

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  02/05/2025
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50948</p> <p>Based on interviews, and record review the facility failed to treat each resident with respect and dignity for 1 (Resident #1) of 5 residents reviewed for dignity.</p> <p>1. CNA C tapped Resident #1 on the nose and told Resident #1 You we're being mean to me.</p> <p>The noncompliance was identified at PNC. The noncompliance began on 10/18/2024 and ended on 10/18/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could affect residents in the facility and could cause the residents to feel uncomfortable and disrespected.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 02/05/2025 reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: acute respiratory failure with hypoxia (lungs unable to provide oxygen to the body), end stage heart failure, hypertension, unsteadiness on feet, and muscle weakness.</p> <p>Record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 13 which indicated Resident #1 was cognitively intact.</p> <p>Record review of the provider investigation report dated 10/18/2024 reflected interviews of CNA C and Resident #1 disclosed CNA C pushed Resident #1's nose and told Resident #1 You were being mean to me while assisting Resident #1 with her cell phone. Skin assessments were conducted, and no injuries or bruising were noted. Resident #1 denied any pain or discomfort. CNA C was removed from the schedule pending the facility's investigation and once the investigation was concluded CNA C was informed, she would not return to the facility. Further investigation, documentation, and evidence confirmed the allegation.</p> <p>Record review revealed a skin assessment performed on 10/23/2024 on Resident #1 with no found injuries and Resident #1 denied pain or discomfort .</p> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/2025 at 12:00 pm the ADON stated Resident #1 discharged from the facility in December 2024. The ADON stated she did not witness the incident between Resident #1 and CNA C, but she conducted the interview with CNA C after the incident. She stated CNA C informed her that she responded to Resident #1's call light and assisted Resident #1 by grabbing her cell phone from the charger. She stated CNA C stated she provided care to Resident #1 earlier, and Resident #1 was mean to her. She stated CNA C stated after she handed Resident #1 her cell phone from the charger, CNA C stated she gently tapped Resident #1 on her nose and told her You were being mean to me earlier. She stated CNA C stated she told Resident #1 if she needed anything to call her and left the room. She stated per the skin assessment, no injuries or bruising were noted. She stated CNA C was removed from the schedule pending the facility's investigation. She stated once the investigation was concluded, CNA C would not return to the facility. She stated safe surveys were completed and staff were in serviced on abuse and neglect which including customer service. The ADON stated CNA C was an agency aide.</p> <p>In an interview on 02/05/2025 at 12:10pm the DON stated Resident #1 was admitted to the facility for ninety days and discharged from the facility to home in December 2024. The DON stated she did not witness the incident between Resident #1 and CNA C. She stated she was informed CNA C tapped Resident #1 on the nose and told her Resident #1 was being mean to her. She stated CNA C admitted to gently tapping the Resident #1 on the nose and stated Resident #1 was mean to her. She stated CNA C was removed from the schedule pending the facility's investigation. She stated once the facility concluded their investigation, CNA C was informed she would not return to the facility. She stated CNA C was an agency aide. She stated safe surveys were conducted and staff were in-serviced on abuse and neglect including customer service.</p> <p>In an interview on 02/05/2025 at 12:20pm CNA F stated she never observed staff being disrespectful to residents by hitting or pinching residents. She stated if she observed staff being abusive, neglectful, or disrespectful towards residents she would inform the abuse coordinator. She stated staff are in serviced on abuse, neglect, and customer service every month or when an incident take place.</p> <p>In an interview on 02/05/2025 at 1:20pm Rep stated Resident #1 was discharged from the facility before Christmas. She stated Resident #1 called her immediately after the incident with CNA C. She stated Resident #1 informed her that after CNA C assisted Resident #1 with her cell phone, CNA C pushed Resident #1's nose and told Resident #1 something, but she could not recall what was said by CNA C. She stated Resident #1 was upset and did not appreciate CNA C pushing her nose. She stated she immediately notified the facility and reported this to the SW. She stated Resident#1 did not disclose any injuries or bruising from the incident. She stated CNA C did not continue to care for Resident #1, she was informed CNA C was no longer working at the facility.</p> <p>In an attempted interview on 02/05/2025 at 1:25pm with Rep stated Resident #1 was admitted to the hospital and was unavailable to be interviewed.</p> <p>In an interview on 02/05/2025 at 2:24pm the SW stated Rep B contacted her and informed her Resident #1 was upset because CNA C told Resident #1, she was being mean to her and pushed her nose while assisting Resident #1 with her cell phone. She stated she interviewed Resident #1, and she told her what CNA C did to her and Resident #1 stated she felt CNA C pushing her nose was not done in a nice way. She stated she notified the ADM and was instructed to conduct safe surveys for residents assigned to the same hall as Resident #1. She stated all staff was in serviced on abuse and neglect and customer service following the incident.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/2025 at 3:52pm CNA G stated she never observed staff being disrespectful, abusive, or neglectful to residents because she would report staff immediately. She stated she never observed staff pinching or tapping residents. She stated if staff was observed being disrespectful, abusive, or neglectful, this should be reported to the ADM. She stated staff are in serviced on abuse and neglect or customer service every pay day or weekly. She stated staff failing to report abuse or neglect could cause continued abuse.</p> <p>In an interview on 02/05/2025 at 6:17pm the ADM stated she's been employed at facility for eight weeks. She stated she was not the ADM when the incident occurred with Resident #1 and CNA C. She stated abuse and neglect was not tolerated. She stated expectations of staff were to ensure they were following the facility's policy and procedure on abuse and neglect. She stated the incident between Resident #1 and CNA C was the result of staff not following the facility's policy and procedure.</p> <p>In an interview on 02/06/2025 at 8:25am CNA C stated she was an agency aide and she only worked one or two shifts at the facility prior to the incident. She stated earlier that day, she provided care to Resident #1, and she was mean to her while providing care. She stated later in the day, she responded to Resident #1's call light and assisted Resident #1 by removing Resident #1's cell phone from the charger and handing Resident #1 her cell phone. She stated she gently tapped Resident #1 on her nose and asked Resident #1 Why were you being mean to me earlier? She stated she then told Resident #1 if she needed anything call her and exited Resident #1's room. She stated the residents she was close with; she tapped them on their nose. She stated she did not hurt the residents, and she did not do anything to hurt Resident #1. She stated she's been a CNA for [AGE] years and never hurt anyone. She stated prior to working any shifts at the facility, she received training on abuse and neglect and customer service.</p> <p>Record review of in-service training record dated 10/18/2024 revealed all staff were in serviced by the ADM on abuse prohibition and protocol.</p> <p>Record review of safe surveys dated 10/18/2024 revealed the SW conducted safe surveys on verbal residents assigned to the same hall as Resident #1. No concerns noted.</p> <p>Record review of the facility's policy titled Policies on Abuse Prohibition and Protocol dated 09/07/2022; revised 01/23/2024, Policy Statement: To develop policies and procedures that prohibits abuse, neglect, involuntary seclusion, and misappropriation of property for all residents. 1. Abuse- the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50948</p> <p>Based on interviews and record review, the facility failed to ensure each resident received assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents.</p> <p>1. CNA A failed to apply a gait belt to Resident #1 prior to transferring the resident from the wheelchair to the bed. Resident #1 fell and suffered a bruise to the right armpit area with a small skin tear when CNA A was unable to secure Resident #1 to prevent the fall.</p> <p>This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life.</p> <p>The noncompliance was identified at PNC. The noncompliance began on 11/25/2024 and ended on 11/25/2024. The facility had corrected the noncompliance before the survey began.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 02/05/2025 reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: acute respiratory failure with hypoxia (lungs unable to provide oxygen to the body), end stage heart failure, hypertension, unsteadiness on feet, and muscle weakness.</p> <p>Record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 13 which indicated Resident #1 was cognitively intact.</p> <p>Record review of Resident #1's care plan dated 11/26/2024 reflected the resident was at risk for falls and 1 person assist for transfer and ambulation with a gait belt.</p> <p>Record review revealed a skin assessment performed on 11/25/2024 on Resident #1 with no found injuries, but Resident #1 complained of pain in the right armpit and the right side of rib cage. PRN medication was administered for pain relief and the physician was informed and x-ray ordered.</p> <p>Record review revealed a skin assessment performed 11/26/2024 on Resident #1 with a large bruise to the right arm near armpit with a small tear. X-ray results were negative.</p> <p>Record review of the provider investigation report dated 11/26/2024 reflected interviews of CNA A and Resident #1 disclosed CNA A failed to use a gait belt while transferring Resident #1 from the wheelchair to the bed. Skin assessments and x-rays were conducted and the skin assessment showed delayed bruising and she had negative x-ray results. CNA A was suspended pending the facility's investigation and once the investigation was concluded CNA A was separated from employment. Further investigation, documentation, and evidence confirmed the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/2025 at 12:00 pm the ADON stated Resident #1 discharged from the facility in December 2024. The ADON stated she did not witness Resident #1's fall, however she completed the assessment and interviewed CNA A after the fall. The ADON stated CNA A informed her while assisting Resident #1 with a transfer, Resident #1 needed to be changed and requested to stand up as CNA A performed incontinence care. She stated CNA A stated as she briefly slid away from Resident #1 to throw the brief in the trashcan, Resident #1 was still standing near the bedside and lost her balance and fell . She stated Resident #1 had delayed pain and bruises. She stated she conducted an assessment and at the time of the fall she did not note any injuries. She stated an hour after the fall, Resident #1 complained of pain in the right armpit area and the right of the ribcage. The ADON stated PRN pain medications were administered and Resident #1's physician was notified, and x-rays were ordered. She stated during post fall follow up, it was noted Resident #1 had a bruise on her right arm near her armpit area and a small skin tear. She stated CNA A stated she had her gait belt but did not use the gait belt while transferring Resident #1. She stated staff performing incontinence care while a resident was standing was not typical and staff were expected to perform incontinence care while the resident was sitting. She stated safe surveys were conducted for all verbal residents on the same hall as Resident #1. She stated she educated staff on fall prevention including the use of gait belts during transfers and abuse. She stated her and the DON monitored transfers with gait belts daily for three weeks. She stated CNA A was suspended following the fall pending the facility's investigation. She stated once the investigation was concluded, CNA A was terminated.</p> <p>In an interview on 02/05/2025 at 12:10pm the DON stated Resident #1 was admitted to the facility for ninety days and discharged from the facility to home in December 2024. The DON stated she did not witness the fall that occurred with Resident #1. She stated she was informed Resident #1 fell during a transfer conducted by CNA A. She stated she was informed CNA A assisted Resident #1 with a transfer from the wheelchair to the bed but before doing so, CNA A performed incontinence on Resident #1 in a standing position. She stated she was informed Resident #1 requested CNA A to change her brief while standing. She stated she was informed CNA A moved away from Resident #1 while she was standing to throw the brief away, and Resident #1 fell . She stated she was informed Resident #1 was not wearing a gait belt during the transfer. She stated during the time of the fall, no injuries were noted, and Resident #1 had a delayed pain. She stated during post fall follow up, a bruise and skin tear was noted to Resident #1's right arm near her armpit. The DON stated staff were expected to use a gait during all transfers. She stated staff was expected to perform incontinence care while the resident was sitting as best practice. She stated safe surveys were conducted on all verbal residents that resided on the same hall as Resident #1. She stated staff was educated on abuse and neglect and fall prevention including the use of a gait belt. She stated her and the ADON monitored transfers with gait belts daily for about three weeks. She stated CNA A was suspended pending the facility's investigation, and once the investigation concluded CNA A was released from employment.</p> <p>In an interview on 02/05/2025 at 1:20pm with Rep B for Resident #1 stated Resident #1 was discharged from the facility before Christmas. She stated Resident #1 called her immediately after she fell . She stated Resident #1 informed her that CNA A lifted her out of the wheelchair to move her to the bed, and CNA A walked off to throw something in the trash and Resident #1 fell when CNA A walked away. She stated the facility notified her during the fall but did not inform her about any injuries. She stated she was informed two days later by the facility that Resident #1 had a bruise to her right arm from the fall. She stated the facility informed her that Resident #1's doctor was notified, and x-rays were ordered. She stated after this incident, Resident #1 did not have any additional falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an attempted interview on 02/05/2025 at 1:25pm with Rep stated Resident #1 was admitted to the hospital and was unavailable to be interviewed.</p> <p>In an interview on 02/05/2025 at 1:45pm with CNA A she stated she worked at the facility for no more than four months. CNA A stated she assisted Resident #1 with a transfer from the wheelchair to the bed. She stated before transferring Resident #1 she performed incontinent care by changing Resident #1's brief. She stated she wheeled the chair to Resident #1's bedside and instructed Resident #1 to grab the bedrail. She stated Resident #1 requested to stand while she changed her brief. She stated she did as Resident #1 requested and changed her brief while Resident #1 was in a standing position. She stated after she changed Resident #1's brief, she turned her body slightly away from Resident #1 to throw the brief in the trashcan. She stated as she turned away Resident #1 tried moving herself without any assistance which caused Resident #1 to fall. She stated she received assistance from the ADON or nurse to get Resident #1 up. She stated Resident #1 had delayed bruises and pain. She stated after the fall, Resident #1 did not complain of any pain and the nurse did not identify any bruises or injuries. She stated the next day, Resident #1 complained of pain, and had a bruise on her right arm near her underarm area. She stated she used a gait belt primarily with ambulatory residents. She stated when transferring Resident #1, she would sometimes use a gait belt. She stated on this day, she did not use a gait belt when transferring Resident #1. She stated the facility provided her a gait belt the third or fourth week after she was hired. She stated she did not receive education on transfers and how or when to use a gait belt. She stated the facility suspended her pending their investigation. CNA A stated once the facility concluded their investigation, she was informed using a gait belt during transfers was the facility's policy and due to her not using a gait belt during the transfer with Resident #1, the facility told her she was released from employment.</p> <p>In an interview on 02/05/2025 at 4:54pm with CNA D stated she is an agency CNA, and she was education transferring residents by using a gait prior to her interacting with residents. She stated the facility also provided her a gait belt. She stated before she transferred a resident, she asked the nurse because she only works in the facility occasionally. She stated the risk of staff not using a gait belt could hurt staff and the resident could fall. She stated when providing incontinence care, she ensured residents were sitting down and not standing because resident legs could get weak, and the resident could fall.</p> <p>In an interview on 02/05/2025 at 5:00pm with CNA E stated when providing incontinence care she did not change residents standing up, she changed residents sitting in the bed. She stated she did not know why staff would change a resident standing. She stated she always used a gait belt when transferring residents and the ADON did in services on lifting residents and using a gait belt. She stated she also demonstrated to the ADON a transfer while using a gait belt. She stated the ADON periodically checked staff to ensure all staff know how to use a gait belt.</p> <p>In an interview on 02/05/2025 at 6:17pm the ADM stated she's been employed at facility for eight weeks. She stated she was not the ADM when the incident occurred with Resident #1 and CNA A. She stated during transfers, her expectations of staff were to ensure they were following the facility's policy and procedure on fall prevention during transfers and following instructions given by the charge nurse. She stated the incident between Resident #1 and CNA A was the result of staff not following the facility's policy and procedure which caused Resident #1 to fall and have an injury.</p> <p>Record review of CNA A's employee file revealed CNA A was educated on fall prevention competency including the use of a gait belt dated 10/02/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of in-service training record dated 11/25/2024 and 11/26/2024 revealed all nursing staff were in serviced by nursing management on fall prevention including the use of gait belt and policies on abuse prohibition and protocol .</p> <p>Record review of safe surveys dated 11/26/2024 revealed the SW conducted safe surveys on verbal residents assigned to the same hall as Resident #1. No concerns noted.</p> <p>Record review of the facility's policy titled Safe Lifting and Movement Rights dated July 2017, Policy Statement: In order to protect the safety and wellbeing of staff, residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 8. Enough slings, in the right sizes required by residents in need, will be available at all times. As an alternative, residents with lifting and movement needs will be provided with single- resident use disposable slings. 11. Safe lifting and movement of residents is part of an overall facility employee health and safety program.</p>		