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	04/20/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided consistent with professional standards of practice, for 1 of 3 residents (Resident #99) reviewed for respiratory care. The facility failed to ensure that Resident #99's oxygen tubing was bagged in a plastic bag when not used, and the nasal cannula was not dragging on the floor. 2. The facility failed to ensure that Resident #99 was receiving continuous oxygen per physician orders when she was observed without oxygen. These failures could place residents at increased risk of receiving inadequate oxygen support and infections that could result in a decline in health. Findings included: Record review of Resident #99's Quarterly MDS Assessment, dated 03/11/2026, reflected an [AGE] year-old female, admitted to the facility on [DATE]. She had a BIMS score of 09, which indicated she had moderate cognitive impairment. Resident #99 was identified as requiring oxygen therapy. Her diagnosis included chronic respiratory failure with hypercapnia (a specific type of respiratory failure characterized by elevated levels of carbon dioxide in the blood), and Chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe). Record review of Resident #99's Care Plan, dated 11/11/2025, reflected Resident #99's has altered respiratory status/Difficulty Breathing. Identified goals included: Resident #99 to have no complications related to shortness of breath. Interventions included will have Oxygen as per physicians' orders. Record review of Resident #99'active Physician's Orders dated 04/20/2026, reflected oxygen (2 liters per minute) via nasal cannula continuously for Order start date 12/12/2025 . Physicians order dated 12/11/2025 reflected .Check O2 sats Q shift and keep O2 at or greater than 92%. During an observation on 04/20/2026 at 11:34AM, Resident #99 was in the wheelchair in her room. Resident #99 had a portable oxygen tank on the back of the wheelchair and the oxygen nasal canula (a flexible, lightweight tube used to deliver supplemental oxygen) was dragging on the floor while the resident wheeled herself around her room. During an interview on 04/20/2026 at 11:40 AM, CNA A stated she did not know that the nasal canula was dragging on the floor. She stated that LVN A called for help to transfer Resident #99 to bed and that was how she got into Resident #99's room. She stated the oxygen tubing should not be dragging on the floor because of possible infection. During an interview on 04/20/2026 at 11:49 AM, LVN A stated Resident #99 had a physician's order for continuous oxygen therapy. He stated that the nasal cannula was on the floor when he entered Resident #99's room. LVN A stated the last time he saw Resident# 99, her nasal cannula was in place in her nostril, and she was receiving oxygen from the concentrator in her room. LVN A stated the risk to the residents was shortness of breath, respiratory distress (difficulty breathing, where a person struggles to get enough air, often showing rapid, shallow, or labored breathing and other signs of low oxygen), and confusion. LVN A stated the risk of a resident's nasal canula dragging on the floor was infection. He stated he had been in-serviced on infection control and respiratory care. During an interview on 04/20/2026 at 2:02 PM, LVN B stated she was the Infection preventionist for the facility. She stated her expectation was that the assigned nurse should check the oxygen tubing as part of overall assessment to make sure the tubing was not on the floor. She stated the facility policy was to change oxygen tubing every week on Thursday night shift and PRN. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated tubing should not be on the floor to prevent it from getting contaminated. She stated when the tubing is not in use it should be stored in a plastic bag. She stated the risk to the resident if tubing was on the floor was infection and shortness of breath. She stated that the nurses had been in serviced on infection control, use of standard precaution and oxygen tubing care. During an interview on 04/20/2026 with the DON at 4:12 PM, she stated her expectation, for residents with physician's orders for continuous oxygen, was for those residents to always have access to oxygen. The DON stated the risk of a resident not receiving continuous oxygen, as ordered, included not getting enough oxygen and the potential for shortness of breath. The DON also stated the risk of the oxygen nasal canula dragging on the floor was infection. She stated the staff had been in-serviced on infection control respiratory care. Record review of the facility's Oxygen Administration policy, undated reflected, . Purpose of Oxygen therapy is to aid in breathing as ordered by the physician.administered by way an oxygen nasal cannula or mask . The procedure includes . Report immediately to charge nurse all signs or symptoms or any failure ofequipment.15. Change water in humidifier daily. Water in humidifier should be maintained andchanged, as necessary. Oxygen cannula, tubing, and humidifier bottle should be changed weekly and prn. Record review of the facility's Infection Prevention and Control program, undated reflected: Appropriate cleaning, storage, disinfecting, disposal of equipmento Low level disinfection is used for non-critical equipmento Medical equipment, devices and supplies are disposed of in accordance with facility policy.