

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Pure Health Transitional Care at Texas Health Pres		STREET ADDRESS, CITY, STATE, ZIP CODE 8200 Walnut Hill Lane Main 5 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for 1 of 4 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 received dressing changes and assessments of her nephrostomy sites. This failure could place residents at risk of pain, the nephrostomy tubes becoming dislodged, and infection. Findings include: Record review of Resident #1's admission MDS assessment, dated 7/10/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnosis which included respiratory failure, diabetes, and hydronephrosis (swelling of both kidneys caused by a buildup of urine). Resident #1 had a BIMS score of 15, which indicated intact cognitive status. Record review of Resident #1's provider progress note, dated 7/10/2026, reflected the resident had a pelvic mass which caused her kidneys to buildup fluid. The resident underwent nephrostomy tube placement (a procedure that inserted a thin tube directly into the kidneys through the skin in the lower back to drain urine) on 6/24/2026. The provider noted in the progress note to keep nephrostomy tubes in place and provide nephrostomy care. Record review of Resident #1's provider orders, dated 7/8/2026, reflected there was an order for dressing change daily of Resident #1's nephrostomy sites. Record review of Resident #1's skin assessment, completed on 7/8/2026 and 7/17/2026, by the wound nurse reflected the nurse documented no abnormal findings at nephrostomy sites. There was no documentation of wound care provided by the wound nurse. Record review of Resident #1's treatment administration record, from 7/8/2026 to 7/16/2026, there was documentation of nephrostomy output recorded by the wound nurse, RN A and LVN B. Record review of Resident #1's hospital record, dated 7/17/2026 at 12:42 PM, reflected the resident was transferred to the ED for pain at her nephrostomy sites. Imaging in the ED, dated 7/17/2026, reflected there was no indwelling right-sided nephrostomy tube, left-sided nephrostomy tube was still intact. Record review of Resident #1's treatment record, from date 7/8/2026 to 7/16/2026, there was documentation that dressing was changed daily by the wound nurse, RN A and LVN B. In an observation on 7/22/2026 at 8:00 AM, revealed Resident #1 was inpatient at the hospital. Resident #1 had two intact and dressed nephrostomy sites on her lower back, labeled 7/21/2026. In an interview with Resident #1 and family member, who was Resident #1's MPOA, on 7/22/2026 at 8:05 AM revealed the dressings on the resident's nephrostomy sites were still labeled as 7/7/26 when the resident was taken to the ED on 7/17/2026. The family member stated she called emergency services because Resident #1 was in pain and she noticed reduced output on one of her nephrostomy draining bags. Resident #1 stated she did not receive dressing changes while she was at the facility. The family member stated the hospital replaced one of the tubes and dressed the sites. In an interview with the facility's wound nurse on 7/22/2026 at 11:45 AM, the wound nurse (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she only provided a dressing change for Resident #1 one time. The wound nurse stated Resident #1 did not have an open wound, therefore, it was the floor nurse's responsibility to check the nephrostomy sites, perform dressing changes, and record output. She stated she was not sure why the dressings on Resident #1 were still labeled with the date 7/7/26. She stated she did not remember Resident #1's nephrostomy tube getting dislodged while she was at the facility. In an interview with RN D on 7/22/2026 at 12:00 PM, she stated she was the assigned nurse working with Resident #1 on the day she was transferred to the hospital. She stated she did not work with the resident prior to that day. RN D stated there was nothing unusual from the resident on that day, she stated Resident #1 did not report any pain. She stated family came in and called 911 without asking the facility and the resident was transferred to the hospital. In an interview with RN A on 7/22/2026 at 12:05 PM, she stated she delegated all dressing changes for Resident #1 to the wound nurse. She stated she did not perform dressing changes for Resident #1 while the resident was residing at the facility. She only recorded output of the nephrostomy bags and made sure the dressing was still intact. She stated she did not realize the dressing was from 7/7/2026. She stated she was not aware if the tube was dislodged because she did not perform dressing changes. She stated the dressing looked normal and there was no abnormal leakage or pain reported by the resident. She stated she marked the dressing was done because she thought it was done by the wound nurse. In an interview with LVN B on 7/22/2026 at 1:43 PM, she stated she remembered Resident #1 having 2 nephrostomy tubes but she did not provide any dressing change. She stated she thought it was the wound nurse's responsibility. She stated she checked and recorded output and if the dressing was intact, but she did not look at the date labeled on dressings. She stated there was no leakage or skin issue at the nephrostomy sites. In an interview with the ADON on 7/22/2026 at 12:10 PM, she stated she expected nursing staff to follow provider orders. She stated all nurses should ensure any wound dressings were performed and labeled, ensure no signs of infection, redness or swelling, ensure tubes were in place. She stated she was not sure when there was an in-service on quality of care, resident assessment, and dressing change provided. She stated she would discuss with the DON, who was out of town, and she would provide in-services to all nursing staff to ensure to follow provider's orders. In an interview with the facility's administrator on 7/22/2026 at 1:08 PM, he stated he expected his staff to provide care based on physician's order and to verify the orders if they had questions. He stated he was not sure what went wrong. He stated he would work with the team to make sure there was clear communication between staff to ensure quality care was provided. An attempt to interview Provider C on 7/22/2026 at 1:30 PM, was unsuccessful. The administrator stated provider C was in a meeting. A return call was not received from Provider C. Record review of facility's Routine Resident Checks policy, revised 08/2024, reflected staff shall make routine resident checks to help maintain resident safety and well-being. Routine resident checks involve [.] identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. Record review of facility's Medication and Treatment Order, revised 8/2024, reflected Facility licensed staff will provide care to patients according to provider orders. Record review of facility's Wound Care policy, 9/2024, reflected Verify that there is a physician's order for this procedure. The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The name and title of the individual performing the wound care. 4. Any change in the resident's condition. 5. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment and the reason(s) why. 8. The signature and title of the person recording the data.		