STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview, observation, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents, (Resident #1) reviewed for care plans. 1. The facility failed to follow the care plan dated 07/05/24 when staff failed to ensure a pillow was always under Resident #1's feet who had a DTI to the heel, while she was in the bed on 02/19/25. This failure could place residents at risk of not receiving the necessary care and services. Findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female, with an initial admitted [DATE], and a re-admitted [DATE]. Resident #1 had a diagnosis of non-traumatic acute subdural hemorrhage (blood leaks between the brain and the skull), Type 2 Diabetes (body does not use insulin properly or produce enough insulin), Hypothyroidism (thyroid gland does not produce enough thyroid hormone), Muscle weakness, Chronic Kidney Disease, Wedge Compression Fracture (spinal fracture), Dementia (loss of memory and other mental capabilities), and Arthritis (joint inflammation and damage). Record review of Resident #1's Quarterly MDS Assessment, dated 12/26/24, reflected Resident #1 had a BIMS score of 3, which meant Resident #1 had a very low level of cognition. The MDS also noted Resident #1 did not display any behavioral symptoms like threatening others, screaming, cursing at others, hitting, scratching, pacing, or rummaging. The MDS noted Resident #1 did not display and rejection of care. Pressure ulcers were listed under skin conditions on the MDS quarterly assessment. Record review of an active physician's order, dated 08/05/25 reflected the following: Order Summary: Off load both heels with pillow while patient in bed at all time (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
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Every shift for promoting wound healing Record review of Resident #1's Care Plan, with an initial date of 03/17/24, and a revision date of 07/05/24, reflected the following: Resident #1 required ADL assistance such as Bed Mobility. It noted an extensive assist from staff to turn and reposition in bed when necessary. Resident #1 required total dependency for transfers, dressing, eating, hygiene, and toileting. Resident #1 had potential for pressure ulcers due to immobility. Resident #1 had a DTI to the heel. Revision noted on 08/07/24, Resident #1, Off load both heels with a pillow at all times while patient is in bed to promote wound healing. Resident #1 was resistive to care (refuses baths and medications) Record review of the progress notes on Resident #1's electronic record did not reflect any notations of Resident #1's refusal of the pillow used for her feet or any notes on Resident #1 moving the pillow from under her feet. In an interview and observation on 02/19/25 at 2:05 PM, Resident #1 was observed, as she laid in her bed and watched television. Resident #1's heels were not propped up on a pillow or anything else. There was no pillow observed at the end of Resident #1's bed. Resident #1 stated she was fine. She stated she did not have any concerns or issues at the facility. In an interview on 02/19/25 at 2:25 the Nurse Practitioner stated she saw Resident #1 a few times, and she had no concerns for the facility's care of Resident #1. The Nurse Practitioner stated there was a wound care doctor that handled Resident #1's wound care. The Nurse Practitioner stated she had not seen any concerns with Resident #1's wounds when she completed her general care. In an observation on 02/19/25 at 4:35 PM, Resident #1 was observed as she laid in her bed. There was no pillow observed at the foot of her bed. Resident #1's feet were not offloaded. A telephone interview was attempted on 02/19/25 at 4:55 PM to Resident #1's Wound Care Doctor, but there was no answer. In an observation on 02/19/25 at 5:54 PM, Resident #1's feet hung off the side of the bed. There was no pillow at the foot of the bed. In an interview on 02/19/25 at 5:59 PM, the DON stated Resident #1 made small movements, like adjusting her cover, but did not get out of bed on her own. The DON stated Resident #1 was not able to swing her feet around to get out of the bed. The DON stated Resident #1 usually had a pillow at the foot of the bed to offload her feet. In an observation and interview on 02/19/25 at 6:03 PM, the DON observed Resident #1 as she laid in bed with no pillow at the foot of the bed, and Resident #1's feet were not offloaded. The DON pointed to a pillow that sat on Resident #1's wheelchair and stated that was the pillow that was used to offload Resident #1's feet. The DON stated she was not sure why the pillow was not on the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview on 02/19/25 at 6:19 PM, the DON stated a staff member just changed Resident #1's sheet and put the pillow back at the foot of the bed to offload Resident #1's heels. The DON stated that was the first time she noticed Resident #1 without the pillow at the foot of the bed and feet offloaded. The DON stated she would update the care plan and note interventions to ensure Resident #1's heels were always offloaded. The DON stated she would also have the ADONs check to ensure Resident #1's feet were offloaded. The DON stated the risk of Resident #1 heels not offloaded was pressure that would lead to skin breakdown and a lower level of care. In an interview on 02/19/25 at 7:01 PM, the MDS Coordinator stated she ensured the care plans were completed and reflected all concerns. She stated she was unaware of Resident #1's feet not being offloaded. The MDS Coordinator stated she was taught that a general note of a refusal of care on the care plan would cover all concerns. The MDS Coordinator confirmed there was not a specific mention of any concerns with not offloading or Resident #1 interfering with offloading of her heels. The MDS Coordinator stated she was not aware of a risk, since a general note of refusal was on the care plan. In an interview on 02/19/25 at 7:16 PM, the Administrator stated before today, he was not aware of the issue with Resident #1's heels not offloaded. The Administrator stated he was not a medical practitioner, so he would have to ask Resident #1's doctor if there were risks associated with her heels not offloaded. The Administrator stated Resident #1's overall care plan should have addressed all care concerns. He stated interventions should have been listed on Resident #1' care plan if there were concerns of her interfering with the offload of her heels. Record review of the facility's policy titled, Care Plans Comprehensive Person-Centered, dated 2001, revised 03/2022, reflected the following: Policy Statement 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. Policy Interpretation and Implementation I. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as pai1 of the comprehensive assessment. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 7. 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: (I) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (3) d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. l0. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: 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 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on observation, record review and interview, the facility failed ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers from developing 1 (Resident #1) of 6 residents reviewed for pressure ulcers. The facility failed on 02/19/25 to use a pillow under Resident #1's heels, at all times, to offload Resident #1's heels to prevent pressure ulcers or skin breakdown. This failure could affect residents at risk for pressure ulcers of developing new or worsening existing pressure ulcers. Findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female, with an initial admitted [DATE], and a re-admitted [DATE]. Resident #1 had a diagnosis of non-traumatic acute subdural hemorrhage (blood leaks between the brain and the skull), Type 2 Diabetes (body does not use insulin properly or produce enough insulin), Hypothyroidism (thyroid gland does not produce enough thyroid hormone), Muscle weakness, Chronic Kidney Disease, Wedge Compression Fracture (spinal fracture), Dementia (loss of memory and other mental capabilities), and Arthritis (joint inflammation and damage). Record review of Resident #1's Quarterly MDS Assessment, dated 12/26/24, reflected Resident #1 had a BIMS score of 3, which meant Resident #1 had a very low level of cognition. The MDS also noted Resident #1 did not display any behavioral symptoms like threatening others, screaming, cursing at others, hitting, scratching, pacing, or rummaging. The MDS noted Resident #1 did not display and rejection of care. Pressure ulcers were listed under skin conditions on the MDS quarterly assessment. Record review of an active physician's order, dated 08/05/25 reflected the following: Order Summary: Off load both heels with pillow while patient in bed at all time Every shift for promoting wound healing In an interview and observation on 02/19/25 at 2:05 PM, Resident #1 was observed, as she laid in her bed and watched television. Resident #1's heels were not propped up on a pillow or anything else. There was no pillow observed at the end of Resident #1's bed. Resident #1 stated she was fine. She stated she did not have any concerns or issues at the facility. In an observation on 02/19/25 at 4:35 PM, Resident #1 was observed as she laid in her bed. There was no pillow observed at the foot of her bed. Resident #1's feet were not offloaded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675447	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was attempted on 02/19/25 at 4:55 PM to Resident #1's Wound Care Doctor, but there was no answer. In an observation on 02/19/25 at 5:54 PM, Resident #1's feet hung off the side of the bed. There was no pillow at the foot of the bed. In an interview on 02/19/25 at 5:59 PM, the DON stated Resident #1 made small movements, like adjusting her cover, but did not get out of bed on her own. The DON stated Resident #1 was not able to swing her feet around to get out of the bed. She stated she and the staff were aware that Resident #1's feet needed to be offloaded. The DON stated Resident #1 usually had a pillow at the foot of the bed to offload her feet. In an observation and interview on 02/19/25 at 6:03 PM, the DON observed Resident #1 as she laid in bed with no pillow at the foot of the bed, and Resident #1's feet were not offloaded. The DON pointed to a pillow that sat on Resident #1's wheelchair and stated that was the pillow that was used to offload Resident #1's feet. The DON stated she was not sure why the pillow was not on the bed. In a follow up interview on 02/19/25 at 6:19 PM, the DON stated a staff member just changed Resident #1's sheet and put the pill back at the foot of the bed to offload Resident #1's heels. The DON stated that was the first time she noticed Resident #1 without the pillow at the foot of the bed and feet offloaded. The DON stated the risk of not offloading Resident #1's feet was skin breakdown and a lower level of care. In an interview on 02/19/25 at 7:16 PM, the Administrator stated before today, he was not aware of the issue with Resident #1's heels not offloaded. The Administrator stated Resident #1's heels should have been offloaded to prevent further health issues. Record review of the facility's policy titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated 2001 with a revision date of 04/2018, reflected the following: Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses.