STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675765	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Place	5515 Glen Lakes Dr Dallas, TX 75231

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 - Minimal harm or potential for 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** 46486 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 resident reviewed for fall risk and injury. The facility failed to ensure Resident #1 had fall interventions in place, while in bed unattended. This failure could place residents at risk of falls, injuries, pain, and hospitalization . It was determined the noncompliance was identified as a past non-compliance. The facility had corrected the noncompliance before the survey began. Findings included: Record review of Resident #1's undated Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses Unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #1's Quarterly MDS dated [DATE] reflected resident could not complete the interview for BIMS. Her Functional Abilities and Goals revealed resident was total dependent on staff for eating, oral hygiene, toileting, showers/baths, dressing, and personal hygiene. Record review of the Care Plan for Resident #1 dated 07/07/24 reflected she was at risk for falls, impaired balance, impaired mobility, impaired strength, and poor safety awareness. Goal: Resident #1 will have no falls with injury through next review. Approach: Resident #1 will have a fall mat placed next for safety. Discipline: Nursing, Chartable task, No. Record review of the provider incident report dated 07/12/24, reflected staff in-services on fall precautions completed 07/09/24, fall prevention competency test for all staff, safe surveys completed 7/12/24, and progress notes to show monitoring from fall for three days. Record review of the provider incident report dated 07/12/24 Record review of neurological checks which were completed 7/10/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Place	5515 Glen Lakes Dr Dallas, TX 75231

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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of progress note dated 7/08/2024 which revealed Resident #1 was prescribed 50 mg of Tramadol twice a day which was tolerated with no complications. Observation on 07/30/2024 at 9:47 AM of Resident #1 revealed she was in bed. Bed was in lowest position. Fall mat on the floor. In an interview on 07/31/2024 at 12:53 AM, CNA D stated she dressed Resident #1, placed the Hoyer sling under her and left Resident #1 to go take another resident to the dining area. CNA D stated once in the dining area she saw the breakfast trays were there, so she washed her hands and started passing trays. CNA D stated she did not go back to get Resident #1. CNA D stated Resident #1 was left unattended, fall mat was pushed under bed. CNA D stated that upon completion of passing trays she observed few staff members running towards Resident #1's room she asked, what happened and another staff member told her Resident #1 had a fall. CNA D stated that she observed Resident #1 get assessed and then she was asked to make a statement and then was told she was suspended pending investigation and left the building. CNA D stated once investigation was completed, she was able to return to work, when she returned, she was reeducated on fall precautions before she was able to go on the floor. In an interview on 7/30/2024 at 1:13 PM with Resident #1's family member revealed Xray was complete and no fractures or broken bones. In an interview on 7/31/24 with 1:50 p.m., with ADON A she stated that RN B came running into her office to tell her that Resident #1 had fell . ADON A stated when she got to the room a medication aide was in the room with Resident #1. ADON A stated that she provided Resident #1 with a complete head to toe assessment, to include range of motion and pain levels and noted there was an abrasion on the left side of Resident #1's forehead which was bleeding. ADON A stated that the abrasion was cleaned, and Resident #1 was placed back in bed. ADON A called the physician and an order for x-ray was placed. ADON A called the hospice nurse and family to inform them of the accident with injury. ADON A stated she conducted a behavior change/written warning and suspended the CNA D. ADON A stated that the fall mat was not in place and that Resident #1's bed was high at the time of fall. ADON A stated that Resident #1 admitted to the facility a fall risk and the interventions that were in place prior to the fall were bed in lowest position and fall mat when Resident #1 was in bed. ADON A stated that they added more frequent rounds and quarter rails as additional interventions for Resident #1 to prevent falls and injuries. In an interview on 7/31/2024 at 7:00 p.m., with the DON she stated that at 9:45 a.m. on 07/07/24 she received a call from ADON A who stated that Resident #1 had fell . The DON stated that ADON A conducted the assessment, called the physician, notified the family and hospice nurse, started the investigation, and suspended CNA D. The DON revealed an x-ray of the skull was completed with no negative findings. The DON stated that CNA D had left the bed high and that there was no fall mat in place. The DON stated CNA D was suspended for a couple of days, and upon return CNA D was reeducated on fall risk/precautions. Record review of the facility's policy titled, Fall Prevention undated reflected, 5) Environmental factors to be considered in preventing falls include appropriate lighting, adhesive strips or non-skid mats on slippery floors, night lights, unobstructed walkways, handrails in hallways and bathrooms, electronic warning devices, and rest stops (a chair midway between bed and bathroom). Locking the wheels on beds, keeping beds low, increasing chair height to ease rising, and using wedge cushions can all help prevent falls from beds and chairs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 - Minimal harm or potential for actual harm Residents Affected - Few	It was determined the noncompliance was identified as a past non-compliance. The facility had corrected the noncompliance before the survey began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on observation, interview, and record review the facility failed to ensure that residents are free of significant medications error for 1 (Resident #45) of 5 residents reviewed for medications errors. The facility failed to ensure Resident #45 received Vancomycin 750 mg every 12 hours on 1/23/24 as ordered by the physician. This failure placed all resident who received medications at risk of not getting their medications as ordered which could result in residents not receiving the therapeutic benefits of the antibiotic to treat and prevent bacterial infections that could result in decreased quality of life. The non-compliance was corrected prior to survey entry as evidenced by Resident #45 received the Vancomycin on 01/24/24, ADON A completed a medication error form, and RN E was re-educated. Findings included: Record review of Resident #45's admission face sheet dated 07/30/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis (a serious bone infection that occurs when new bone tissue becomes infected), overactive bladder, dysphagia (difficulty swallowing), diarrhea, unsteadiness on feet, cognitive communication deficit, Dysarthria and anarthria (speech disorders), Parkinsonism (brain condition that cause slowed movements, rigidity (stiffness) and tremors) , Type 2 diabetes (body doesn't produce enough insulin or doesn't use insulin properly), Hyperlipidemia (abnormally high levels of lips in the blood), Bipolar disorder (mental health disorder that causes intense mood episodes), Major depressive disorder (serious mood disorder that can affect how people feel, think and function). Resident #45 discharged on [DATE]. Record review of Resident #45's MDS, a Comprehensive Item Set, dated 01/27/24, revealed a BIMS score of 14, which indicated his cognitive skills for daily decision making were intact; and required 2 persons assist with mobility in bed. Record review of Resident #45's physician's order dated 1/23/2024 at 4:14 p.m. revealed: Vancomycin 750 mg for diagnosis of acute osteomyelitis, left ankle and foot every 12 hours to be started on 01/23/2024. First dose at 9:00 am and second dose at 9:00 pm Record review of Resident #45's medication administration history dated 1/23/24 through 1/29/24 revealed on 1/23/24 at 9:10 p.m. that vancomycin 750 mg was not administered due to drug unavailable. The medication administration history also revealed Resident #45 received his first dose of vancomycin 750 mg on 1/24/24 at 11:28 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/30/24 with 12:50 p.m., LPN C stated that the facility did not have a medication aide on the long-term care side of the facility and that the nurses conducted medication pass. LPN C stated that when a resident arrived at the facility, they were to pull orders for the resident, verify medications availability, if they were not available, nurses contact the physician and the physician provides new order. LPN C stated they placed the order with the pharmacy and followed orders as prescribed. LPN C stated that the pharmacy delivered medication to the facility within four hours. LPN C stated she was not aware of any resident who had not received medication in allotted timeframe of orders. In an interview on 7/31/24 with 1:50 p.m., ADON A, she stated that the expectation of the medication aides and nurses when residence admit to the facility was to make sure they pulled the residents orders and checked the statsafe (electronic emergency/stat-dose cabinet that allows long term care facilities to provide more responsive patient care) to ensure the facility had medication on-hand. ADON A stated that if the facility did not have the medication, then they were to call the physician and the physician would provide instructions/orders to either put in an order to the pharmacy or would change the prescription/order to something else. ADON A stated that the pharmacy was good, and the facility received items within two to six hours upon a resident admittance to the facility. ADON A stated the medication aides and nurses were to follow physician orders. ADON A stated that she did not recall any residents not receiving their medication on time, but stated if a resident were left unmedicated depending on what was being treated it could lead to infection. In an interview on 7/31/2024 at 7:00 p.m. the DON stated that the expectation of the medication aide and nurses was to order medication for residents within one hour of admittance to the facility. The DON stated that the pharmacy delivered medication to the facility twice per day and would make emergency runs if required. The DON stated that if the medication did not arrive at the facility, they were to notify her (the DON) so she could assist in obtaining the resident's required medication in the allotted time. The DON stated that the facility had not had any issues getting medication. The DON stated if their contracted pharmacy was out of a medication, staff could go to a local community pharmacy to see if they had the medication, if the community pharmacy did not have the medication, staff were to contact the physician and the physician would change the order to another medication. The DON stated that it would be a medication error if there were no medication in the statsafe, pharmacy did not provide medication and staff did not have the doctor change the order to something else and the resident went 24 hours without their ordered medication. The DON stated that as soon as there was a medication error, staff completed a medication error form, which was a written warning that provided the description of the error, if there were any adverse effects, interventions and signature of the person who made the error and who noticed the error. Record review of medication error form dated 1/24/24 reflected ADON A discovered the medication error and RN E was the staff member who made the error on 1/23/24. The medication error form reflected that vancomycin 750 mg was not administered to Resident #45 as directed and ADON A reeducated RN E on where to locate medication. Record review of the facility policy titled Administering Medications dated April 2019 reflected in part . Policy Statement: Medications are administered in a safe and timely manner, and as ordered. Policy Interpretation and Implementation: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Medications errors are documented, reports, and reviews by QAPI committee to inform process changes and or the need for additional staff training. 7. Medications are administered withing one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The process of receiving and interpreting prescriber's order-dispensing, administering, and monitoring of all medications. The non-compliance was corrected prior to survey entry as evidenced by Resident #45 received the Vancomycin on 01/24/24, ADON A completed a medication error form, and RN E was re-educated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on observation, interview and record review, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of concern for 1 (Resident #45) of 5 resident's beds for residents reviewed for bed inspection. The facility failed to conduct regular inspections of the beds to identify risks and problems. This failure could place residents at risk of skin irritation and dignity. The Findings Include: Record review of Resident #45's admission face sheet dated 07/30/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis (a serious bone infection that occurs when new bone tissue becomes infected), overactive bladder, dysphagia (difficulty swallowing), diarrhea, unsteadiness on feet, cognitive communication deficit, Dysarthria and anarthria (speech disorders), Parkinsonism (brain condition that cause slowed movements, rigidity (stiffness) and tremors) , Type 2 diabetes (body doesn't produce enough insulin or doesn't use insulin properly), Hyperlipidemia (abnormally high levels of lips in the blood), Bipolar disorder (mental health disorder that causes intense mood episodes), Major depressive disorder (serious mood disorder that can affect how people feel, think and function). On 1/28/24, Resident #45 was discharged . Record review of Resident #45's MDS, a Comprehensive Item Set, dated 01/27/24, revealed a BIMS score of 14, which indicated his cognitive skills for daily decision-making were intact and required 2 people to assist with mobility in bed. In an interview on 7/30/24 at 11:00 a.m., the family member of Resident #45 stated on 1/23/2024 Resident #45 was placed on a mattress that looked worn out and she turned the resident on his side and observed the resident had blue peelings from the mattress that covered his entire back. Resident #45 family member stated there was not a flat sheet on the bed, just a disposable bed pad under the resident. In an interview on 7/31/24 at 1:50 p.m., ADON A stated she believed Resident #45 arrived at the facility on a Sunday (1/21/24), and while making rounds, she observed Resident #45 family upset and asked the family what was going on, and ADON A stated that Resident #45's family member showed her what happened with the bed. ADON A apologized and stated she would take care of it. ADON A called the equipment company to have them bring another mattress over as that mattress peeling was not acceptable. ADON A stated the mattress blue flakes/peeling of the mattress on the resident could cause skin irritation due to the company stating that the mattress breaks down due to the use of cleaning chemicals. ADON A stated that the resident was not on the mattress more than one day and that first time she had ever seen that, and it had not happened since. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Walnut Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5515 Glen Lakes Dr Dallas, TX 75231	

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/31/24 at 7:00 p.m., the DON stated she was informed of the mattress peeling after the company had been called. The company replaced the mattress; Resident #45 was not on the mattress more than one day. The DON stated that nurses are required to inspect mattresses to ensure the mattresses are in good condition.