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	10/17/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44937 Based on interview and record review, the facility failed to coordinate assessments with the PASARR program for 2 of 5 residents (Residents #13 and #69) reviewed for PASARR. The facility failed to ensure Resident #13 and Resident #69's PASARR Level One screening accurately reflected their diagnosis of mental illness. This failure placed the residents at risk of not receiving specialized services for their mental illness. Findings included: 1. Record review of Resident #13's Admission Record reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #13's comprehensive MDS assessment, dated 07/17/24, reflected her BIMS score was 5 which indicated cognition was moderately impaired. Diagnoses included Stroke, Hypertension (high blood pressure), Depression (low mood), and bipolar disorder (manic depression). Record review of Resident #13's care plan, problem edited 09/13/24 reflected she was at risk for adverse reactions to psychotropic medications related to major depressive disorder. Goal: Resident will have no signs or symptoms of adverse reactions related to psychotropic medications. Interventions: Administer psychotropic medications as ordered and monitor effectiveness. Evaluate quarterly and attempt to reduce medication to keep on lowest therapeutic dose. Monitor mood and behavior every shift. Try non pharmaceutical interventions prior to administering as needed psychotropics. Record review of Resident #13's Electronic Health Record reflected she had a PASRR Level I screening dated 06/06/24 that was negative for mental illness. There was no documentation of a new PASARR Level I screening conducted at the facility after admission, and there was also no PASRR II evaluation from the local authority. 2. Record review of Resident #69's Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675765	A. Building B. Wing	10/17/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #69's comprehensive MDS, dated [DATE] reflected her BIMS score was 8 which indicated cognition was moderately impaired. Diagnoses included End Stage Renal Disease (kidney failure), Hypertension (high blood pressure), Type II Diabetes (high blood sugar), bipolar disorder (manic depression). Record review of Resident #69's care plan, problem start date 09/22/24 reflected she was at risk for adverse reactions to psychotropic medications related to bipolar disorder, current episode, mild or moderate severity. Goal: Resident will have no signs or symptoms of adverse reactions related to psychotropic medications. Interventions: Administer psychotropic medications as ordered and monitor effectiveness. Evaluate quarterly and attempt to reduce medication to keep on lowest therapeutic dose. Monitor mood and behavior every shift. Try non pharmaceutical interventions prior to administering as needed psychotropics. Record review of Resident #69's Electronic Health Record reflected she had a PASRR Level I screening dated 09/20/24 that was negative for mental illness. There was no documentation of a new PASARR Level I screening conducted at the facility after admission, and there was also no PASRR II evaluation from the local authority. Interview on 10/16/24 2:30 PM, the MDS Coordinator stated she thought Resident #69 may have been discussed in a morning meeting that Resident #69 was misdiagnosed as having bipolar disorder. The MDS Coordinator stated she had recently been getting a lot of PASRRs from the hospital that were showing negative more often and she had to review both the diagnoses and Resident #69's PASRR. Observation and record review on 10/16/24 2:38 PM of Resident #69's PASRR Level I with the Social Worker revealed she had never completed a request for a new PASRR to have been completed. The Social Worker then stated Resident #69's PASRR was showing negative; however, the resident had a diagnosis for bipolar disorder. The Social Worker stated she had not heard that Resident #69's diagnosis for bipolar disorder was entered inaccurately. The Social Worker stated the MDS Coordinator was responsible for reviewing both the diagnoses and the PASRR upon admission for each resident to ensure they were accurate. The Social Worker stated if there was a discrepancy in the documents, The MDS Coordinator would alert her to complete a PASRR screening, if the screening was positive, she would then alert the local authority for an evaluation. The Social Worker stated if a diagnosis or screening was missed, such as this one, it would place residents at risk of not receiving services. Interview on 10/16/24 at 2:45 PM with the DON revealed she was not aware of Resident #13 and #69's PASRR was showing a negative reading. According to the DON, Resident #13 and #69 had a diagnosis of bipolar disorder. The DON stated both MDS Coordinator and the Social Worker were responsible for reviewing, having, and completing accurate PASRRs for residents upon admission so they can have the services they need. Interview and observation on 10/16/24 3:08 PM, the MDS Coordinator stated she was responsible to review and ensure PASRR screenings were updated and correct for both Resident #13 and Resident #69. The MDS Coordinator stated if there was a discrepancy in resident's diagnoses or the PASRR screenings, she was responsible to alert the Social Worker so a screening could be done in-house by the Social Worker. The MDS Coordinator stated by not reviewing and double checking resident PASRR screenings along with diagnoses, placed residents at risk of not receiving needed services. (continued on next page)

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	10/17/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/17/24 at 4:57 PM, the Administrator stated the MDS Coordinator and the Social Worker was responsible for making sure diagnoses and PASRRs were accurate. The Administrator stated if there was a discrepancy on the PASRR, the facility needed to redo the PASRR and follow additional steps if the PASRR was negative. The Administrator stated the facility placed Resident #13 and Resident #69 at risk of not getting the proper services for their care. Record review of the facility's Admission Criteria policy, revised March 2019, reflected: .Our facility admits only residents who's medical and nursing care needs can be met. .9. All new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority.

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	10/17/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to revise and review the care plan for 1 of 5 residents (Resident #78) reviewed for comprehensive care plans. The facility failed to revise and review Resident #78's care plan for his use of a Foley catheter. This failure could lead to the residents not receiving the care they require, resulting in inadequate care. Findings included: Record review of Resident #78's admission face sheet reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #78's MDS assessment, dated 08/30/24, reflected Resident #78's cognition was intact with a BIMS score of 15. His diagnoses included sepsis (body's response to infection causing injury to its own tissues and organs), Type 2 diabetes (high blood sugar), and lack of coordination. The MDS reflected the resident required substantial/maximum assistance with toileting, and he required the use of an indwelling catheter. The MDS reflected the resident had a discharge goal to be independent. Record review of Resident #78's care plan, last reviewed/revised 10/09/24, did not indicate his use of a Foley catheter or need for catheter care. Observation and interview on 10/15/24 at 11:04 AM with Resident #78 revealed he was lying in his bed. His catheter was hanging in a low position on the bed facing the door with a blue protective cover. According to Resident #78, he came to the facility for rehabilitation due to a fall. Resident #78 stated he entered the facility with the catheter. Resident #78 stated he had been working with facility staff on taking the catheter in and out. Resident #78 stated today he practiced using a leg catheter. Observation and interview on 10/17/24 at 12:41 PM with Resident #78 revealed his catheter bag hanging in a low position on the side of the bed facing the door with a blue privacy cover. According to Resident #78, he was assessed during incontinence care to ensure the catheter was emptied and in place. Resident #78 stated he did not experience any pain during care. He stated he had no problems with the way staff assisted him during incontinence care. According to Resident #78, he was going to discharge soon, and he had been training to care for his catheter. Resident #78 stated he emptied the bag himself with the help of therapy. Interview on 10/17/24 at 12:50 PM with the Physical Therapist revealed she had been working with Resident #78 on catheter care. Physical Therapist stated she thought Resident #78 was going to discharge home with the catheter and wanted to ensure he was going to be able to know how to properly empty the bag and care for it. According to Physical Therapist, she was well aware the resident had the catheter bag because she worked with him during physical therapy. (continued on next page)

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	10/17/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 1:20 PM with RN I revealed Resident #78 entered the facility a couple of months ago with use of Foley catheter. According to RN I, he had not noticed whether the care plan included the use of the Foley catheter. According to RN I, the admitting nurse was responsible for entering orders upon admission and this should have then triggered for the care plan to be updated. RN I stated there was no risk involved for Resident #78's catheter because he was receiving incontinent care checks every two hours by the aide assigned to him which included care for the catheter. RN I stated during incontinent care staff would observe Resident #78's catheter therefore provided care for it. RN I did not address if there was care required that only a nurse could do or how care was being documented by the aide. Interview on 10/17/24 at 1:59 PM with the ADON revealed she was aware Resident #78 had a catheter. The ADON stated she was not aware Resident #78's care plan did not show use of a catheter. The ADON stated Resident #78 was scheduled to discharge home on unknown date, so he recently went to the urologist to have the catheter removed . The ADON stated Resident #78 was not able to be seen and had to return to the facility with the catheter administered. The ADON stated she removed the orders and removed the catheter from the care plan because he was to have it removed. The ADON stated when Resident #78 was not able to have the catheter removed at the urologist, the catheter was removed by facility staff for 2 days, until it had to be readministered due to him having fluid retention and not able to void. The ADON stated she must have forgotten to add the catheter care back to the care plan. The ADON stated she was responsible for ensuring Resident #78's care plan was revised and updated. The ADON stated not updating and revising the care plan placed him at risk of not having everyone aware of his care needs. Interview on 10/17/24 at 2:45 PM with the DON revealed Resident #78 had a catheter at the hospital prior to entering the facility. The DON stated, we tried to remove the catheter by sending him to a urologist however that was unsuccessful. The DON stated, we then tried to remove it here but [Resident #78] was not able to retain his bladder, so we relaced it. The DON stated the ADON was responsible for updating Resident #78's care plan, I think she discontinued the care when he went to have it removed. The DON stated Resident #78's care plan should have been updated so it could be planned for care. Record review of facility policy revised March 2022 titled Care Plans, Comprehensive Person - Centered reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person - centered care plan: a. Includes measurable objectives and timeframes. b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' ongoing conditions change. The interdisciplinary team reviews and updates the care plan: (continued on next page)

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	10/17/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. When there has been a significant change in the resident's condition. b. When the desired outcome is not met. c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment.

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	10/17/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure that the facility provided the services, care and equipment to assure that a resident maintains, and/or improves to his/her highest level of range of motion and mobility for 1 of 5 residents (Resident #42) reviewed for rehabilitative services. The facility failed to provide Resident #42 with Restorative Nursing to maintain his current level of range of motion. This failure could place Resident #42 at risk of not being able to maintain his previous level of function. Findings included: Record review of Resident #42's face sheet dated 10/17/24 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #42's MDS assessment, dated 09/29/24, reflected Resident #42 had a BIMS score of 14 indicating his cognition was intact with diagnoses that included Stroke (poor blood flow to the brain), Heart Failure (impairment in the heart's ability to fill and pump blood), and Hemiplegia or Hemiparesis (weakness on one side of the body). His MDS indicated Resident #42 had functional limitation in range of motion for both upper and lower extremities on both sides of body. His MDS indicated Resident #42 was dependent on staff for shower/bathing and toileting hygiene; substantial/maximum assistance with upper and lower body dressing. His MDS indicated zero days for the provision of the restorative nursing program. Record review of Resident #42's care plan, last reviewed/revised 09/26/24, did not indicate his order or use for restorative therapy. Problem start date 08/22/24: ADLs Functional Status/Rehabilitation Potential: Specialized Rehabilitation Therapy (S): Resident Needs Physical Therapy R/T Diagnosis of Neuromuscular Re-Education and Therapeutic Modalities Prn for Pain. Goal: Resident will achieve maximum potential and goals as specified on his/her therapy/treatment plan. Interventions: Arrange therapy schedule so there is no conflict with activities the resident enjoys attending. Encourage resident to participate in therapy. Monitor progress. Therapist and nursing to collaborate care and services to maximize resident's accomplishments. Record review of Resident #42's Restorative Nursing Program Communication Form dated September 2024 reflected: AROM: BUE, BLE 20 reps X 3 sets Splint 3 X a week Bed Mobility: side to side 10 reps X 2 sets (primary purpose for bed mobility: prevent skin breakdown and respiratory) (continued on next page)

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	10/17/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Communication: Lower extremity AROM Right Lower extremity 15-25 reps X sets Left Lower extremity AAROM/PROM Special Instructions: Bed positioning for postural alignment Signed by the Restorative Aide Record review of Resident #42's Restorative Nursing Program Communication Form dated November 2023 reflected: AROM: BUE, BLE 20 reps X 3 sets Other: Bed to wheelchair 2-3 times a week for 2-3 hours Bed Mobility: side to side 5-10 reps X 2 sets (primary purpose for bed mobility: prevent skin breakdown and respiratory) Signed by the Restorative Aide Record review of Resident #42's Restorative Nursing Documentation Tool dated July 2024 reflected: Plan of Care - Blank Documentation and Minutes - Blank Progress Notes and Review - Blank Interview on 10/15/24 at 10:55 AM with the Family Member revealed Resident #42 never got restorative care after he had surgery last fall. According to the Family Member, the Director of Rehabilitation kept saying he did, however, there was no documentation to prove otherwise. The Family Member stated Resident #42 had surgery in August 2023 and completed physical therapy for about 2-3 weeks. The Family stated he should have followed up with restorative therapy afterwards; however, the facility did not provide any. The Family Member stated, he still needs exercise, they did nothing, they wrote him off! According to the Family Member, Resident #42 just had another surgery and was cleared to start physical therapy last Friday, 10/11/24; however, he had not started as of yet. The Family Member stated she had a conversation with the Director of Rehabilitation and discussed documentation that showed Resident #42 could bear weight on his foot, but the facility required a physician order to start the therapy. The Family Member stated she was concerned that the facility wrote him off by indicating to providers that there was no improvement, leaving him without any exercise or therapy for six months. (continued on next page)

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	10/17/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/15/24 at 3:00 PM with Resident #42 revealed him sitting in bed, leaning to his right side. Resident #42 stated the only concern he had was that he recently had surgery and wanted to ensure he was going to have physical therapy. Resident #42 stated he recently spoke with the Director of Rehabilitation, and she required an order or documentation that he was allowed to bear weight. Resident #42 stated he had been in contact with the physician and was waiting to hear when he could start physical therapy. According to Resident #42 this was his second surgery, and he did not have restorative therapy services after the first surgery so he wanted to ensure the facility would follow his physical therapy with restorative therapy; it was important to him that he continued with an exercise plan. During interview with Resident #42 there was no observations of contractures, Resident #42 stated he currently took a neurotoxic protein therefore required the use of restorative therapy so that his muscles would not stiffen and he could benefit from the use. Interview on 10/16/24 10:52 AM with the Director of Rehabilitation revealed restorative therapy programs were typically for long-term residents, and once the resident ended with the therapy department, they are no longer seen by therapy. She stated the therapist would educate the resident's aide, the aide signs off on the restorative treatment, and the Restorative Aide would get a copy . The Director of Rehabilitation stated Resident #42 was discharged from physical therapy a couple of weeks ago. The Director of Rehabilitation stated Resident #42 was on restorative therapy for his upper arm, he was to have a splint for his hand. According to the Director of Rehabilitation, Resident #42 was currently on restorative therapy which was just to provide contracture management. The Director or Rehabilitation stated she had spoken with Resident #42 concerning current request for physical therapy, and had reached out to the physician for an order to confirm Resident #42 was weight bearing and could begin with physical therapy services. Interview and record review on 10/16/24 at 3:00 PM with the Restorative Aide revealed Resident #42 was currently on restorative therapy, however, she attempted a couple of times to administer his sling, but he would refuse. According to the Restorative Aide, once Resident #42 refused she alerted the therapy department and did not attempt again to provide the sling. When asked if she was educated by therapy staff on his restorative goals, she stated yes and that it was only to apply the sling. When asked when was the last time she attempted to complete restorative therapy with Resident #42 she replied, it was a long time ago and could not provide a date. The Restorative Aide stated she was responsible for providing restorative therapy to Resident #42. The Restorative Aide stated not providing the restorative therapy placed Resident #42 at risk of contractures and not maintaining his level of range in motion. The Restorative Aide provided a copy of Resident #42's forms from the therapy department. According to the Restorative Aide, she did not have a recent restorative request for Resident #42. (continued on next page)

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	10/17/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/17/24 at 2:45 PM with the DON revealed she was aware of Resident #42 being on restorative therapy. The DON stated the facility had a restorative aide that worked with him on range of motion. According to the DON, Resident #42 was on restorative therapy until he recently returned from the hospital and services ended because he was going to be picked up for physical therapy. The DON stated an order was usually written by the therapy department and they provided her a copy so that she was aware of who was on restorative therapy and their goals. According to the DON, if a resident was refusing services, it was the responsibility of the Restorative Aide to let her know so that therapy department could visit with resident to understand why they were refusing services. The DON stated not providing restorative therapy services to Resident #42 placed him at risk of decreased mobility. Record review of the therapy orders by the DON for Resident #42's restorative therapy resulted in the DON stating she was not aware that Resident #42 had not been receiving restorative therapy services. She further stated his expectations were unreal, he thinks he can get up and walk again. The DON stated Resident #42 had her personal cell phone and could contact her at any time with his complaints. Record review of facility's Restorative Nursing Services policy, revised July 2017, reflected: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. 1. Restorative nursing care consist of nursing interventions that may or may not be accomplished by formalized rehabilitative services. (physical, occupational or speech therapist) 2. Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. 4. The resident or representative will be included in determining goals and the plan of care. 5. Restorative goals may include, but are not limited to supporting and assisting the resident in: a. adjusting or adapting to change abilities; b. developing, maintaining or strengthening his/her physiological and psychological resources; c. maintaining his/her dignity, independence and self-esteem; and d. participating in the development and implementation of his/her plan of care.

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	10/17/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities for 1 of 4 residents (Resident # 65) reviewed for tube feeding. The facility failed to ensure LVN E checked for g-tube placement and administered Resident #65's bolus feeding formula via gravity flow when she plunged 120 mL of formula via syringe through her g-tube. This failure could place residents with g-tubes at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #65's admission face sheet reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with a re-admission on 09/30/24. Record review of Resident #65's quarterly MDS assessment, dated 09/14/24, reflected the resident's cognition was intact with a BIMS score was 15. The MDS reflected the resident's diagnoses included stroke, dysphagia (swallowing difficulty) following cerebral infarctio, dysarthria (speech sound disorder) following cerebral infarction, and hypertension (high blood pressure). The MDS also reflected the resident received a mechanically altered diet. The MDS did not reflect the resident had any recent surgeries or that she had a feeding tube. Record review of Resident #65's care plan, problem start date 09/30/24 reflected the resident was at risk for aspiration related to tube feeding secondary to oropharyngeal dysphagia. The care plan reflected: Currently on formula, give 120 cc via Gtube x 5 per day, free water flushes are 100 cc every 6 hours. Goal: Resident will have no aspiration related to tube feeding. Interventions: Enteral assessment prior to feeding and medication: Special Instructions: Assess tube placement and site condition prior to and after medication administration, apply dry dressing if needed, and documents findings four times a day. Enteral Feeding formula at 120 cc 5x per day. Enteral Free Water to 100 ml every 6 hours. Special Instructions: Head of bed at 45 degrees, 90 degrees for all meals. 100% supervision with all meals and medications every 6 hours. Enteral Tube Site Care Special Instructions: Cleanse tube insertion site (skin) with normal saline, pat dry, apply split sponge and dressing every shift. Record in and out Special Instructions: Record all intake of fluids and output under vital signs in clinical records. Record review of Resident #65's Physician Orders reflected the following orders: 1. Enteral Nutrition - Syringe (Bolus) via Gravity (continued on next page)

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	10/17/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Special Instructions: Policy and Procedure for GI Feed Syringe (Bolus) via Gravity Check gastric residual volume (GRV) of 150 mL or less. If greater than 150 mL hold feeding, retest in 30 minutes. If GRV remains above 150 mL hold and notify Medical Doctor Four Times A Day 09:00, 13:00, 17:00, 21:00 09/30/2024 2. Enteral: Enteral Feeding: Formula: Bolus Feeding Give 120 mL 5 X Day Special Instructions: Record Formula, Strength, And Hours Per Day 5 Times Per Day 07:00, 10:00, 13:00, 16:00, 19:00 10/11/2024 Observation on 10/17/24 at 1:01 PM revealed LVN E did not check the g-tube placement before administering bolus feeding for Resident #65. LVN E then checked for residual which resulted in zero amount. Next, LVN E used a syringe to administer 50 cc of water in g-tube and allowed gravity to empty the syringe. LVN E then poured a full syringe of formula, as the flow of formula was slow to empty LVN E then used the syringe to plunge the feeding formula into the g-tube. LVN E then administered the remaining formula, which also flowed slowly by gravity. LVN E then used the syringe again to plunge the remaining formula. LVN E was then observed to use gravity flow for the remaining 50 cc of water after administering the formula. Interview on 10/17/24 at 1:05 PM, LVN E stated, We normally don't have this problem of the formula emptying slow. LVN E stated she became concerned when the flow of the formula was moving slowly through the syringe. LVN E stated she administered 10 cc of air and pulled back to check for residual and did not have any. LVN E stated Resident #65 was not in distress and the formula was not backing up, so she assisted because it did not seem like it was flowing at all. LVN E stated, I assisted the bolus with push, and I should not have, LVN E stated what I should have done was checked Resident #65's placement to hear the whoosh, then checked for residual, and I could have added water to loosen the flow. LVN E stated she was responsible for administering the bolus feeding properly, not doing so placed Resident #65 at risk for placing gas into the abdomen and potential aspiration. Interview on 10/17/24 at 1:59 PM with the ADON revealed Resident #65 was new to bolus feedings and was to receive five feedings per day. The ADON stated she was not notified about the bolus feeding with Resident #65. She stated she expected nursing staff to follow protocol when administering bolus feeding by first checking for placement, then residual, and allowing the feeding to flow via gravity. The ADON stated she could not recall the last time an in-service was completed regarding bolus feedings. The ADON stated the resident's nurse was responsible for administering the feeding and not doing so properly placed Resident #65 at risk for having air on the stomach and possibly aspiration. Interview on 10/17/24 at 2:45 PM with the DON revealed the nursing staff was responsible for administering bolus feedings. The DON stated she expected nursing staff to check for placement prior to administering the feeding. The DON stated nursing staff should allow the feeding to flow by gravity and not assist. The DON stated not doing so placed the resident at risk of having a tummy ache and having air on the stomach. (continued on next page)

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	10/17/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Maintaining Patency of a Feeding Tube (Flushing) policy, revised November 2018, reflected: The purpose of this procedure is to maintain patency of a feeding tube. Steps in the Procedure: .Confirm placement of tube. Flush with 30 mL, or prescribed amount, of warm water after checking gastric residual volume. For intermittent feeding, flush with warm water before and after the feeding. Attach sixty (60) mL syringe with out plunger to tube. Unclamp tube and pour 30 mL (or amount ordered) warm water into syringe. Allow water to flow by gravity into feeding tube. If the feeding tube is clogged: a. check the tubing for kinks. b. Add 30 mL (or prescribed amount) warm water to the syringe. c. With water in the syringe, apply a gentle back and forth motion with the plunger to try to dislodge the clog.

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	10/17/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44140 Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 18 of 90 days (07/27/24, 07/28/24, 08/03/24, 08/04/24, 08/10/24, 08/11/24, 08/17/24, 08/24/24, 08/31/24, 09/07/24, 09/08/24, 09/21/24, 09/22/24, 09/28/24, 10/05/24, 10/06/24, 10/12/24 and 10/13/24) reviewed during a look back period from 07/20/24 to 10/17/24 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 07/27/24, 07/28/24, 08/03/24, 08/04/24, 08/10/24, 08/11/24, 08/17/24, 08/24/24, 08/31/24, 09/07/24, 09/08/24, 09/21/24, 09/22/24, 09/28/24, 10/05/24, 10/06/24, 10/12/24 and 10/13/24. This failure could place residents at risk for not having their nursing and medical needs met and improper care. Findings included: Record review of the facility's Timecard Reports from 07/20/24 to 10/17/24 reflected the following: - Saturday 07/27/24 - RN F worked a total of 6 hours and 3 minutes consecutively on Saturday from 5:56 PM to 11:59 PM; - Sunday 07/28/24 - RN H worked a total of 6 hours and 1 minute consecutively on Sunday from 5:58 PM to 11:59 PM; - Saturday 08/03/24 - RN F worked a total of 6 hours and 2 minutes consecutively on Saturday from 5:57 PM to 11:59 PM; - Sunday 08/04/24 - RN H worked a total of 6 hours consecutively on Sunday from 5:59 PM to 11:59 PM; - Saturday 08/10/24 - RN F worked at total of 6 hours and 3 minutes consecutively on Saturday from 5:56 PM to 11:59 PM; - Sunday 08/11/24 - RN H worked a total of 6 hours and 4 minutes consecutively on Sunday from 5:55 PM to 11:59 PM; - Saturday 08/17/24 - RN F worked a total of 6 hours and 3 minutes consecutively on Saturday from 5:56 PM to 11:59 PM; - Saturday 08/24/24 - RN F worked a total of 6 hours and 2 minutes consecutively on Saturday from 5:57 PM to 11:59 PM; - Saturday 08/31/24 - RN F worked a total of 6 hours and 1 minute consecutively on Saturday from 5:58 PM to 11:59 PM; (continued on next page)

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	10/17/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Saturday 09/07/24 - RN F worked a total of 5 hours and 59 minutes consecutively on Saturday from 6:00 PM to 11:59 PM; - Sunday 09/08/24 - RN H worked a total of 6 hours and 4 minutes consecutively on Sunday from 5:55 PM to 11:59 PM; - Saturday 09/21/24 - RN F worked a total of 6 hours and 1 minute consecutively on Saturday from 5:58 PM to 11:59 PM; - The Timecard Report reflected there was no RN coverage for Saturday 09/22/24; - The Timecard Report reflected there was no RN coverage for Saturday 09/28/24; - Saturday 10/05/24 - RN F worked a total of 6 hours and 2 minutes consecutively on Saturday from 5:57 PM to 11:59 PM; - Sunday 10/06/24 - RN H worked a total of 5 hours and 59 minutes consecutively on Sunday from 6:00 PM to 11:59 PM; - Saturday 10/12/24 - RN F worked a total of 6 hours and 1 minute consecutively on Saturday from 5:58 PM to 11:59 PM; and - Sunday 10/13/24 - RN H worked a total of 6 hours and 3 minutes consecutively on Sunday from 5:56 PM to 11:59 PM. Interview on 10/17/24 at 4:08 PM with the Staffing Coordinator revealed she was responsible for completing the nursing schedules. She stated she was unaware of the requirement for an RN to work 8 consecutive hours each day. She stated she thought she was covered since the facility RNs worked 12 hours shifts 6:00 AM-6:00 PM and 6:00 PM-6:00 AM. She stated she completed the nursing schedules weekly, and the DON would review the nursing hours. She stated she had not been told anything regarding RN coverage. She stated the times when they were short in RN hours, the DON would come in and help. She stated it was important to have an RN in the facility because they completed assessments. Interview on 10/17/24 at 4:15 PM with the DON revealed the Staffing Coordinator was responsible for completing the nursing schedules. She stated herself and the Administrator would review the nursing schedules during morning meetings, and she would be informed of what weekend she needed to come in and work. She stated she was aware of the 8 consecutive hours for RN coverage. She stated for the weekends when the facility did not have an RN working, she would come in and work. However, she was unsure what days she worked during the weekends. She stated the potential risk of not having an RN in the facility would be needing an RN to assist with assessments. Interview on 10/17/24 at 4:46 PM with the Administrator revealed the Staffing Coordinator was responsible for completing the nursing schedules. She stated the DON and other staff were responsible for reviewing them. She stated she was aware of the 8 consecutive hours for RN coverage. She stated she thought they had an RN for 8 hours, but they did not. She stated they missed it when reviewing the nursing schedules. She stated there was no risk for not having an RN in the building because they had LVNs, and the LVNS were aware of what to do. She stated RNs were a requirement and were needed to complete assessments and to be able to pronounce. (continued on next page)

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	10/17/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Department Duty Hours, Nursing Services policy, revised May 2019, reflected the following: Our facility has developed and assigned duty hours for the nursing services department. .4. There will be eight hours of RN coverage provided 7 days/week.

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	10/17/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on 1 of 3 medication carts (2 North Hall Nurses cart) and 3 of 3 residents (Residents #3, #134 and #136) reviewed for pharmacy services. The facility failed to ensure Hall 2North Hall nurses medication cart contained accurate narcotic logs for Residents #3, #134 and #136. The failure could place residents at risk for medication error, drug diversion, and delay in medication administration. Findings included: 1. Record review of Resident# 3's Entry MDS assessment, dated 10/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis of pain. The resident had moderate cognitive impairment with a BIMS score of 12. Record review of Resident #3's physician's orders dated 08/14/24 reflected an order for the resident to received Lyrica (pregabalin) 100 mg 1 tablet by mouth two times a day for pain. 2. Record review of Resident# 134's Entry MDS Assessment, dated 10/13/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included pain and local infection of the skin. The resident had intact cognition with a BIMS score of 15. Record review of Resident #134's physician's orders dated 10/07/24 reflected orders for the resident to receive one tablet of Hydrocodone 5 mg acetaminophen 325 mg (pain medication) by mouth every six hours as needed for pain and Lyrica (pregabalin) 75 mg 1 tablet by mouth three times a day. 3. Record review of Resident# 136's comprehensive MDS assessment, dated 10/17/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis of pain. The resident had moderate cognitive impairment with a BIMS score of 12. Record review of Resident #136's physician's orders dated 10/11/24 reflected orders for the resident to receive Tramadol 50 mg 1 tablet by mouth every 4 hours as needed for pain and Lorazepam 0.5 mg 1 tablet by mouth once daily as needed for anxiety. Observation and record review on 10/16/24 at 10:25 AM with LVN G of the 2 North Hall Nurses medication cart and the Narcotic Administration Records revealed the following: - Resident #3's Narcotic Administration Record for pregabalin 100 mg was last signed off on 10/15/24 for one-tablet dose given at 7:56 PM, for a total of 7 pills remaining, while the blister pack count was 6 pills. (continued on next page)

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	10/17/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #134's Narcotic Administration Record for Hydrocodone 5 mg/acetaminophen 325 mg was last signed off on 10/15/24 for a one-tablet dose given at 8:14 PM for a total of 9 pills remaining while the blister pack count was 8 pills and pregabalin 75 mg was last signed off on 10/15/24 for one-tablet dose given at 8:00 PM, for a total of 7 pills remaining, while the blister pack count was 6 pills. - Resident #136's Narcotic Administration Record for lorazepam 0.5 mg was last signed off on 10/15/24 for a one-tablet dose given at 11:45 AM for a total of 26 pills remaining while the blister pack count was 25 pills and Tramadol 50 mg was last signed off on 10/16/24 for one-tablet dose given at 05:34 AM, for a total of 32 pills remaining, while the blister pack count was 31 pills. Interview with LVN G on 09/25/24 at 10:40 AM revealed she administered: - pregabalin 100 mg 1 tablet to Resident #3 at 8:00 AM; - pregabalin 75 mg 1 tablet and hydrocodone 10-235 mg one tablet to Resident #134 at 8:00 AM; and - Lorazepam 0.5 mg 1 tablet and tramadol 50 mg 1 tablet to Resident #136 at 8:00 AM. She stated she had administered these medications during the morning medication pass, but she had not signed off on the Narcotic Administration Record log that the drugs had been administered. She stated she gave the residents the medication, and she was supposed to sign off on the Narcotic Administration Record log when she was done with passing all the morning medications. She stated she knew she was supposed to sign-out on the Narcotic Count Sheet after administration and on the Medication Administration Record, but she did not. She stated failure to log off would cause the narcotic count to show less on the next count, and it could lead to medication error and drug diversion. She stated she had done an in-service on medication administration. Interview on 10/17/24 at 9:56 AM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the Medication Administration Record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. The DON stated failure to document could lead to discrepancy, drug diversion, and medication error. She stated it was her responsibility to perform checks on the medication cart. She stated she had checked Friday, as it was her routine, to ensure they had enough pills for the weekend. She stated she had done training of staffs on narcotic logs documentation and medication administration. Record review of the facility trainings reflected in-services on medications needed to be signed as staff gave them on 10/24/23. LVN G attended the training. Record review of the facility's current Medication Administration procedures policy, dated April 2019, reflected: .22.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23.As required or indicated for a medication, the individual administering the medication records in the resident's medical record: (continued on next page)

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	10/17/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The date and time the medication was administered. b. The dosage. c. The route of administration. g. The signature and title of the person administering the drug.

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	10/17/2024

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures for notification for 1 of 18 residents (Resident #284) reviewed for laboratory services. The facility failed to promptly notify Resident #284's physician after the results from a UA C&S, which was ordered on 10/31/23, were received on 11/04/23 showing the resident had bacteria (Escherichia Coli (E.Coli) ESBL and Providencia Stuartii) in her urine. On 11/09/23, the resident experienced a change of condition with lethargy. She was sent to the hospital where she was admitted for sepsis due to a UTI. An Immediate Jeopardy (IJ) was determined to have existed from 10/31/23 to 11/09/23. The IJ was removed on 11/09/23 because there were no other residents affected or concerns with laboratory services. The facility remained out of compliance with a scope isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This deficient practice placed the residents at high risk of, or the likelihood of, serious injury or harm by not receiving treatment, developing complications, and the development of sepsis. Findings included: Record review of Resident #284's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility 06/10/20. Her diagnoses included heart failure, hypertension (high blood pressure), chronic respiratory failure, pressure ulcer of sacral region (a triangular-shaped bone located at the base of the spine, between the lumbar vertebrae (lower back) and the coccyx (tailbone), and presence of urogenital implants (A bulking agent is injected into the walls of the urethra to treat stress incontinence caused by a weak sphincter muscle). Resident #284 had a BIMS score of 11, meaning she had moderate impaired cognition. The resident required total dependence of two staff members for bed mobility, dressing, and transfers. The MDS further reflected the resident had a catheter and was always incontinent of bowel. Resident #284 did not return to the facility after she was sent out to the hospital on 11/09/23 and family transferred her to another nursing facility. Record review of Resident #284's care plan edited on 05/28/23 reflected the resident was at risk for UTI's related to the foley catheter used for the diagnosis of a wound to sacral area. Approaches included monitor for signs and symptoms of a UTI such as foul odor of urine, visible sediments in urine, fever, dysuria (blood in urine), complaints of abdominal pain and changes in mental status. Other approaches included to monitor labs and the medical doctor orders. Record review of Resident #284's progress note dated 10/31/23 documented by LVN A reflected the following: (continued on next page)

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	10/17/2024

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident's [Family] requested for [Resident #284]'s urine sample to be collected for lab due to its color, this nurse called [Physician] and he ordered urine to be collected and sent to lab. Urine sample is pending for lab pick up. Record review of Resident #284's progress note dated 11/05/23 documented by LVN B reflected the following: .upon assessment patient no c/o pain or discomfort. observed urine pink in color. Changed catheter bag today and emptied Record review of Resident #284's progress note dated 11/09/23 documented by LVN C reflected the following: 11/08/23 Resident was lethargic opening eyes for a short moment when aroused but not verbally responding. After a while resident was awake making eye contact and blinking when spoken to but still not speaking. Resident would not open her mouth to drink when offered or take HS medications. B/P-137/85, T-98.3 P-102, R-18 SpO2 95% NC 3Lpm. [Family] at bedside and requested resident be sent to hospital. [Doctor] notified. N/O to send to ER for further evaluation. 2230 Resident transported to [Hospital] via stretcher X2 [by two] EMT accompanied by [family]. Record review of Resident #284's UA results reflected they were collected on 10/31/23, ready to view on 11/03/23, and printed on 11/04/23. The results reflected there were 2 micro-organisms found in the resident's urine: Final: >100,000 CFU/ML of Escherichia Coli (E.Coli) ESBL isolated. (E.coli is a serious type of bacteria that can cause urinary tract infections that make them resistant to a wide range of antibiotics) <25,000 CFU/ML of Providencia Stuartii also isolated. (bacteria that can cause urinary tract infections) Record review of Resident #284's hospital records dated 11/09/23 reflected the following: .Severe sepsis gram negative bacteremia (a life-threatening bloodstream infection that occurs when bacteria enters the bloodstream) related to a UTI Patient is critically ill with sepsis due to gram negative bacteremia. At high risk for deterioration with one or more organ damage, including death (continued on next page)

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	10/17/2024

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/16/24 at 10:41 AM with LVN A revealed Resident #284's family requested a UA because she felt like the resident's urine was dark in color. LVN A said she collected the urine, had it sent to the lab and gave report to the oncoming nurse, LVN J, and she (LVN J) acknowledged she would follow-up. LVN A said she was off for about 4 days and upon returning, she realized the no one had obtained the UA results from the computer system. LVN A did not recall many details after that nor did she recall what was or was not done with Resident #284. LVN A did recall the DON made a big fuss and was upset and called her (LVN A) asking why Resident #284's urine had been collected and was asked to write a statement about what happened and it was turned into the DON. LVN A further stated Resident #284 had been sent to the hospital sometime after she had collected the resident's urine, but could not recall dates. LVN A did not recall if Resident #284 was ever put on antibiotics. LVN A said she spoke to LVN J to ask why she had not followed up on Resident #284's UA, but she did not recall the answer. Attempts to call LVN J on 10/17/24 were unsuccessful. Interview on 10/17/24 at 9:20 AM with LVN C revealed she vaguely recalled the circumstances around the time she sent Resident #284 out to the hospital other than the resident was not alert or as responsive as she usually was. LVN C said she recalled there was a conversation, did not recall with who , about the resident's UA being collected and later they were questioning the results but did not recall any other details. LVN C further stated they had received in-services on the lab processes and following up after Resident #284's incident. Interview on 10/17/24 at 1:29 PM with the DON revealed she did not know Resident #284 had been admitted to the hospital, 11/08/23, for a UTI. The DON said she did not recall much of what happened around the time Resident #284 was sent to the hospital. The DON said she had recently reviewed the resident's labs and the results showed the UA contained some micro-organisms but she was not able to find any evidence the resident was ever on any antibiotics around the time the labs were ordered and obtained and the resident was sent to the emergency room , 10/31/23 - 11/08/23. The DON further stated there were some in-services done on labs around the time Resident #284 was sent out to the hospital, but they were not related to the resident's incident and just general in-services. The DON did not recall having any staff write statements on the incident. Record review of the in-sevices dated 11/09/23 reflected staff were educated on lab procedures from obtaining the labs orders, calling the doctor with the results, documenting in the progress notes, and contacting the family with the results as well. Interview on 10/17/24 at 9:13 AM with the Administrator revealed she did not recall the circumstances around the time Resident #284 was sent to the hospital (11/08/23). The Administrator said it appeared Resident #284's doctor did not get the UA results so the nurses received education on how to order labs, and to call the doctor when the results came in. The Administrator excused herself and upon returning she stated she had misspoke and the lab in-services were not related to Resident #284's incident. The Administrator further stated risks of not following up on lab results could lead to other health issues. (continued on next page)

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	10/17/2024

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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/16/24 at 1:14 PM with Resident #284's Physician revealed the resident had a lot of chronic UTI's and they would check her urine at any given time and the results were positive. The Physician said it was the facility staff's responsibility to follow-up on any lab orders but he stated he did not recall if he got UA results for Resident #284 and he would need to check his system and follow-up, but he never did. The Physician read Resident #284's UA results and he stated that most of the time he would have started the resident on an antibiotic and he also said he thought Resident #284 had been sent to the hospital for hypoxia (lack of enough oxygen). Record review of the facility's current, undated Lab and Diagnostic Test Results policy reflected the following: .1. When test results are reported to the facility, a nurse will first review the results. .3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition Options for Physician Notification .1. A physician can be notified by phone, fax, voicemail, e-mail, pager, or a telephone message .a. Facility staff should document information about when, how, and to whom the information was provided and the response. .b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification .

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Residents #15, #30 and #50) reviewed for infection control. 1. The facility failed to ensure LVN L put on appropriate PPE (gown) before entering Resident #50's room to administer medications via gastronomy tube to Resident #50, who was on enhanced barrier precautions. 2. The facility failed to ensure MA D disinfected the blood pressure cuff between blood pressure checks for Residents #15 and #30 during medication administration. These failures placed residents at risk of cross contamination and the spread of infection. Findings included: 1. Record review of Resident #50's Quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE] with a re-admission on 07/01/23. The resident had severe cognitive impairment with a BIMS score of 2, and her diagnoses included gastrostomy tube (a feeding tube placed through the skin and stomach wall), and the MDS reflected she had a feeding tube for nutrition. Record review of Resident #50's care plan dated 10/05/24 reflected: Focus: [Resident #50] requires an enhanced barrier precaution rule out feeding tube. Goal: [Resident #50] will remain infection-free with MDRO (multidrug-resistant organism) through the next review date. Interventions: Ensure PPE is available for use on the resident during care . Wear a gown and gloves during high-contact care activity. Record review of Resident #50's physician order dated 04/15/24 reflected: observe enhanced barrier precautions every shift. [Resident 50's] on enhanced barrier precautions. Observation on 10/16/24 at 7:25 AM revealed LVN L was preparing to provide Resident #50 medications. Resident #50's door had the following sign: Stop, enhanced barrier precautions -providers and staffs must also wear Gown and Gloves. There was PPE outside the room. LVN L performed hand hygiene and donned a pair of gloves. Without donning a gown, LVN L then provided Resident #50 medications via her gastrostomy tube. Interview on 10/16/24 at 7:58 AM, LVN L stated she was the nurse assigned to Resident #50. LVN L stated she saw the PPE at the door, and she was aware they were for enhanced barrier. She stated the PPE was supposed to be worn during care, at all times, but she forgot. She stated any resident who had a catheter, g-tube, or wound was on enhanced barrier precautions. She stated the risk of not donning PPE was that it could lead to the spread of infection. She stated she had done training on enhanced barrier precautions. (continued on next page)

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #15's Quarterly MDS assessment dated [DATE] reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] with a re-admission on 10/04/24. The resident's cognition was severely impaired, and she had a diagnosis of hypertension (high blood pressure). Record review of Resident #15's care plan dated 10/05/24 reflected: Focus: resident is at risk for elevated blood pressure greater than 200/100 rule out hypertension. Goal: resident will have no s/sx no episode of blood pressure greater than 200/100.Interventions: administer cardiac medication as ordered. Record review of Resident #15's October 2024 physician orders reflected an order for amlodipine besylate oral tablet 10 mg once a day, Carvedilol oral tablet 3.125 mg twice daily, and losartan oral tablet 25 mg tablet twice daily. 3. Record review of Resident #30's quarterly MDS assessment, dated 09/20/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident was cognitively intact with a BIMS score of 15, and she had a diagnois of essential hypertension (elevated blood pressure). Record review of Resident #30's care plan dated 12/11/2023 reflected: Focus: resident is at risk for elevated blood pressure rule out hypertension. Goal: [Resident #30] will have no signs and symptoms, no episode of blood pressure. Interventions: administer medication as ordered. Record review of Resident #30's October 2024 Physician Orders reflected an order for propranolol oral tablet 10 mg 1 tablet by mouth one time a day. Hold for pulse less than 55, and spironolactone 50mg oral tablet once a day. Observation on 10/16/24 at 08:05 AM revealed MA D performing morning medication pass, during which time MA D checked Resident #15's blood pressure. MA D did not disinfect the blood pressure cuff after using it on Resident #15. MA D put the blood pressure cuff on top of the medication cart after use.MA D performed hand hygiene before administering the medications and after administering medications. Observation on 10/16/24 at 08:45 AM revealed MA D continued to perform morning medication pass, during which time she checked the blood pressure of Resident #30. MA D used the same blood pressure cuff after using it on Resident #15. MA D did not disinfect the blood pressure cuff before using it on Resident #30. She placed the blood pressure cuff on top of the cart. Interview on 10/16/24 at 09:09 AM with MA D revealed reusable equipment, like blood pressure cuffs, should be disinfected with wipes between each resident-use (before and after use on each resident) to prevent transmitting of infection from one resident to another.MA D stated she did not have any reason as to why she was not disinfecting the blood pressure cuff between residnets.MA D stated she had completed training on infection control, handwashing, and disinfection of reusable equipment. (continued on next page)

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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/17/2024 at 10:04 AM, the DON stated she expected staff to put on PPE when providing care to a resident who had a wound, catheter, or a g-tube. She stated residents who were on enhanced barrier precautions had signs on their doors to indicate the resident was on enhanced barrier precautions. The DON stated Resident #50 was on enhanced barrier precautions due to having a g-tube, and staff should put on PPE before providing any type of care. The DON stated it was her expectation for staff to disinfect the blood pressure cuffs between residents. She stated the potential risk of not putting on PPE and disinfecting the blood pressure cuffs between residents would be spread of infection. She stated the facility had done training on infection control and enhanced barrier precautions. Record review of training on enhanced barrier precautions dated 07/07/24, reflected LVN L attended. Record review of Training on Disinfecting Items Between Residents, dated 08/07/24, reflected MA D was not in attendance. Record review of the facility's Employee Training on Infection Control policy, revised December 2023, reflected: .5. The infection preventionist and administrator identify disciplines or individuals who need task- or job specific infection prevention and control training beyond that provided by initial orientation or policies and procedures, for example: .b. cleaning and disinfection of reusable medical equipment. Record review of the facility's Enhanced Barrier Precautions policy, dated 03/22/24, reflected: 1. Enhanced barrier precautions (EBP) are used as infection prevention and control intervention to reduce the spread of multi-drug resistant organism to residents.3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: a. Dressing b. Bathing /showering c. Providing hygiene. .g. Device care use (.feeding tube)