incidents to Management, which included to call Management and never send text messages. The DON stated that LVN A was directed to write a nurses' note about the incident in Resident #1's Chart in EMR (a specialized software vendor offering EHR (Electronic Health Record) and practice management tools for independent pediatricians). LVN A was then suspended pending the facility's investigation and terminated on 05/29/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675754	A. Building B. Wing	05/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traymore Nursing Center	4315 Hopkins Ave Dallas, TX 75209

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the Administrator on 05/31/25 at 5:07 PM, he stated that on 05/29/25 he received a text message from LVN A stating that Resident #1 was found unresponsive in his room. He stated that he notified the ADON and DON and told them to meet him at the facility. The Administrator stated that all parties arrived at the facility around the same time and the police were outside of the facility and would not allow anyone into the facility. The Administrator stated that the Fire Department reported to the Police Department that there was a suspicious death at the facility, which the Police Department notified their Homicide Department. The Administrator stated that the police spoke with residents and staff inside the building while the building was being blocked off. The police eventually allowed the ADON, DON and Administrator into the building and stated that there were not any concerns. Management interviewed LVN A, LVN B, LVN C and CNA D and CNA E to obtain everyone's account of what occurred. The Administrator stated that LVN A went into Resident #1's room sometime during her shift and observed Resident #1 unconscious sitting in his wheelchair in his room. He later learned that Resident #1 was Full Code and LVN A, LVN B, and LVN C did not perform CPR on Resident #1. The Administrator stated that paramedics arrived at the facility and notified the Medical Examiner that Resident #1 was unresponsive and did not have any vital signs. The Administrator stated that the Medical Examiner pronounced Resident #1 deceased and the police did not feel that Resident #1 died under any suspicious circumstances. The Administrator stated he observed Resident #1 in his wheelchair in his room, and he was leaning to the side, and he had something in his hand, which he later found out was the cap from his dialysis port. The Administrator stated that he received a statement from LVN A, and she stated that she did not perform life saving measures on Resident #1 who was Full Code. The Administrator stated that LVN A was immediately suspended and then terminated of employment due to not following Resident #1's Advanced Directives, Physician Order and Code Status in the Care Plan by not performing CPR on Resident #1. The noncompliance was identified as PNC. The IJ began on 05/29/25 and ended on 05/30/25. It was verified that the facility had corrected the noncompliance before the survey began. on 05/31/25 through the following: In a telephone interview with CNA D on 05/31/25 at 1:57 PM, revealed she had been employed at the facility for 5 months. CNA D stated that on 05/29/25 and 05/30/25, she had taken several In-service Trainings on CPR and chest compressions, how to know if someone is a Full Code, and that the CNA's will need to get the Crash Cart and to get the Nurse. CNA D stated that LVN A had not returned to work at the facility after 05/29/25. CNA D stated that she was now CPR Certified. CNA D stated that there was a risk of a resident dying if they were a Full Code and no one does any CPR on them. In a telephone interview with CNA E on 05/31/25 at 2:08 PM, revealed she had been employed at the facility for 1 year. CNA E stated that LVN A had not returned to work at the facility after 05/29/25. CNA E stated that on 05/29/25 and 05/30/25, she had taken several In-service Trainings on CPR Training, Code Status and how to perform CPR. CNA E stated that she was now CPR Certified. CNA E stated that there was a risk of a resident passing away if they were a Full Code and no one does any CPR on them. In an interview with LVN G on 05/31/25 at 5:30 PM, stated that on 05/29/25, she received In-service Training on how to perform CPR, when to do CPR, and the Full Code/DNR List will be printed every day for staff to have access to, if needed. LVN G stated that LVN A had not returned to work at the facility after 05/29/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675754	A. Building B. Wing	05/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traymore Nursing Center	4315 Hopkins Ave Dallas, TX 75209

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA H on 05/31/25 at 5:46 PM, he stated he had taken an In-service Training on CPR. CNA H stated that he received a CPR Training at the facility, and he learned about the AED and the correct way to use the AED. CNA H stated that there were adult and baby simulation figures that were used in the CPR Training, which made the course more hands on and easier to learn the right techniques to use when performing CPR on an adult and baby. CNA H stated that after the CPR Training at the facility, he was now certified to perform CPR. CNA H stated that LVN A had not returned to work at the facility after 05/29/25. CNA H stated that the risk of not performing life saving measures on a resident who was full code was that there was a potential for death. In an interview with RN I on 05/31/25 at 6:01 PM, she stated that she had been employed at the facility for one ½ years. RN I stated that she had taken In-service Trainings on CPR on 05/29/25, Mock CPR Quiz and CPR Trainings on how and when to perform CPR on residents. RN I stated that LVN A had not returned to work at the facility after 05/29/25. RN I stated that the risk of not performing CPR on a resident who was Full Code was that the resident could have died because CPR was not [TRUNCATED]