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	04/04/2026

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 0689 Level of Harm - Actual harm 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 interviews, observations, and record reviews, the facility failed to ensure that residents receive adequate supervision and assistance to prevent accidents for one (Resident #2) of seven residents reviewed for falls.1. LVN A failed to remain with Resident #2 when he was in the bathroom, which resulted in the resident having an unwitnessed fall in the bathroom. Resident #2 was found alone on the floor in the bathroom by CNA B. Resident #2's unwitnessed fall in the bathroom on 03/30/26 caused a small laceration, with blood, to his head.2. LVN A failed to ensure he had assistance while transferring Resident #2 from his bed to wheelchair and from wheelchair to toilet, per his hospital discharge paperwork on 03/26/26 and PT Evaluation on 03/27/26. Resident #2 required the assistance of two-persons for ADL care including toileting. These failures placed residents at risk for falls, serious injuries, and hospitalization.Findings Included:Record review of Resident #2's Face Sheet reflected, he was a was a [AGE] year-old male admitted to the facility on [DATE]. Resident #2's diagnoses included: benign neoplasm of the brain (non-cancerous, slow-growing abnormal cell mass), Cerebral edema (excess fluid accumulation in brain tissue), hemiplegia (a severe or total paralysis on one side of the body) and hemiparesis (paralysis) following cerebral infraction (a type of ischemic stroke caused by blocked blood flow to the brain, leading to tissue death) affecting the left non-dominant side, and supra-ventricular tachycardia (rapid heart rate). Resident #2 discharged from the facility to the hospital on [DATE]. Record review of Resident #2's admission and Entry MDS Assessments revealed they were incomplete. Resident #2's BIMS Score was unknown. Record review of Resident #2's Care Plan printed 04/03/2026 reflected, Focus:Resident requires assist with ADLs r/t left sided hemi (paralysis)Date Initiated: 03/30/2026Revision on: 04/03/2026 Goal:Resident is able to perform self-care to optimal level and maintained strength and endurance x 90 daysDate Initiated: 03/30/2026Target Date: 06/28/2026 Interventions:Encourage independence in performance of self-care and mobility within limitations.Date Initiated: 03/30/2026 Provide level of support to complete dressing, toilet use, personal hygiene, and bathing needs q shift.Date Initiated: 03/30/2026 Therapy to eval and tx if indicated.Date Initiated: 03/30/2026. Focus:The resident is at risk for falls due to new environment and/or age.3-30-2026 Fall with laceration to head.Date Initiated: 03/30/2026Revision on: 04/03/2026 Goal:The resident will be free of falls through the review date.Date Initiated: 03/30/2026Target Date: 06/28/2026 Interventions:3-30-2026 Remind to use call light for assistance and encourage use of bed pan.Date Initiated: 04/03/2026 Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.Date Initiated: 03/30/2026 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.Date Initiated: 03/30/2026 The resident needs a safe environment with: Clutter free, reachable call light, the bed in low position at night.Date Initiated: 03/30/2026Revision on: 04/03/2026 Focus:Resident had a history of falling or other identified risk factors that result in increased risk of falling.Date Initiated: 03/30/2026 Goal:[Resident #2] will not experience any injuries from falls x 90 days.Date Initiated: 03/30/2026Target Date: 06/28/2026 Interventions:Anticipate and meet resident needs.Date Initiated: (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 - Actual harm Residents Affected - Few	03/30/2026 Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed.Date Initiated: 03/30/2026 Ensure that the resident is wearing appropriate footwear (SPECIFY and describe: correct client footwear i.e. brown leather shoes, tartan bedroom slippers (indoor footwear), black nonskid socks) when ambulating or mobilizing in w/c.Date Initiated: 03/30/2026 Provide activities that promote exercise and strength building where possible.Date Initiated: 03/30/2026 Remind [Resident #2] to ask for assist for all ambulation.Date Initiated: 03/30/2026 Focus:The resident is on anticoagulant therapy.Date Initiated: 03/30/2026Revision on: 03/30/2026. Record review of Resident #2's Discharge Paperwork from the hospital on dated 03/26/26, [Resident #2] was a fall risk and required a 2 person assist with ADL's. Record review of Resident #2's Order Summary Report printed 04/03/26, reflected a phone order date of 03/27/26 with start date of 03/28/26 for Enoxaparin Sodium Injection Solution Prefilled Syringe 40 MG/0.4ML (Enoxaparin Sodium) Inject 0.4 ml subcutaneously one time a day for ANTICOAGULATION for 30 Days. Resident #2's Order Summary report did not reflect any information regarding ADL assistance. Record review of Resident #2's PT Evaluation on 03/27/26, reflected he needed max assistance (2 person assist) to support and maintain balance and required maximum assistance (2 person assist) with functional transfer. The OT Evaluation reflected that Resident #2 required total assistance x 2 with toileting. Record review of Resident #2's Nurses Progress Notes on PCC (a leading cloud-based software platform and Electronic Health Record (EHR) designed for the senior care, long-term, and post-acute care) revealed:On 03/30/26 at 1:15 PM, LVN A documented, Unwitnessed fall, Resident roommate contacted staff that roommate was on the floor in the bathroom and needed help. Resident was found on the floor with blood on his head. Bleeding Stopped by staff immediately. Resident #2 was transported to the hospital via ambulance due to being on blood thinners and for further observation. Record review of Resident #2's Neuro Checks by LVN A on 03/30/26 at 1:15 PM, 1:30 PM, 1:45 PM and 2:OO PM reflected there were no concerns. Record review of Resident #2's Fall Investigation Worksheet written by LVN A effective on 03/30/26 at 1:15 PM reflected that Resident #2 had a Pain Level of 9 out of 10. LLVN A documented that Resident #2 was assisted by 2 staff members. LVN documented that Resident #2 was lifted from the floor manually and transferred from the floor to the chair. Record review of Resident #2's Order Summary Report, printed 04/03/26 revealed no information stating he required the assistance of two-persons for ADL care. Record review of the facility's Incidents by Incident Type Logs for 01/03/2026 to 04/03/2026 revealed no information regarding the unwitnessed fall Resident #2 had on 03/30/26. Record review of Resident #2's Interdisciplinary Discharge summary dated [DATE] reflected, he was discharged from the facility to an acute hospital on [DATE]. In an interview with LVN A on 04/03/26 at 9:59 AM, he stated that he entered Resident #2's room to assist him with incontinence care. LVN A stated that he transferred Resident #2 from his bed to his wheelchair and wheeled him to the bathroom and placed the resident on the toilet. LVN A stated that Resident #2 told him that he did not need him to be in the bathroom and he wanted to have some privacy. LVN A stated that he granted the resident's request, educated the resident on call light safety and usage and then placed the call light in the bathroom in reach for Resident #2. LVN A stated that he exited the bathroom and left the door to the bathroom ajar. LVN A stated that he waited outside of the resident's room in the hallway for Resident #2 to be finished in the restroom. LVN A stated that while outside in the hallway, her heard something like a crash and ran into Resident #2's room and observed the resident on the floor. LVN A stated that he then exited Resident #2's bathroom and room and observed CNA B in the hallway and told her that Resident #2 had fallen and was on the floor in his bathroom. LVN A stated that he and CNA B picked up Resident #2 from the floor and placed him in his wheelchair and then transferred him onto his bed. LVN A stated Resident #2 had some staples on his head due to having a brain tumor removed prior to being admitted to the facility. LVN A stated that he did a head-to- toe assessment on Resident #2, which revealed a small laceration with some blood on the top of the resident's head. LVN A stated that he cleaned the area and provided Resident #2 neurological checks, which revealed no concerns. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LVN A stated he notified management including the ADON, and Resident #2's MD and was advised to have Resident #2 transported via ambulance to the hospital due to the resident having staples on his head from his previous brain tumor removal surgery, and was on prescribed blood thinner medication. LVN A stated that he notified Resident #2's FM about 3 hours after the unwitnessed fall. LVN A stated that he was prescribed the medication Adderall for his ADD or ADHD and he wanted to make sure that he finished his paperwork about Resident #2's fall and his other assignments prior to contacting Resident #2's FM because he wanted to ensure he had everything completed. LVN A stated that he was given a 1:1 by the ADON due to Resident #2's FM being notified several hours after Resident #2's fall and being transported to the hospital. LVN A stated he had to be previously educated on falls, incidents, and notifying the family prior to the Resident #2's fall on 03/30/26. LVN A stated that Resident #2 was newly admitted to the facility and he had not read any information regarding the level of care the resident needed. LVN A then stated that he made a mistake earlier during the interview and was not outside of Resident #2's room when he had fallen in the bathroom. LVN A stated that he was standing outside of the bathroom and the door was ajar and he observed Resident #2's fall. LVN A stated that the risk of a resident being a 2 person assist for ADL's and being assisted by 1 person was that the resident could become unstable and become off balance and fall. LVN A stated that harm could be caused to a resident that required a 2 person assistance for ADL's while toileting and left alone in the bathroom included broken bones, cuts and fractures. In an interview with CNA B on 04/03/2026 at 10:14 AM, she stated that she was in the same hallway as Resident #2 when she heard some yelling down the hallway. CNA B stated she entered Resident #2's room and she observed him on the floor in the bathroom. CNA B stated that she exited Resident #2's room and told her nurse [LVN A] that she reentered Resident #2's room and observed him on the floor. LVN A and CNA B picked up Resident #2 from the floor and transferred him to his wheelchair and then wheeled him to his bed and transferred him to the bed. CNA B stated that she observed a small cut on the top of Resident #2's head. CNA B stated that the cut was observed with some blood. CNA B stated that LVN A did a head-to-toe assessment on Resident #2 and she left the room. CNA B stated that Resident #2 was transported via ambulance to the hospital shortly after his fall in the bathroom. CNA B stated that she did not know if Resident #2 was a 2 person assist because she had not assisted him with any ADL's, since he was a fairly newly admitted resident. CNA B stated that the risk of leaving a person who was a 2 person assist on the toilet alone was that they could fall and hurt themselves. She stated that they could be harmed by hitting their head on something and cutting their head, such as Resident #2 did on 03/30/26. In an interview with Resident #2's FM on 04/03/26 at 11:15 AM, he stated that Resident #2 was admitted to the facility on [DATE]. The FM stated that Resident #2 had a large incision with staples on his head prior to having surgery for having a tumor in his brain removed. The FM stated that the facility was advised by himself and the hospital prior to Resident #2 being discharged from the hospital and admitted to the facility, that Resident #2 required assistance with his ADL's and was a 2 person assist and was a high fall risk. The FM stated that he was notified 4 hours after Resident #2's fall at the facility by LVN A, which was unacceptable. The FM stated that Resident #2 had a small laceration on the top of his head from the fall that occurred at the facility. The FM stated that LVN A lied to him about the circumstances of Resident #2's fall stating that [LVN A} was present in Resident #2's bathroom and room and witnessed the fall. The FM stated that according to Resident #2's roommate, LVN A assisted Resident #2 to the bathroom and placed him on the toilet and then exited the room. The FM stated the roommate said LVN A was not outside of the bathroom or room when Resident #2 had a fall. The FM stated that [Resident #2] was discharged from the facility on 03/30/26. The FM stated that the facility stated that LVN A was outside of the bathroom when Resident #2 had fallen according to LVN A. The FM stated that Resident #2 would not be returning to the facility after being discharged from the hospital. In an observation and interview with Resident #2 at the hospital on [DATE] at 1:13 PM, he was alert and was seated in a chair beside his bed and was watching television. Resident #2 was observed wearing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	non-slip socks and was eating lunch at the bedside table. Resident #2 stated that on a Friday he was admitted to the facility and on the following Monday, he had a fall in the bathroom at the facility. Resident #2 stated that he placed his call light in his room on to request assistance from the staff to go to the restroom. Resident #2 stated that LVN A entered his room and transferred him from his bed to his wheelchair and then wheeled him to the bathroom. Resident #2 stated LVN A placed him on the toilet and did not give a conversation about call light safety. He stated that LVN A exited the bathroom and left the door to the bathroom almost closed. Resident #2 stated that he did not request for LVN A to leave the bathroom for privacy. Resident #2 stated that both conversations never happened. Resident #2 stated that he did not know what happened to LVN A after he was placed on the toilet and he could not view him from toilet because the bathroom door was closed. Resident #2 stated that he tried to wipe himself and ended up losing his balance and fell on the floor in the bathroom, which caused the bathroom door to open. Resident #2 stated that he began to yell for help and his roommate saw him and left the room to get assistance. Resident #2 stated CNA B arrived and then left to get LVN A and both picked him up and placed him in his wheelchair and then placed him in his bed. Resident #2 stated that he received a small cut on the top of his head, which caused some bleeding but it was not near the surgical incision and staples on his head. Resident #2 stated that he wore non-slip socks all the time when he was at the facility. Resident #2 began to cry and stated that he knew that his health has taken a change for the worst since his surgery, which he had a tumor removed from his head and he knew that he needed assistance with his ADL's. He stated that he did not know why LVN A left him alone on the toilet, which caused his fall at the facility; Resident #2 stated that his health was still not the same prior to his surgery, but he has been eating and gaining more strength and it will take some time, but he someday wanted to be more independent versus depending on others to care for him. Resident #2 stated that he did not want to return to the facility because his fall could have been prevented. In an interview with NP C at the hospital on [DATE] at 2:01 PM, she stated that Resident #2 was admitted to the hospital from the facility on 03/30/26 after having a fall at the facility. NP C stated that Resident #2 sustained a small laceration to his head from his fall on 03/30/26. NP C stated according to Resident #2's discharge paperwork, dated 03/26/26, the resident should have been a 2 person assist according to the documentation on his discharge paperwork on 03/26/26. NP C stated that Resident #2's Neurological Checks had resulted in no concerns. NP C stated that Resident #2 was to remain in the hospital for observation and had seen an improvement with him since he had been at the hospital. In an interview with the DOR on 04/04/26 at 4:33 PM, revealed on 03/27/26 a PT Evaluation was conducted on Resident #2. The DOR stated Resident #2's PT Evaluation reflected he needed max assistance (2 person assist) to support and maintain balance and required maximum assistance (2 person assist) with functional transfer. The OT Evaluation reflected that Resident #2 required total assistance x 2 with toileting. The DOR stated that she normally would submit the documentation for the OT/PT Evaluations every week and due to Resident #2 being at the facility for 3 days, his information was not inputted into his medical charts. In an interview with Resident #3 on 04/04/26 at 9:30 AM, he stated that Resident #2 had been his roommate from 03/27/26 to 03/30/26. Resident #2 stated on 03/30/26, he observed Resident #2 use his call light to request assistance from staff to escort him to the bathroom. Resident #3 stated on 03/30/26 he observed LVN A enter their room. Resident #3 stated that Resident #2 told LVN A that he needed assistance with walking to the bathroom. Resident #3 said that LVN A assisted Resident #2 to the bathroom and then closed the door and exited their room. Resident #3 stated that he did not hear Resident #2 tell LVN A that he needed some privacy and to leave the bathroom. Resident #3 stated that about 2-3 minutes after LVN A exited the bathroom and room, he heard a loud sound, which he described as a loud thumping sound. Resident #3 stated that he was in his motorized wheelchair beside his bed when he heard the loud sound. Resident #3 stated that he then heard Resident #2 yelling and asking for help. Resident #3 stated that the bathroom door was open and he observed Resident #2 on the floor. Resident #3 stated that he observed some blood and a cut on the top of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #2's head. Resident #3 stated that he exited the room and went down the hall and observed CNA B in the hallway. Resident #3 stated that he did not observe LVN A outside of the bathroom and/or door to this room when he exited the room. Resident #3 stated that he notified CNA B and told her that his roommate, Resident #2, had fallen in the bathroom and was on the floor. Resident #3 stated that CNA B entered the bathroom and observed Resident #2 on the bathroom floor. CNA B then exited the bathroom and room and returned with LVN A. In an interview with the Administrator on 04/04/2026 at 12:14 PM, she stated that she had been employed at the facility for 1 year. The Administrator stated that the DON was currently on leave and would return to the facility on [DATE]. The Administrator stated that Resident #2 was admitted to the facility on [DATE] and was discharged to the hospital on [DATE]. She stated that she spoke with LVN A on 03/30/26 and he stated that he was standing outside of Resident #2's bathroom door when the fall occurred, therefore the fall was considered as being a witnessed fall. The Administrator stated that she was unaware that Resident #2's unwitnessed fall was not documented on the Accident/Incident Log for 03/30/26. She stated that her expectation was for any resident that has a fall (witnessed/unwitnessed/injuries) be documented on the facility's Accident/Injury Log. She stated that she was unaware that LVN A told the surveyor a different recollection of the circumstances with Resident #2's fall on 03/30/26. She stated that she advised the ADON to give LVN A a written reprimand due to the incident, but instead the ADON provided 1:1 in-service training to LVN A instead. The Administrator stated that LVN A was told that he would be terminated from employment from the facility on 04/04/26, but he decided to resign instead. The Administrator stated that her expectation was for staff to always tell the truth, to prevent other unforeseen circumstances and situations from occurring. She stated that she would reeducate and retrain all staff via in-service trainings and also talk to the DOR to ensure that the therapy evaluations were entered for staff to review, if and when needed. An attempted telephone call to the ADON on 04/04/2026 at 12:35 PM was unsuccessful. An attempted telephone call to LVN A on 04/04/2026 at 12:38 PM to obtain more information about Resident #2's fall on 03/30/26 was unsuccessful. Record Review of the facility's In-Service Training Report on 03/25/26 for all staff on Falls Protocol reflected, All staff can assist in the prevention of resident falls and the responsibility in processing a resident's fall. LVN A and CNA B signed the In-Service Training Log. Record review of the facility's undated policy, Quality of Care reflected, Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility will ensure that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Optimal improvement is expected in each resident's condition within the limits of the resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process. Activities of Daily Living:Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility will provide the appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living. The facility will provide care and/or services for the following activities: Hygiene (bathing, dressing, grooming and oral care; Mobility (transfer and ambulation, including walking); Elimination (toileting); Dining (eating, including meals and snacks); and Communication (speech, language, and other functional communication systems). Based on each resident's comprehensive assessment, appropriate treatment and services are provided for all residents to help them maintain or improve their abilities to perform activities of daily living. A program to maintain and/or restore residents' abilities to improve or maintain the activities of daily living functions is available to all residents. Participation in the program is based on residents' needs identified in the comprehensive assessments, the medical opinion of residents' attending physicians and residents' desire to participate in the program. If a resident is unable to (continued on next page)

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