

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: 675754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER Traymore Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 7 residents (Resident #14) reviewed for call light system access. The facility failed to ensure Resident #14 had access to their call light by allowing it to remain clipped to a curtain at the foot of the bed, out of the resident's reach. This failure could place residents at risk for delayed assistance and an inability to request help when needed. Findings Included: Record review of Resident #14's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had severely impaired cognitive function. Diagnoses included: cerebral infarction (a type of stroke caused by blocked blood flow to the brain), major depressive disorder (a long-term, severe sadness that affects daily life), metabolic encephalopathy (a brain dysfunction from chemical imbalance), dementia (severe decrease in memory and intellectual functioning), hypertension (high blood pressure), hyperlipidemia (high cholesterol), cataract (cloudy lens in the eye that affects vision), muscle weakness (less strength or control in muscles), dysphagia (trouble swallowing), and ataxic gait (unsteady, uncoordinated walk). He used a walker to assist with walking. He required staff supervision or hands-on help for daily care tasks like toileting hygiene, bathing, dressing, and grooming. He also required similar support for mobility tasks like turning in bed, sitting up, standing, and toilet transfers. The resident had occasional urinary and bowel incontinence. Record review of Resident #14's Comprehensive Care plan dated 05/15/2025 showed a fall risk focus: Resident has a history of falling or other identified risk factors that result in increased risk of falling. Goal: I will not experience any injuries from falls x 90 days (i.e., for a 90-day period). Interventions included: Anticipate and meet resident needs. Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. During an interview and observation on 07/20/2025 at 12:00 PM, Resident #14 was observed in bed. The call light was clipped to the privacy curtain, out of the reach of the resident. Due to cognitive impairment, he was unable to provide reliable information during the interview. During an interview and observation on 07/21/2025 at 10:00 AM, the call light for Resident #14 was observed clipped to the privacy curtain, out of the reach of the resident. Resident #14 was in bed at the time. At 10:02 AM LVN A confirmed the placement of the call light and stated she was unsure why it was clipped to the curtain. She acknowledged that all staff were responsible for ensuring the call lights were within reach and identified it as one of the three key items checked during resident care and rounds (rounds are routine checks on all residents). During an interview with RN B on 07/21/2025 at 1:15 PM, she stated she was assigned to Resident #14, and stated she first rounded at 6:15 AM that morning and the call light was clipped to the curtain. She stated she repositioned it to be within the residents' reach. RN B acknowledged the risk posed to a resident unable to reach their call light could cause the resident to not be able to call for help if they fell. During an interview with the DON on 07/22/2025 at 2:15 PM, she stated she became aware of the call light concern on 07/21/2025 by a CNA. The DON stated that unless care planned otherwise, call lights were to always be within reach, whether the resident was in or out of bed. She confirmed staff were expected to round hourly and ensure the call light was (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within reach. She acknowledged that not having access to a call light was a safety issue and could prevent a resident from calling for help if they did fall. Record review of the facility's undated call light policy stated in Procedure #9: The call light must always be within resident's reach before you leave the room.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for a Level II resident review for one (Resident #9) of four residents reviewed for PASRR services. The facility failed to identify a discrepancy between a negative PASRR Level I evaluation and the resident's mental disorder diagnosis during admission. Due to this failure, the facility did not refer Resident #9 for a Level II PASRR Evaluation. This failure could place residents at risk of not receiving necessary care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. Findings included: Review of Resident #9's Face sheet, dated 07/22/2025, reflected she was a [AGE] year old female, who was admitted to the facility on [DATE], with diagnoses including respiratory failure unspecified with hypercapnia (a condition where the respiratory system cannot adequately remove carbon dioxide), essential hypertension (high blood pressure), Type 2 diabetes mellitus without complications (a condition where the body does not use insulin properly), chronic kidney disease, stage 4 (severely reduced kidney function), schizoaffective disorder, unspecified (symptoms of both schizophrenia and mood disorder) and muscle weakness (less strength or muscle control). Resident #9 did not have a dementia diagnosis. Review of Resident #9's MDS Assessment, dated 06/17/2025, reflected she had a documented diagnosis of Schizophrenia, and was prescribed an antipsychotic medication. Review of Resident #9's PASRR Level I Screening, dated 07/18/2024, reflected she did not have a mental illness, intellectual disability or developmental disability (negative). Review of Resident #9's electronic medical record reflected no evidence that any additional PASRR Level II Screenings or evaluations had been completed since the initial PASRR Level I Screening was conducted on 07/18/2024. Review of Resident #9's Comprehensive Care Plan, dated 06/08/2025, reflected she had a Schizoaffective Disorder focus: The resident has a communication problem r/t Schizoaffective Disorder. Goal: The resident will be able to make basic needs known on a daily basis through review date. Interventions included: Anticipate and meet needs. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident is trying to express. During an interview with the MDS Coordinator on 07/21/2025 at 4:30 PM, the MDS coordinator stated that based on Resident #9's diagnosis of schizoaffective disorder, the resident's Level I PASRR was incorrectly marked negative, and she should have a Level II PASRR evaluation. When asked who was responsible for identifying a discrepancy between the negative Level I PASRR and the resident's diagnosis, the MDS coordinator stated it was the responsibility of the MDS coordinator. The MDS coordinator stated she was the corporate MDS nurse and had covered this facility since May 2025. She stated there had been a lot of employee turnover in the MDS office and lack of continuity. The MDS coordinator stated she completed a form 1012 on 07/21/2025 for Resident #9. (A form 1012 is a Mental Illness/Dementia Resident Review form, used by facilities to determine whether to submit a new positive PASRR Level I screening form on the Long Term Care Portal because further evaluation is needed.) The MDS Coordinator identified the risk for the resident is that they may need mental health services and not get them. Record review of the facility's PASRR policy (not dated) stated the following: If during a resident's stay they receive a new diagnosis from their physician that could be considered a positive PASRR for MI, ID, or DD, the facility will complete a form 1012 and follow through to see if a physical or mental evaluation is needed. If the PE determines that the resident's negative PASRR for MI, ID, or DD is positive then the record will reflect a positive PASRR for MI, ID, or DD.		