

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 07/25/2025
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)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse and neglect for 1 of 3 residents (Resident #1) reviewed for abuse. The facility failed to ensure that resident #1 was free of physical abuse when LVN A blocked the resident from propelling into the nurses' station. LVN A then initiated a confrontation with Resident #1 when she became physical with the resident after the resident wheeled away from the nurse's station. LVN A nudged a cell phone to the back of Resident #1's head, when the resident reacted and slapped LVN A's arm, LVN A grabbed the resident's arm firmly. LVN pointed her finger at the resident and left the area. LVN A returned and continued the confrontation and subsequently hit Resident #1 on top of the head with an open hand on 07/07/2025. The noncompliance was identified as PNC. The IJ started on 07/07/2025 at 10:30 AM and ended on 07/08/2025. The facility had corrected noncompliance before the investigation had begun. These failures could place residents at risk for emotional distress, fear, decreased quality of care, and further abuse. Findings included: Record review of Resident #1's face sheet, dated 07/24/2025, indicated an [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #1 had diagnoses that included: Wernicke's Encephalopathy (Damage caused to the brain from poor nutrition or alcoholism), Depression, Psychotic Disorder with delusions due to known physiological condition, Alcohol dependence with alcohol-induced dementia, Restlessness and agitation. Record review of Resident #1's quarterly MDS assessment, dated 06/27/2025, indicated a BIMS score of 99 meaning that the interview was unable to be completed. Resident #1's cognitive skills were noted as moderately impaired (decisions poor; cues/supervision required). Resident #1 was noted to be able to recall Staff names and faces, and she could recall that she was in a nursing home/hospital swing bed. Record review of Resident #1's Care Plan, dated 06/24/2025 indicated Resident #1 had Behavior (verbal): Resident has made Verbally Abusive expressions, threats, or inappropriate verbiage towards self, staff other resident's or visitors. Behavior: [Resident #1] is at risk for injury related to resistance to care. the resident is at risk for adverse consequences related to receiving antipsychotic medication. Resident is on Lexapro Seroquel Wellbutrin. Record review of Resident #2's quarterly MDS, dated [DATE] indicated a BIMS score of 12 meaning Resident #2 had moderate cognitive impairment. Resident #1 was indicated to have no Potential Indicators of Psychosis. Record review of the Provider Investigation Report dated 07/08/2025, incident categorized as abuse and incident signed by the ADM on 07/08/2025. PIR indicated the incident occurred on 7/7/2025 at 7:00PM. The PIR indicated that LVN A had hit Resident #1 and it was witnessed by Resident #2 and recorded on facility video. Description of the Allegation: [Resident #1] stated at 6:30 PM on 7/7/2025 that a nurse had hit her. She stated where the incident took place. Security cameras were checked and it did not show the event stated by [Resident #1]. On 7/8/2025 another resident expressed to nurse management that she had witnessed the event stated by [Resident #1]. When cameras for the area were checked it was confirmed. [Resident #1] has a history of being verbally and physically aggressive with staff. The nurse [LVN A] and pushed it into [Resident #1's] head. No injuries noted from assessment conducted on 7/8/2025 at 1:30 PM. Investigation Findings Confirmed. Provider Action Taken Post Investigation, Safe Surveys were done. No other incidents were reported, in-services were held on Aggressive residents and Abuse and Neglect. Review of Resident #1's witness statement, dated 07/07/2025 indicated that Resident #1 expressed to the DON that LVN A had hit her on her head. Review of Resident #2's witness statement, dated 07/08/2025 indicated Resident #2 witnessed LVN A hit Resident #1 intentionally on the head while seated at a dining room table. Record Review of LVN A's personnel file revealed that LVN A had been terminated on 07/08/2025. In an interview on 07/24/2025 at 11:30 AM, CNA B revealed that she recently had in-services on Aggressive Residents and Abuse. She was able to identify the ADM as her ANE Coordinator and she was able to identify 5 types of abuse. She stated that if a resident were to become aggressive with her she would give the Resident some space to let them cool down, or she might offer a snack or activity to re-direct the resident. She stated that she had seen no change in Resident #1's behavior or manner. In an interview on 07/24/2025 at 12:15 PM the ADON revealed that Resident #1 had refused to participate in the BIMS scoring questions. She revealed that Resident #1 was able to recall very well, was alert and oriented to person, place, and time and was generally a very good historian. The ADON revealed that Resident #1 could be verbally aggressive to staff. She stated that when she interviewed LVN A about the incident, LVN A indicated that Resident #1 had kirked at her. The ADON further revealed that after viewing the video of the incident</p>