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	04/14/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interviews,observation and record reviews, the facility failed to ensure resident has the right to be free from neglect for one (Resident #1) of eight residents reviewed for abuse neglect. On 2/21/2025, CNA A transferred Resident #1 without a gait belt from the shower chair to the bed. As a result, Resident #1 suffered a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Oversight and monitoring of direct care staff (nurse aides), was not addressed. CNA A transferred Resident #1 inappropriately on 2/21/25 causing a left lower extremity fracture, was not retrained and or monitored, and then CNA A transferred Resident #1 inappropriately on 04/07/25 causing a right lower extremity fracture. CNA A was aware Resident #1 required two staff to transfer but transfered the resident alone. This failure resulted in an Immediate Jeopardy situation on 04/10/2025. While the IJ was removed on 4/14/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm due to staff needing more time to monitor the effectiveness for the plan of removal for accidents and hazards. These failures could place residents at risk of serious harm, pain, and serious injury. Findings included: 1. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 15 (indicated no cognitive impairment). Section GG of the assessment revealed Resident #1 was dependent on staff to provide all the effort when toileting, showering, and when changing positions from sitting to standing. Section I of the MDS indicated Resident #1 had diagnoses of a left tibia (shin bone) fracture, multiple sclerosis (a disease that affects the nervous system and causes muscle weakness), and lack of coordination. Record review of Resident #1's care plan with a revision date of 4/08/2025 revealed Resident #1 sustained a fracture to the lower left extremity (left leg) on 2/26/2025 and sustained an additional fracture to the right lower extremity (right leg) on 4/07/2025. Resident #1's care plan was updated on 4/08/2025 and indicated a mechanical lift should be used for transfers. No transfer information prior to 4/08/2025 was found on the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's progress note dated 2/21/2025 at 10:51 a.m. by RN B revealed Resident #1 had stated she bumped her knee against the shower chair, and an order was received for an x-ray. Record review of Resident #1's incident report dated 2/21/2025 completed by RN B revealed CNA A notified RN B that Resident #1 hit her knee against the shower chair during a transfer in the shower room. Record review of Resident #1's x-ray dated 2/21/2025 revealed Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Record review of Resident #1's hospital orthopedic progress note dated 2/28/2025 revealed pain had improved and was better controlled since the splint (a medical device designed to immobilize the leg) was applied to the left leg while in the hospital. 2. Record review of Resident #1's progress note dated 4/07/2025 at 1:07 p.m. by RN B revealed Resident #1 had reported that she hit her right foot against the shower chair when transferred from the shower chair to the bed and an x-ray had been ordered. Record review of Resident #1's incident report dated 4/07/2025 completed by RN B revealed Resident #1 reported right foot pain and had reported she hit her right foot against the shower chair when being transferred from the shower chair to the bed. Record review of Resident #1's x-ray dated 4/07/2025 revealed an oblique fracture (a bone break that occurs at an angle to the bone's long axis) to the right distal diaphysis of the tibia (lower area of the shin bone) that was reported to the facility on [DATE] at 11:17 p.m. Record review of Resident #1's progress note dated 4/08/2025 at 10:18 a.m. by RN B revealed an order was received from NP JJ to send Resident #1 to the hospital. Record review of Resident #1's progress note dated 4/08/2025 at 10:36 a.m. by RN B revealed Resident #1 was transported to the hospital via ambulance. Record review of Resident #1's hospital history and physical dated 4/08/2025 revealed Resident #1 was being seen for right lower extremity pain. Resident #1 reported she was being moved to transfer from her wheelchair and got her leg stuck and twisted. The hospital notes also revealed an oblique fracture through the distal tibial shaft (a bone break that occurs at an angle to the lower area of the shin bone). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview and observation on 4/09/2025 at 11:04 a.m., Resident #1 reported that both of her legs had been broken. Resident #1 stated that her left leg had been broken over a month ago when CNA A transferred her from the shower chair to the bed. Resident #1 reported that her right leg had been broken a few days ago when she was transferred again by CNA A from the shower chair to the bed. Resident #1 stated that both times her foot had gotten caught between the shower chair and the bed. Resident #1 reported that she was not sent to the hospital immediately after fracturing the first leg and did not remember how long it took before she was sent to the hospital. Resident #1 stated she was in pain after both fractures until she was sent to the hospital because the facility was not able to administer strong enough pain medications. Resident #1 stated they did not send her to the hospital until the next day after the second fracture. Resident #1 reported when she fractured her right leg a few days ago that she had felt it pop in the right leg when CNA A transferred her from the shower chair to the bed. Resident #1 reported her right leg got caught behind the shower chair, and CNA A transferred her from the shower chair to the bed by herself. Resident #1 reported the facility sent her to the emergency room the next day after breakfast. Resident #1 stated she was in pain before they sent her to the hospital, and they gave her pain medication. Resident #1 reported the pain medication did not work, and she was still in pain. Resident #1 stated before her legs were fractured that she only got out of bed for therapy and showers but was unable to do therapy since the injuries occurred. Resident #1 lifted her blanket and revealed both of her legs were wrapped with soft gauze and ACE wrap. The right leg appeared bigger than the left. Resident #1 reported her pain was currently well managed. In an interview on 4/09/2025 at 12:42 p.m., CNA A reported she was transferring Resident #1 from the shower chair to the bed on 2/21/2025. CNA A stated Resident #1's left leg did not pivot with the resident when transferring her, and her foot stayed stuck to the floor in the same position. CNA A reported the leg twisted when she transferred Resident #1, and Resident #1 reported that she heard her leg pop. CNA A stated Resident #1's left leg also bumped the bed during the transfer. CNA A stated she did not use a gait belt and was by herself during the transfer. CNA A reported no training was completed before or after this incident, and she had been working at the facility for around six months. CNA A reported when she transferred Resident #1 on 4/07/2025 that she had CNA C with her, but stated CNA C did not know what she was doing. CNA A reported CNA C leaned Resident #1 forward in the shower chair, and Resident #1 bumped her right leg on the shower chair. CNA A reported Resident #1 complained of pain to her right leg, but CNA A transferred Resident #1 to the bed anyway because the shower chair was hurting her. CNA A reported CNA C did not know to get on the other side of Resident #1 to help with the transfer, so CNA A did the transfer by herself. CNA A reported that Resident #1 complained of pain when she was transferred to the bed, and CNA A notified RN B. CNA A reported a gait belt was not used for the second transfer because Resident #1 did not like gait belts. In an interview on 4/09/2025 at 12:59 p.m., RN B stated that Resident #1 complained of pain to her left leg on 2/21/2025. RN B stated Resident #1 had told him that her left leg got caught in the shower chair, and Resident #1 reported she heard it pop. RN B stated x-rays were ordered, and Resident #1 did have a fracture. RN B stated the fracture to the right leg occurred when CNA A transferred Resident #1 back to bed from the shower chair. RN B stated Resident #1 told him she bumped her leg on the shower chair, and RN B was unsure if CNA A was by herself during the transfer. RN B stated x-rays were ordered which revealed a fracture to the right leg. RN B reported he had not received any training over transfers since either incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/09/2025 at 1:35 p.m., CNA C reported she did not assist CNA A when Resident #1 was transferred. CNA C stated she was in training and did not work with CNA A on 4/07/2025. CNA C reported she was not in the room when Resident #1 was transferred, and she was working a different hall. In an interview and observation on 4/09/2025 at 2:02 p.m., the DON stated Resident #1 told her she hit her foot when she was transferred on 2/21/2025 from the shower chair to the bed. The DON stated she thought Resident #1 was a two-person transfer prior to this incident. The DON confirmed by looking at her computer that Resident #1's care plan did not contain any information regarding transfers until 4/08/2025. The DON reported that the CNAs would know how to transfer residents because they were orientated to their hall and received report from each other. The DON stated she did not know if CNA A was by herself after the first incident. The DON stated they were still investigating the incident that occurred on 4/07/2025, and she was not sure of what happened yet. The DON stated that CNA A told her there was another CNA assisting with the transfer, but the DON was not sure who the other CNA was. The DON stated CNA A knew she was not supposed to transfer Resident #1 by herself. The DON confirmed Resident #1 sustained a fracture to her right leg after being transferred from the shower chair to the bed on 4/07/2025. In an interview on 4/09/2025 at 2:54 p.m., Resident #1 confirmed that CNA A was alone when she was transferred from the shower chair to the bed both times. Resident #1 reported no one had offered to use a gait belt, but that was a good idea. In an interview and observation on 4/10/2025 at 1:54 p.m., ADON D reported a mechanical lift should have been used to transfer Resident #1 prior to the first incident on 2/21/2025. ADON D stated there was a list of residents that required a mechanical lift for transfers that was located in the CNA assignment book at the nurse's station. ADON D then obtained the assignment book and revealed a list of residents that required the use of a mechanical lift. ADON D confirmed Resident #1 was the last name on the list, but the list was not dated. Record review of facility in-service regarding Turning and positioning, dated 3/15/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. Record review of facility in-service regarding Positioning resident with a fracture, dated 02/27/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. A record review of the facility's policy titled Accidents and Incidents - Investigating and Reporting, dated 2001, revealed All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator . Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. A record review of the facility's policy titled Lifting Machine Policy and Procedure, dated 11/01/2016, revealed Review the resident's care plan to assess for any special needs of the resident . Two (2) clinical person who have been trained to use this lifting device are required to perform this procedure. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's policy titled Abuse, Neglect and Exploitation, revised on 7/01/2020, revealed neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of Resident #2's Annual MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 12 (indicated mildly impaired cognition). Section I of the MDS revealed Resident #2 had diagnoses of muscle weakness, severe morbid obesity (overweight), and anxiety disorder. Record review of Resident #2's care plan with a revision date of 3/31/2025 revealed Resident #2 indicated she was a fall risk and had poor safety awareness. In an observation on 4/11/2025 at 12:02 p.m., CNA FF and CNA GG were preparing to transfer Resident #2 from the bed to the wheelchair using a mechanical lift. The top of the sling was placed under the shoulders of Resident #2. The bed was not locked. The wheelchair was not locked. CNA FF positioned the lift over Resident #2. CNA FF placed two blue sling loops on two of the mechanical lift hooks. CNA GG placed two green sling loops on two of the mechanical lift hooks. CNA FF began lifting the resident in the sling using the mechanical lift. Resident #2 was lying flat in the sling as she was lifted. CNA FF positioned Resident #2 over the wheelchair using the mechanical lift while CNA GG guided Resident #2 in the sling. CNA GG attempted to position Resident #2 over the wheelchair, but Resident #2 remained in a laying position. The surveyor requested the CNAs stop the transfer and called for assistance. CNA EE entered the room and assisted CNA GG in positioning Resident #2 in more of a sitting position over the wheelchair. Resident #2 was lowered into the wheelchair without injury. In an interview on 4/11/2025 at 12:44 p.m., CNA FF reported they had trouble transferring Resident #2 using the mechanical lift because the sling was too small. CNA FF reported they had additional slings but was unsure if they had the right size for Resident #2. CNA FF was unable to continue with the interview because she had to feed a resident. In an observation and interview on 4/11/2025 at 1:42 p.m., CNA EE and CNA FF were in Resident #2's room, and CNA FF stated they were going to transfer Resident #2 with the mechanical lift from the wheelchair to the bed. CNA FF reported the sling under Resident #2 was too small, and they would look for a new sling after transferring Resident #2. The surveyor requested the CNAs not to transfer the resident. The surveyor notified the ADM, and the ADM told the CNAs not to transfer Resident #2. The ADM brought the DOR to the room. The DOR checked the sling and reported it was the appropriate size because two inches of the sling was visible on each side of Resident #2. The DOR reported he would assist CNA FF with transferring Resident #2 from the wheelchair to the bed using the mechanical lift. CNA FF positioned the mechanical lift over Resident #2. The DOR connected the sling loops to the mechanical lift in the following order: left upper hook had a green sling loop, right upper hook had a black loop, the right lower hook had a green loop, the lower left hook had 3 loops (green, purple, and black). The wheelchair was not locked, and the bed was not locked. CNA FF lifted Resident #2 in the sling using the mechanical lift. Resident #2 was lying flat in the sling as she was lifted. CNA FF positioned Resident #2 in the sling over the bed and lowered the resident to the bed. CNA FF and the DOR pulled the resident up in the bed. The bed was not locked and moved as they repositioned Resident #2. The DOR reported that the colored loops do not have to match when using the lift. The DOR reported the most important thing is that the resident is comfortable. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the mechanical lift sling's owner manual, with a print date of December 2023, revealed The top edge of the sling should be slightly above the resident's head . Place the straps of the sling over hooks of the swivel bar or cradle and be sure to match the corresponding strap and/or strap colors on each side of the sling for an even lift of the resident . Colored straps make it easy to connect both side of the sling equally. Always ensure there is sufficient head support when lifting a resident . WARNING: Wheelchair wheel locks MUST be in a locked position before lowering the resident into the wheelchair for transport . When the resident is lifted from the surface, they will be raised to a sitting position. In an interview on 4/11/2025 at 3:12 p.m., the ADM was notified of concerns regarding transfer observations. The ADM reported PT HH was coming to the facility to provide individual training to the DON and ADONs. The ADM reported all staff would be retrained on safe transfers and complete a competency test after completing the training. In an interview on 4/11/2025 at 4:32 p.m., PT HH reported that the ADM had tasked her with training the DON and ADONs concerning safe transfers with mechanical lifts and transfers with a gait belt. PT HH stated that the DON and ADON performed a safe transfer using her as the patient. PT HH stated that she watched the DON and the ADON train two sets of CNAs. PT HH stated that the CNA's then performed safe transfers using her as the patient for each team of CNAs. PT HH stated they performed the transfers safely and stated that until further notice CNAs were to be observed by a nurse every time that they perform a mechanical lift transfer. The ADM, the DON, ADON D, ADON E, and the MDS Nurse were provided the IJ template on 4/10/2025 at 3:13 p.m. and notified that an Immediate Jeopardy situation had been identified due to the above failures. The plan of removal was approved on 4/12/2025 at 3:19 p.m. and reflected: Problem: Failure of safety during transfer for resident # 1. Interventions: On 4/10/2025 the center will in-service nursing staff on where to find the resident's care plan to determine how to care for the resident. This care plain is found on the electronic screen system on each hall and general area. The resident transfer section on the care plan will tell the Nursing tea member how the resident is to be transferred. On 4/10/2025 the center will educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. On 4/10/2025 the center will complete a skills check-off tool on the nursing team members so they can demonstrate the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both resident and staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following in services were immediately initiated by . Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM . will ensure these team members are removed from the time clock and PCC access removed, this will be monitored until 100% complete or the team members are terminated. On going in-service will be completed by . the DON; ADON D and ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Systemic Change 4/11/2025: On 4/11/2025 it was found that identified CNAs were not following the education and Skills check-off they had completed before they started their shift. . (IDT Team - I) decided to bring in a Licensed Physical Therapist to educate, complete a skills check-off list, and post-test on transferring a resident. On 4/12/2025 PT educated, completed a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with .DON; ADON D and ADON E. After they completed and passed their education, PT observed DON; ADONs educate, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with 3 CNAs. Moving forward only DON; ADONs, and PT will be able to in-service, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices. Moving forward a resident can only be transferred using a Hoyer lift with a licensed nurse present. This practice will continue until the (IDT Team - I) decides the CNAs are able to complete this transfer without supervision. The following in services were immediately initiated by Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON and ADONs until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. The following in-services were initiated by Chief Nursing Officer on 4/10/2025: Nursing Department (CNAs): - In-service nursing staff on where to find the resident's care plan to determine how to care for the resident. (See in-service 600-1) - Educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. (See in-service 600-2) (See Check-off list 600-2) (See Post-test 600-2). The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON. The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring as of 4/11/2025: The DON and ADONs will monitor resident transfers by CNA every shift for 7 days. Administrator will monitor this process daily for the next 7 days. The DON and ADONs will test nursing staff on where to find the resident's care plan every shift for 7 days. The ADM will monitor this process daily for the next 7 days. QAPI: 1. Ad Hoc QA meeting held on 4/10/2025 to discuss causes, in-services and review interventions. 2. Any negative findings in the monitoring and/or auditing system will be reviewed and addressed by the QAPI committee for a potential systemic change. Monitoring of the plan of removal included: In an interview on 4/14/2025 at 1:48 p.m., ADON D reported CNA A had come into the facility and completed training and then was placed on suspension. ADON D stated she was not sure if CNA A would be returning to work after the investigation. ADON D reported RN B was out of the country on vacation but would receive training before returning to work on the floor. ADON D reported that she received training from PT HH. In an interview on 4/14/2025 at 4:13 p.m., the DON reported the ADONs and herself received individual training from PT HH and trained every CNA and nurse themselves. The DON reported that a nurse would be required to be in the room with two CNAs every time a mechanical lift was used, indefinitely. The DON reported that herself and the ADONs would continue to monitor transfers on every shift for the next seven days. The DON reported that herself and the ADONs would also continue to monitor the CNAs and ensure they were able to access care plans for the next seven days. Interviews were conducted with 27 employees from 4/12/2025 starting at 3:55 p.m. and continued through 4/14/2025 at 4:13 p.m. All employees interviewed were able to verify how to access the residents' care plans and identify patients that required a mechanical lift, how to properly transfer residents, and reported they had received hands on training on how to transfer a resident using a mechanical lift, a sit-to-stand lift, and a gait belt. All interviewed staff reported they had received in-services concerning safe transfers, accessing resident care plans, and completed training hands-on transfer training by the DON or ADONs. Interviewed staff members and shifts included: ADON D - worked all shifts ADON E - worked all shifts RN F - worked 2:00 p.m. to 10:00 p.m. RN G - worked all shifts RN H - worked weekend shift 6:00 a.m. to 10:00 p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN I - worked 6:00 a.m. to 2:00 p.m. LVN J - worked all shifts LVN K - worked 10:00 p.m. to 6:00 a.m. LVN L - worked weekend shift 6:00 a.m. to 10:00 p.m. LVN M- worked 2:00 p.m. to 10:00 p.m. LVN N- worked 2:00 p.m. to 10:00 p.m. LVN O- worked 6:00 a.m. to 2:00 p.m. CNA P - worked 2:00 p.m. to 10:00 p.m. CNA Q - worked 2:00 p.m. to 10:00 p.m. CNA R - worked 6:00 a.m. to 2:00 p.m. CNA S - worked 2:00 p.m. to 10:00 p.m. CNA T - worked 2:00 p.m. to 10:00 p.m. CNA U - worked 10:00 p.m. to 6:00 a.m. CNA V - worked 6:00 a.m. to 2:00 p.m. CNA W - worked 2:00 p.m. to 10:00 p.m. CNA X - worked 2:00 p.m. to 10:00 p.m. CNA Y - worked 10:00 p.m. to 6:00 a.m. CNA Z - worked all shifts CNA AA - worked 2:00 p.m. to 10:00 p.m. CNA BB - worked 10:00 p.m. to 6:00 a.m. LVN CC - worked 8:00 a.m. to 5:00 p.m. CNA DD - worked 6:00 a.m. to 2:00 p.m. Record review of facility in-service titled Where to find a resident's care plan, dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. (continued on next page)

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The Highlands Guest Care Center	9009 Forest LN Dallas, TX 75243

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility in-service titled Abuse and Neglect, dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. Record review of facility in-service titled Safety with Hoyer Lift and Transfers with Gait Belt, Check-Off, Post Test dated 4/11/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A completed training and the post-test on 4/12/2025. In an observation on 4/13/2025 at 8:20 p.m., CNA T and CNA S transferred a resident from a wheelchair to the bed using a mechanical lift. RN G was present and assisted during the transfer. Proper techniques and safety precautions were observed. In an observation on 4/14/2025 at 11:43 a.m., CNA V transferred a resident from the bed to a wheelchair using a gait belt. Proper techniques and safety precautions were observed. In an observation on 4/14/2025 at 1:55 p.m., CNA DD transferred a resident from the bed to the wheelchair using a gait belt. Proper technique and safety precautions were observed. Review of Punch detail report for CNA A dated 04/30/25 for dates 04/06/25 to 04/30/25 reflected the CNA A last full day of work was on 04/08/25 and the CNA A came to the facility for inservice training 04/13/25. CNA A did not return to work at the facility for the remainder of the month. On 04/30/25 at 2:43 PM the facility Administrator provided the following clarification via email: . The facility will ensure that all mechanical transfer train-the-trainer sessions, center random skill checks, and instances where transfering is found to be done incorrectly, will be supervised, monitored, and approved by a licensed physical therapist due to their extensive knowledge of body mechanics and emphasis on safety for both staff and residents during transfers. On 04/14/2025 CNA A, was terminated for failure to follow company policies and procedures while providing resident care The ADM was informed the Immediate Jeopardy was removed on 4/14/2025 at 5:15 p.m. The facility remained out of compliance at a severity level of that was not Immediate Jeopardy and a scope of pattern, due to staff needing more time to monitor the effectiveness of the plan of removal for accidents and hazards.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observations, interviews, and record reviews the facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of nine residents reviewed for accidents and supervision. On 2/21/2025, CNA A transferred Resident #1 without a gait belt from the shower chair to the bed. As a result, Resident #1 suffered a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Oversight and monitoring of direct care staff (nurse aides), was not addressed. CNA A transferred Resident #1 inappropriately on 2/21/25 causing a left lower extremity fracture, was not retrained and or monitored, and then CNA A transferred Resident #1 inappropriately on 04/07/25 causing a right lower extremity fracture. This failure resulted in an Immediate Jeopardy situation on 4/10/2025. While the IJ was removed on 4/14/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm due to staff needing more time to monitor the effectiveness for the plan of removal for accidents and hazards. These failures could place residents at risk of serious harm, pain, and serious injury. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 15 (indicated no cognitive impairment). Section GG of the assessment revealed Resident #1 was dependent on staff to provide all the effort when toileting, showering, and when changing positions from sitting to standing. Section I of the MDS indicated Resident #1 had diagnoses of a left tibia (shin bone) fracture, multiple sclerosis (a disease that affects the nervous system and causes muscle weakness), and lack of coordination. Record review of Resident #1's care plan with a revision date of 4/08/2025 revealed Resident #1 sustained a fracture to the lower left extremity (left leg) on 2/26/2025 and sustained an additional fracture to the right lower extremity (right leg) on 4/07/2025. Resident #1's care plan was updated on 4/08/2025 and indicated a mechanical lift should be used for transfers. No transfer information prior to 4/08/2025 was found on the care plan. 1. Record review of Resident #1's progress note dated 2/21/2025 at 10:51 a.m. by RN B revealed Resident #1 had stated she bumped her knee against the shower chair, and an order was received for an x-ray. Record review of Resident #1's incident report dated 2/21/2025 completed by RN B revealed CNA A notified RN B that Resident #1 hit her knee against the shower chair during a transfer in the shower room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's x-ray dated 2/21/2025 revealed Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Record review of Resident #1's hospital orthopedic progress note dated 2/28/2025 revealed pain had improved and was better controlled since the splint (a medical device designed to immobilize the leg) was applied to the left leg while in the hospital. 2. Record review of Resident #1's progress note dated 4/07/2025 at 1:07 p.m. by RN B revealed Resident #1 had reported that she hit her right foot against the shower chair when transferred from the shower chair to the bed and an x-ray had been ordered. Record review of Resident #1's incident report dated 4/07/2025 completed by RN B revealed Resident #1 reported right foot pain and had reported she hit her right foot against the shower chair when being transferred from the shower chair to the bed. Record review of Resident #1's x-ray dated 4/07/2025 revealed an oblique fracture (a bone break that occurs at an angle to the bone's long axis) to the right distal diaphysis of the tibia (lower area of the shin bone) that was reported to the facility on [DATE] at 11:17 p.m. Record review of Resident #1's progress note dated 4/08/2025 at 10:18 a.m. by RN B revealed an order was received from NP JJ to send Resident #1 to the hospital. Record review of Resident #1's progress note dated 4/08/2025 at 10:36 a.m. by RN B revealed Resident #1 was transported to the hospital via ambulance. Record review of Resident #1's hospital history and physical dated 4/08/2025 revealed Resident #1 was being seen for right lower extremity pain. Resident #1 reported she was being moved to transfer from her wheelchair and got her leg stuck and twisted. The hospital notes also revealed an oblique fracture through the distal tibial shaft (a bone break that occurs at an angle to the lower area of the shin bone). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview and observation on 4/09/2025 at 11:04 a.m., Resident #1 reported that both of her legs had been broken. Resident #1 stated that her left leg had been broken over a month ago when CNA A transferred her from the shower chair to the bed. Resident #1 reported that her right leg had been broken a few days ago when she was transferred again by CNA A from the shower chair to the bed. Resident #1 stated that both times her foot had gotten caught between the shower chair and the bed. Resident #1 reported that she was not sent to the hospital immediately after fracturing the first leg and did not remember how long it took before she was sent to the hospital. Resident #1 stated she was in pain after both fractures until she was sent to the hospital because the facility was not able to administer strong enough pain medications. Resident #1 stated they did not send her to the hospital until the next day after the second fracture. Resident #1 reported when she fractured her right leg a few days ago that she had felt it pop in the right leg when CNA A transferred her from the shower chair to the bed. Resident #1 reported her right leg got caught behind the shower chair, and CNA A transferred her from the shower chair to the bed by herself. Resident #1 reported the facility sent her to the emergency room the next day after breakfast. Resident #1 stated she was in pain before they sent her to the hospital, and they gave her pain medication. Resident #1 reported the pain medication did not work, and she was still in pain. Resident #1 stated before her legs were fractured that she only got out of bed for therapy and showers but was unable to do therapy since the injuries occurred. Resident #1 lifted her blanket and revealed both of her legs were wrapped with soft gauze and ACE wrap. The right leg appeared bigger than the left. Resident #1 reported her pain was currently well managed. In an interview on 4/09/2025 at 12:42 p.m., CNA A reported she was transferring Resident #1 from the shower chair to the bed on 2/21/2025. CNA A stated Resident #1's left leg did not pivot with the resident when transferring her, and her foot stayed stuck to the floor in the same position. CNA A reported the leg twisted when she transferred Resident #1, and Resident #1 reported that she heard her leg pop. CNA A stated Resident #1's left leg also bumped the bed during the transfer. CNA A stated she did not use a gait belt and was by herself during the transfer. CNA A reported no training was completed before or after this incident, and she had been working at the facility for around six months. CNA A reported when she transferred Resident #1 on 4/07/2025 that she had CNA C with her, but stated CNA C did not know what she was doing. CNA A reported CNA C leaned Resident #1 forward in the shower chair, and Resident #1 bumped her right leg on the shower chair. CNA A reported Resident #1 complained of pain to her right leg, but CNA A transferred Resident #1 to the bed anyway because the shower chair was hurting her. CNA A reported CNA C did not know to get on the other side of Resident #1 to help with the transfer, so CNA A did the transfer by herself. CNA A reported that Resident #1 complained of pain when she was transferred to the bed, and CNA A notified RN B. CNA A reported a gait belt was not used for the second transfer because Resident #1 did not like gait belts. In an interview on 4/09/2025 at 12:59 p.m., RN B stated that Resident #1 complained of pain to her left leg on 2/21/2025. RN B stated Resident #1 had told him that her left leg got caught in the shower chair, and Resident #1 reported she heard it pop. RN B stated x-rays were ordered, and Resident #1 did have a fracture. RN B stated the fracture to the right leg occurred when CNA A transferred Resident #1 back to bed from the shower chair. RN B stated Resident #1 told him she bumped her leg on the shower chair, and RN B was unsure if CNA A was by herself during the transfer. RN B stated x-rays were ordered which revealed a fracture to the right leg. RN B reported he had not received any training over transfers since either incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/09/2025 at 1:35 p.m., CNA C reported she did not assist CNA A when Resident #1 was transferred. CNA C stated she was in training and did not work with CNA A on 4/07/2025. CNA C reported she was not in the room when Resident #1 was transferred, and she was working a different hall. In an interview and observation on 4/09/2025 at 2:02 p.m., the DON stated Resident #1 told her she hit her foot when she was transferred on 2/21/2025 from the shower chair to the bed. The DON stated she thought Resident #1 was a two-person transfer prior to this incident. The DON confirmed by looking at her computer that Resident #1's care plan did not contain any information regarding transfers until 4/08/2025. The DON reported that the CNAs would know how to transfer residents because they were orientated to their hall and received report from each other. The DON stated she did not know if CNA A was by herself after the first incident. The DON stated they were still investigating the incident that occurred on 4/07/2025, and she was not sure of what happened yet. The DON stated that CNA A told her there was another CNA assisting with the transfer, but the DON was not sure who the other CNA was. The DON stated CNA A knew she was not supposed to transfer Resident #1 by herself. The DON confirmed Resident #1 sustained a fracture to her right leg after being transferred from the shower chair to the bed on 4/07/2025. In an interview on 4/09/2025 at 2:54 p.m., Resident #1 confirmed that CNA A was alone when she was transferred from the shower chair to the bed both times. Resident #1 reported no one had offered to use a gait belt, but that was a good idea. In an interview and observation on 4/10/2025 at 1:54 p.m., ADON D reported a mechanical lift should have been used to transfer Resident #1 prior to the first incident on 2/21/2025. ADON D stated there was a list of residents that required a mechanical lift for transfers that was located in the CNA assignment book at the nurse's station. ADON D then obtained the assignment book and revealed a list of residents that required the use of a mechanical lift. ADON D confirmed Resident #1 was the last name on the list, but the list was not dated. Record review of facility in-service regarding Turning and positioning, dated 3/15/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. Record review of facility in-service regarding Positioning resident with a fracture, dated 02/27/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. A record review of the facility's policy titled Accidents and Incidents - Investigating and Reporting, dated 2001, revealed All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator . Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. A record review of the facility's policy titled Lifting Machine Policy and Procedure, dated 11/01/2016, revealed Review the resident's care plan to assess for any special needs of the resident . Two (2) clinical person who have been trained to use this lifting device are required to perform this procedure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's policy titled Abuse, Neglect and Exploitation, revised on 7/01/2020, revealed neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of Resident #2's Annual MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 12 (indicated mildly impaired cognition). Section I of the MDS revealed Resident #2 had diagnoses of muscle weakness, severe morbid obesity (overweight), and anxiety disorder. Record review of Resident #2's care plan with a revision date of 3/31/2025 revealed Resident #2 indicated she was a fall risk and had poor safety awareness. In an observation on 4/11/2025 at 12:02 p.m., CNA FF and CNA GG were preparing to transfer Resident #2 from the bed to the wheelchair using a mechanical lift. The top of the sling was placed under the shoulders of Resident #2. The bed was not locked. The wheelchair was not locked. CNA FF positioned the lift over Resident #2. CNA FF placed two blue sling loops on two of the mechanical lift hooks. CNA GG placed two green sling loops on two of the mechanical lift hooks. CNA FF began lifting the resident in the sling using the mechanical lift. Resident #2 was lying flat in the sling as she was lifted. CNA FF positioned Resident #2 over the wheelchair using the mechanical lift while CNA GG guided Resident #2 in the sling. CNA GG attempted to position Resident #2 over the wheelchair, but Resident #2 remained in a laying position. The surveyor requested the CNAs stop the transfer and called for assistance. CNA EE entered the room and assisted CNA GG in positioning Resident #2 in more of a sitting position over the wheelchair. Resident #2 was lowered into the wheelchair without injury. In an interview on 4/11/2025 at 12:44 p.m., CNA FF reported they had trouble transferring Resident #2 using the mechanical lift because the sling was too small. CNA FF reported they had additional slings but was unsure if they had the right size for Resident #2. CNA FF was unable to continue with the interview because she had to feed a resident. In an observation and interview on 4/11/2025 at 1:42 p.m., CNA EE and CNA FF were in Resident #2's room, and CNA FF stated they were going to transfer Resident #2 with the mechanical lift from the wheelchair to the bed. CNA FF reported the sling under Resident #2 was too small, and they would look for a new sling after transferring Resident #2. The surveyor requested the CNAs not to transfer the resident. The surveyor notified the ADM, and the ADM told the CNAs not to transfer Resident #2. The ADM brought the DOR to the room. The DOR checked the sling and reported it was the appropriate size because two inches of the sling was visible on each side of Resident #2. The DOR reported he would assist CNA FF with transferring Resident #2 from the wheelchair to the bed using the mechanical lift. CNA FF positioned the mechanical lift over Resident #2. The DOR connected the sling loops to the mechanical lift in the following order: left upper hook had a green sling loop, right upper hook had a black loop, the right lower hook had a green loop, the lower left hook had 3 loops (green, purple, and black). The wheelchair was not locked, and the bed was not locked. CNA FF lifted Resident #2 in the sling using the mechanical lift. Resident #2 was lying flat in the sling as she was lifted. CNA FF positioned Resident #2 in the sling over the bed and lowered the resident to the bed. CNA FF and the DOR pulled the resident up in the bed. The bed was not locked and moved as they repositioned Resident #2. The DOR reported that the colored loops do not have to match when using the lift. The DOR reported the most important thing is that the resident is comfortable. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the mechanical lift sling's owner manual, with a print date of December 2023, revealed The top edge of the sling should be slightly above the resident's head . Place the straps of the sling over hooks of the swivel bar or cradle and be sure to match the corresponding strap and/or strap colors on each side of the sling for an even lift of the resident . Colored straps make it easy to connect both side of the sling equally. Always ensure there is sufficient head support when lifting a resident . WARNING: Wheelchair wheel locks MUST be in a locked position before lowering the resident into the wheelchair for transport . When the resident is lifted from the surface, they will be raised to a sitting position. In an interview on 4/11/2025 at 3:12 p.m., the ADM was notified of concerns regarding transfer observations. The ADM reported PT HH was coming to the facility to provide individual training to the DON and ADONs. The ADM reported all staff would be retrained on safe transfers and complete a competency test after completing the training. In an interview on 4/11/2025 at 4:32 p.m., PT HH reported that the ADM had tasked her with training the DON and ADONs concerning safe transfers with mechanical lifts and transfers with a gait belt. PT HH stated that the DON and ADON performed a safe transfer using her as the patient. PT HH stated that she watched the DON and the ADON train two sets of CNAs. PT HH stated that the CNA's then performed safe transfers using her as the patient for each team of CNAs. PT HH stated they performed the transfers safely and stated that until further notice CNAs were to be observed by a nurse every time that they perform a mechanical lift transfer. The ADM, the DON, ADON D, ADON E, and the MDS Nurse were provided the IJ template on 4/10/2025 at 3:13 p.m. and notified that an Immediate Jeopardy situation had been identified due to the above failures. The plan of removal was approved on 4/12/2025 at 3:19 p.m. and reflected: Problem: Failure of safety during transfer for resident # 1. Interventions: On 4/10/2025 the center will in-service nursing staff on where to find the resident's care plan to determine how to care for the resident. This care plain is found on the electronic screen system on each hall and general area. The resident transfer section on the care plan will tell the Nursing tea member how the resident is to be transferred. On 4/10/2025 the center will educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. On 4/10/2025 the center will complete a skills check-off tool on the nursing team members so they can demonstrate the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both resident and staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following in services were immediately initiated by . Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM . will ensure these team members are removed from the time clock and PCC access removed, this will be monitored until 100% complete or the team members are terminated. On going in-service will be completed by . the DON; ADON D and ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Systemic Change 4/11/2025: On 4/11/2025 it was found that identified CNAs were not following the education and Skills check-off they had completed before they started their shift. . (IDT Team - I) decided to bring in a Licensed Physical Therapist to educate, complete a skills check-off list, and post-test on transferring a resident. On 4/12/2025 PT educated, completed a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with .DON; ADON D and ADON E. After they completed and passed their education, PT observed DON; ADONs educate, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices with 3 CNAs. Moving forward only DON; ADONs, and PT will be able to in-service, complete a skills check-off list, and post-test on transferring a resident with body techniques and mechanical devices. Moving forward a resident can only be transferred using a Hoyer lift with a licensed nurse present. This practice will continue until the (IDT Team - I) decides the CNAs are able to complete this transfer without supervision. The following in services were immediately initiated by Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON and ADONs until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. The following in-services were initiated by Chief Nursing Officer on 4/10/2025: Nursing Department (CNAs): - In-service nursing staff on where to find the resident's care plan to determine how to care for the resident. (See in-service 600-1) - Educate nursing team members on the process of transferring residents by using their proper body mechanics or using a transfer device for the safety of both residents and staff. (See in-service 600-2) (See Check-off list 600-2) (See Post-test 600-2). The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON. The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the Administrator. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring as of 4/11/2025: The DON and ADONs will monitor resident transfers by CNA every shift for 7 days. Administrator will monitor this process daily for the next 7 days. The DON and ADONs will test nursing staff on where to find the resident's care plan every shift for 7 days. The ADM will monitor this process daily for the next 7 days. QAPI: 1. Ad Hoc QA meeting held on 4/10/2025 to discuss causes, in-services and review interventions. 2. Any negative findings in the monitoring and/or auditing system will be reviewed and addressed by the QAPI committee for a potential systemic change. Monitoring of the plan of removal included: In an interview on 4/14/2025 at 1:48 p.m., ADON D reported CNA A had come into the facility and completed training and then was placed on suspension. ADON D stated she was not sure if CNA A would be returning to work after the investigation. ADON D reported RN B was out of the country on vacation but would receive training before returning to work on the floor. ADON D reported that she received training from PT HH. In an interview on 4/14/2025 at 4:13 p.m., the DON reported the ADONs and herself received individual training from PT HH and trained every CNA and nurse themselves. The DON reported that a nurse would be required to be in the room with two CNAs every time a mechanical lift was used, indefinitely. The DON reported that herself and the ADONs would continue to monitor transfers on every shift for the next seven days. The DON reported that herself and the ADONs would also continue to monitor the CNAs and ensure they were able to access care plans for the next seven days. Interviews were conducted with 27 employees from 4/12/2025 starting at 3:55 p.m. and continued through 4/14/2025 at 4:13 p.m. All employees interviewed were able to verify how to access the residents' care plans and identify patients that required a mechanical lift, how to properly transfer residents, and reported they had received hands on training on how to transfer a resident using a mechanical lift, a sit-to-stand lift, and a gait belt. All interviewed staff reported they had received in-services concerning safe transfers, accessing resident care plans, and completed training hands-on transfer training by the DON or ADONs. Interviewed staff members and shifts included: ADON D - worked all shifts ADON E - worked all shifts RN F - worked 2:00 p.m. to 10:00 p.m. RN G - worked all shifts RN H - worked weekend shift 6:00 a.m. to 10:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2025
NAME OF PROVIDER OR SUPPLIER: The Highlands Guest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 9009 Forest LN Dallas, TX 75243	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN I - worked 6:00 a.m. to 2:00 p.m. LVN J - worked all shifts LVN K - worked 10:00 p.m. to 6:00 a.m. LVN L - worked weekend shift 6:00 a.m. to 10:00 p.m. LVN M- worked 2:00 p.m. to 10:00 p.m. LVN N- worked 2:00 p.m. to 10:00 p.m. LVN O- worked 6:00 a.m. to 2:00 p.m. CNA P - worked 2:00 p.m. to 10:00 p.m. CNA Q - worked 2:00 p.m. to 10:00 p.m. CNA R - worked 6:00 a.m. to 2:00 p.m. CNA S - worked 2:00 p.m. to 10:00 p.m. CNA T - worked 2:00 p.m. to 10:00 p.m. CNA U - worked 10:00 p.m. to 6:00 a.m. CNA V - worked 6:00 a.m. to 2:00 p.m. CNA W - worked 2:00 p.m. to 10:00 p.m. CNA X - worked 2:00 p.m. to 10:00 p.m. CNA Y - worked 10:00 p.m. to 6:00 a.m. CNA Z - worked all shifts CNA AA - worked 2:00 p.m. to 10:00 p.m. CNA BB - worked 10:00 p.m. to 6:00 a.m. LVN CC - worked 8:00 a.m. to 5:00 p.m. CNA DD - worked 6:00 a.m. to 2:00 p.m. Record review of facility in-service titled Where to find a resident's care plan, dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility in-service titled Abuse and Neglect, dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. Record review of facility in-service titled Safety with Hoyer Lift and Transfers with Gait Belt, Check-Off, Post Test dated 4/11/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A completed training and the post-test on 4/12/2025. In an observation on 4/13/2025 at 8:20 p.m., CNA T and CNA S transferred a resident from a wheelchair to the bed using a mechanical lift. RN G was present and assisted during the transfer. Proper techniques and safety precautions were observed. In an observation on 4/14/2025 at 11:43 a.m., CNA V transferred a resident from the bed to a wheelchair using a gait belt. Proper techniques and safety precautions were observed. In an observation on 4/14/2025 at 1:55 p.m., CNA DD transferred a resident from the bed to the wheelchair using a gait belt. Proper technique and safety precautions were observed. The ADM was informed the Immediate Jeopardy was removed on 4/14/2025 at 5:15 p.m. The facility remained out of compliance at a severity level of that was not Immediate Jeopardy and a scope of pattern, due to staff needing more time to monitor the effectiveness of the plan of removal for accidents and hazards. In an observation on 4/14/2025 at 1:55 p.m., CNA DD transferred a resident from the bed to the wheelchair using a gait belt. Proper technique and safety precautions were observed. Review of Punch detail report for CNA A dated 04/30/25 for dates 04/06/25 to 04/30/25 reflected the CNA A last full day of work was on 04/08/25 and the CNA A came to the facility for inservice training 04/13/25. CNA A did not return to work at the facility for the remainder of the month. On 04/30/25 at 2:43 PM the facility Administrator provided the following clarification via email: . The facility will ensure that all mechanical transfer train-the-trainer sessions, center random skill checks, and instances where transfering is found to be done incorrectly, will be supervised, monitored, and approved by a licensed physical therapist due to their extensive knowledge of body mechanics and emphasis on safety for both staff and residents during transfers. On 04/14/2025 CNA A, was terminated for failure to follow company policies and procedures while providing resident care The ADM was informed the Immediate Jeopardy was removed on 4/14/2025 at 5:15 p.m. The facility remained out of compliance at a severity level of that was not Immediate Jeopardy and a scope of pattern, due to staff needing more time to monitor the effectiveness of the plan of removal for accidents and hazards.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observation, interviews and record reviews, the facility failed to provide pain management consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of eight residents reviewed for abuse and neglect. 1. The facility failed to ensure Resident #1 did not experience additional pain after sustaining a fracture on 2/21/2025 to the left distal diaphysis of the tibia (lower area of the shin bone) and was not transferred to the hospital until 2/26/2025 (five days later). 2. The facility failed to ensure Resident #1's pain was accurately assessed and documented. This failure resulted in an Immediate Jeopardy situation on 04/10/2025. While the IJ was removed on 04/14/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm actual harm due to staff needing more time to monitor the effectiveness for the plan of removal for neglect. This failure could place residents at risk of pain, emotional distress, and mental anguish. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 15 (indicated no cognitive impairment). Section GG of the assessment revealed Resident #1 was dependent on staff to provide all the effort when toileting, showering, and when changing positions from sitting to standing. Section I of the MDS indicated Resident #1 had diagnoses of a left tibia (shin bone) fracture, multiple sclerosis (a disease that affects the nervous system and causes muscle weakness), and lack of coordination. Record review of Resident #1's care plan with a revision date of 4/08/2025 revealed Resident #1 sustained a fracture to the lower left extremity (left leg) on 2/26/2025 and sustained an additional fracture to the right lower extremity (right leg) on 4/07/2025. Resident #1's care plan was updated on 4/08/2025 and indicated a mechanical lift should be used for transfers. 1. Record review of Resident #1's progress note dated 2/21/2025 at 10:51 a.m. by RN B revealed Resident #1 had stated she bumped her knee against the shower chair, and an order was received for an x-ray. Record review of Resident #1's x-ray dated 2/21/2025 revealed Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone) that was reported to the facility on [DATE] at 4:13 p.m. Record review of Resident #1's progress notes dated 2/22/2025 at 6:57 a.m. by RN II revealed NP was notified of the x-ray results, and RN II was awaiting a response. The progress note did not reveal how the NP was notified. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/09/2025 at 1:32 p.m., RN II stated he did not think he was the nurse that received the x-ray results for Resident #1 on 2/22/2025. RN II stated he did not remember notifying the NP J. RN II stated he always called or texted NP J with any abnormal lab or x-ray results. RN II reported if the NP did not respond to the text message, then he would have called them. Record review of Resident #1's progress notes dated 2/25/2025 at 2:09 p.m. by RN B revealed NP J was notified of the x-ray results received on 2/21/2025 (four days later) and an order for an orthopedic consult was received. Record review of Resident #1's progress notes dated 2/26/2025 at 6:46 a.m. by RN II revealed NP J was notified of the x-ray results and the morning nurse was briefed for follow up with DON, because there finding of acute fracture by the x-ray. In an interview on 4/09/2025 at 12:59 p.m., RN B stated that Resident #1 complained of pain to her left leg on 2/21/2025. RN B reported Resident #1 complained of pain, so he notified the pain doctor. RN B reported the pain doctor ordered the x-rays. RN B stated Resident #1 had told him that her left leg got caught in the shower chair, and Resident #1 reported she heard it pop. RN B stated x-rays were ordered, and Resident #1 did have a fracture. RN B reported he ordered the x-ray before he left around 2pm and gave report to the oncoming nurse. RN B stated the x-ray results came on the next shift, and the night nurse called the NP. RN B stated he was told in report that the resident had a fracture and he also followed up with the NP. RN B stated the NP told him to send her to the emergency room , and he sent her to the hospital. RN B stated he does not remember exactly when the x-ray results were received or when Resident #1 was sent to the hospital. RN B stated he knows he got an order for an orthopedic consult and an order to send to the emergency room . RN B stated he was unsure when he notified the NP or when he received new orders. In an interview on 4/10/2025 at 1:11 p.m., the DON reported the nurses should call NP JJ 24 hours a day, 7 days a week with lab results and x-ray results. The DON stated if she did not answer then they would call the answering service. The DON stated NP JJ had never given them instructions not to call her after hours. The DON stated they stopped using the answering service about six months ago, and just started calling NP JJ. The DON stated she expected the nurses to call her depending on the emergency and how many times they had called the NP. The DON stated she did not know how many times they should call the NP before calling her and that the nurses should use their own judgement. The DON stated she did not know what happened with Resident #1's x-ray results, and why the doctor was not followed up with. The DON reported she was aware the x-rays were obtained for Resident #1 on 2/21/2025. The DON stated she did not remember if she knew about the results and thought maybe she was off work at that time. In an interview and observation on 4/09/2025 at 2:02 p.m., the DON reported Resident #1 told her she hit her foot when she was transferred from the shower chair to the bed on 2/21/2025. The DON reported she did not remember what happened concerning the x-ray results and would have to check the notes. The DON reported Resident #1 complained of pain after the incident on 2/21/2025, but Resident #1 did have pain medicine. The DON reviewed Resident #1's notes on her computer and confirmed x-rays were ordered for Resident #1 on 2/21/2025, and the NP was notified on 2/22/2025 by RN II, but no response was received. The DON reported RN B received an order for an orthopedic consult on 2/25/2025, but an order to send Resident #1 to the hospital was not received until 2/26/2025. The DON stated she was confused about the incident and did not know why Resident #1 was not sent to the hospital until 2/26/2025. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/09/2025 at 3:56 p.m., NP J reported she was on-call Monday thru Friday from 8am to 5pm. NP J stated any calls or messages after 5pm should have been called in to their call system. NP J stated she did not remember waiting days to send Resident #1 to the hospital and did not remember when she was notified by the facility of the x-ray results from 2/21/2025. NP J stated she did remember giving an order for an orthopedic consult but did not remember waiting to send Resident #1 to the hospital. NP J stated she would have sent Resident #1 to the hospital if she had a fracture because a broken bone in the elderly could delay their healing. NP J stated she expected staff to notify her immediately of changes when she was on-call, and they could send a text if it was not critical. NP J stated if a critical result was received in the middle of the night then they should call the on-call provider. NP J stated the risk to the residents if she was not notified timely was that it could jeopardize the residents' health or life. 2. In an interview and observation on 4/09/2025 at 11:04 a.m., Resident #1 reported that both of her legs had been broken. Resident #1 stated that her left leg had been broken over a month ago when CNA A transferred her from the shower chair to the bed. Resident #1 reported that her right leg had been broken a few days ago when she was transferred again by CNA A from the shower chair to the bed. Resident #1 stated that both times her foot had gotten caught between the shower chair and the bed. Resident #1 reported that she was not sent to the hospital immediately after fracturing the first leg and did not remember how long it took before she was sent to the hospital. Resident #1 stated she was in pain after both fractures until she was sent to the hospital because the facility was not able to administer strong enough pain medications. Resident #1 stated they did not send her to the hospital until the next day after the second fracture. Resident #1 reported when she fractured her right leg a few days ago that she had felt it pop in the right leg when CNA A transferred her from the shower chair to the bed. Resident #1 reported her right leg got caught behind the shower chair, and CNA A transferred her from the shower chair to the bed by herself. Resident #1 reported the facility sent her to the emergency room the next day after breakfast. Resident #1 stated she was in pain before they sent her to the hospital, and they gave her pain medication. Resident #1 reported the pain medication did not work, and she was still in pain. Resident #1 stated before her legs were fractured that she only got out of bed for therapy and showers but was unable to do therapy since the injuries occurred. Resident #1 lifted her blanket and revealed both of her legs were wrapped with soft gauze and ACE wrap. The right leg appeared bigger than the left. Resident #1 reported her pain was currently well managed. Record review of Resident #1's February MAR indicated Resident #1 had a pain level of zero (meaning no pain) out of 10 (meaning severe pain) for every shift (day, evening, and night) except for the following: 2/15/2025 - day shift pain level was listed as a one (mild, barely noticeable pain) 2/16/2025 - day shift pain level was listed as a three (noticeable pain) 2/22/2025 - day shift pain level was listed as a five (moderate pain) All shifts for 2/21/2025, 2/23/2025, 2/24/2025, and 2/25/2025 indicated a pain level of zero (meaning no pain). The February MAR also revealed as needed pain medication was administered twice on 2/22/2025 and 2/23/2025. As needed pain medicationmedication, which was one tablet of hydrocodone 5/325 mg, was not administered on 2/21/2025, 2/24/2025, or 2/25/2025. The MAR revealed Resident #1 did have a Fentanyl pain patch that was changed every 72 hours. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's hospital orthopedic progress note dated 2/28/2025 revealed pain had improved and was better controlled since the splint (a medical device designed to immobilize the leg) was applied to the left leg while in the hospital. In an interview on 4/10/2025 at 1:11 p.m., the DON stated a fractured leg wasis painful, but no one told her Resident #1 was having pain. The DON reported that Resident #1 had pain medication that prevented her from being in excruciating pain and was seen regularly by a pain doctor. The DON stated she expected pain levels to be documented and treated according to the physician's orders. The DON reported the floor nurses monitored the residents' pain levels and were responsible for documenting them. Record review of facility in-service regarding Turning and positioning, dated 3/15/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. Record review of facility in-service regarding Positioning resident with a fracture, dated 02/27/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. CNA A signature not found. A record review of the facility's policy titled Abuse, Neglect and Exploitation, revised on 7/01/2020, revealed neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A record review of the facility's policy titled Pain - Clinical Protocol, revised on 10/2022, revealed The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain . The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated. A record review of the facility's policy titled Pain Assessment and Management, revised on 7/01/2020, revealed Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals . Assess the resident whenever there is a suspicion of new pain or worsening of existing pain . Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including: . (4) fractures. The ADM, the DON, ADON D, ADON E, and the MDS Nurse were provided the IJ template on 4/10/2025 at 3:13 p.m. and notified that an Immediate Jeopardy situation had been identified due to the above failures. The plan of removal was approved on 4/12/2025 at 3:19 p.m. and reflected: Interventions: All residents were immediately assessed on 4/10/2025 for any change in condition from their baseline including pain assessment. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Any resident who verbalized or showed nonverbal signs of pain, was addressed at that time following that resident's physician orders for pain management. On 4/12/2025 either DON; ADON D; ADON E; and LVN CC; will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days. The following in services were immediately initiated by the Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. The ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON; ADON D; ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Post Test will be completed to evaluate team members understanding of in-services covered. The passing score will be 80% - 100%. (See Post-test POR-1) The following in-services were initiated by CNO: Licensed Nurses: How to assess residents for signs and symptoms of pain using a pain scale appropriate for them. (See In-service 600-I1) How to reassess pain after medication administration for effectiveness and process for if not effective. (See In-service 600-I2) Each resident will have a pain management treatment plan as part of their plan of care. (See In-service 600-I3) The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON. The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the ADM. Monitoring as of 4/10/2025: All residents were immediately assessed on 4/10/2025 for any change in condition from their baseline including pain assessment. Any resident who verbalized or showed nonverbal signs of pain, was addressed at that time following that resident's physician orders for pain management. On 4/12/2025 either DON; ADON D; ADON E; and LVN CC; will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following in services were immediately initiated by the Chief Nursing Officer on 4/10/2025. Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. The ADM and HR will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by DON; ADON D; ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Monitoring of the plan of removal included: Interviews were conducted with 27 employees from 4/12/2025 starting at 3:55 p.m. and continued through 4/14/2025 at 4:13 p.m. All employees interviewed were able to verify how to assess residents' pain levels, who to notify, where to document pain levels, and how to identify indicators of pain. All interviewed staff reported they had received in-services concerning signs of pain, using pain scales, and all nurses were in-serviced on reassessing pain after pain medication administration. Interviewed staff members and shifts included: ADON D - worked all shifts ADON E - worked all shifts RN F - worked 2:00 p.m. to 10:00 p.m. RN G - worked all shifts RN H - worked weekend shift 6:00 a.m. to 10:00 p.m. LVN I - worked 6:00 a.m. to 2:00 p.m. LVN J - worked all shifts LVN K - worked 10:00 p.m. to 6:00 a.m. LVN L - worked weekend shift 6:00 a.m. to 10:00 p.m. LVN M- worked 2:00 p.m. to 10:00 p.m. LVN N- worked 2:00 p.m. to 10:00 p.m. LVN O- worked 6:00 a.m. to 2:00 p.m. CNA P - worked 2:00 p.m. to 10:00 p.m. CNA Q - worked 2:00 p.m. to 10:00 p.m. CNA R - worked 6:00 a.m. to 2:00 p.m. CNA S - worked 2:00 p.m. to 10:00 p.m. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA T - worked 2:00 p.m. to 10:00 p.m. CNA U - worked 10:00 p.m. to 6:00 a.m. CNA V - worked 6:00 a.m. to 2:00 p.m. CNA W - worked 2:00 p.m. to 10:00 p.m. CNA X - worked 2:00 p.m. to 10:00 p.m. CNA Y - worked 10:00 p.m. to 6:00 a.m. CNA Z - worked all shifts CNA AA - worked 2:00 p.m. to 10:00 p.m. CNA BB - worked 10:00 p.m. to 6:00 a.m. LVN CC - worked 8:00 a.m. to 5:00 p.m. CNA DD - worked 6:00 a.m. to 2:00 p.m. Record review of facility in-service titled Following Physician Orders to Address Pain dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses. Record review of facility in-service titled Assessing the effectiveness of pain medication given dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. Record review of facility in-service titled Comprehensive Pain Management Treatment Plan dated 4/10/2025 revealed all nursing staff had signed indicating education was completed by all nurses and CNAs. Review of Punch detail report for CNA A dated 04/30/25 for dates 04/06/25 to 04/30/25 reflected the CNA A last full day of work was on 04/08/25 and the CNA A came to the facility for inservice training 04/13/25. CNA A did not return to work at the facility for the remainder of the month. On 04/30/25 at 2:43 PM the facility Administrator provided the following clarification via email: . The facility will ensure that all mechanical transfer train-the-trainer sessions, center random skill checks, and instances where transfering is found to be done incorrectly, will be supervised, monitored, and approved by a licensed physical therapist due to their extensive knowledge of body mechanics and emphasis on safety for both staff and residents during transfers. On 04/14/2025 CNA A, was terminated for failure to follow company policies and procedures while providing resident care (continued on next page)

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	675447	A. Building B. Wing	04/14/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM was informed the Immediate Jeopardy was removed on 4/14/2025 at 5:15 p.m. The facility remained out of compliance at a severity level of actual harm that was not Immediate Jeopardy and a scope of isolated, due to staff needing more time to monitor the effectiveness of the plan of removal for accidents and hazards.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on interview and record review, the facility failed to promptly notify the ordering physician of results which fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for one (Resident #1) of eight residents reviewed for notification of changes. 1. The facility failed to notify and consult with Resident #1's physician on 2/21/2025 when x-ray results were received revealing Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone). Resident #1 was not sent to the hospital until five days later, on 2/26/2025. 2. The facility failed to notify and consult with Resident #1's physician on 4/07/2025 when x-ray results were received revealing Resident #1 had an oblique fracture (a bone break that occurs at an angle to the bone's long axis) to the right distal diaphysis of the tibia (lower area of the shin bone). Resident #1 was not sent to the hospital until the next day on 4/08/2025. This failure resulted in an Immediate Jeopardy situation on 4/10/2025. While the IJ was removed on 4/14/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm due to staff needing more time to monitor the effectiveness for the plan of removal for notification of changes. This failure could place residents at risks of a delay in medical treatment, which could lead to worsening of their condition, hospitalization , or death. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 15 (indicated no cognitive impairment). Section GG of the assessment revealed Resident #1 was dependent on staff to provide all the effort when toileting, showering, and when changing positions from sitting to standing. Section I of the MDS indicated Resident #1 had diagnoses of a left tibia (shin bone) fracture, multiple sclerosis (a disease that affects the nervous system and causes muscle weakness), and lack of coordination. Record review of Resident #1's care plan with a revision date of 4/08/2025 revealed Resident #1 sustained a fracture to the lower left extremity (left leg) on 2/26/2025 and sustained an additional fracture to the right lower extremity (right leg) on 4/07/2025. Resident #1's care plan was updated on 4/08/2025 and indicated a mechanical lift should be used for transfers. 1. Record review of Resident #1's progress note dated 2/21/2025 at 10:51 a.m. by RN B revealed Resident #1 had stated she bumped her knee against the shower chair, and an order was received for an x-ray. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's x-ray dated 2/21/2025 revealed Resident #1 had a fracture to the left distal diaphysis of the tibia (lower area of the shin bone) that was reported to the facility on [DATE] at 4:13 p.m. Record review of Resident #1's progress notes dated 2/22/2025 at 6:57 a.m. by RN II revealed the NP was notified of the x-ray results, and RN II was awaiting a response. The progress note did not indicate how the NP was notified. In an interview on 4/09/2025 at 1:32 p.m., RN II stated he did not think he was the nurse that received the x-ray results for Resident #1 on 2/22/2025. RN II stated he did not remember notifying NP JJ. RN II stated he always called or texted NP JJ with any abnormal lab or x-ray results. RN II reported if the NP did not respond to the text message, then he would have called them. Record review of Resident #1's progress notes dated 2/25/2025 at 2:09 p.m. by RN B revealed NP JJ was notified of the x-ray results received on 2/21/2025 and an order for an orthopedic consult was received. Record review of Resident #1's progress notes dated 2/26/2025 at 6:46 a.m. by RN II revealed NP JJ was notified of the x-ray results and the morning nurse (6a-2pm) was briefed for follow up with DON, because there finding of acute fracture by the x-ray. In an interview on 4/09/2025 at 12:59 p.m., RN B stated that Resident #1 complained of pain to her left leg on 2/21/2025. RN B reported Resident #1 complained of pain, so he notified the pain doctor. RN B reported the pain doctor ordered the x-rays. RN B stated Resident #1 had told him that her left leg got caught in the shower chair, and Resident #1 reported she heard it pop. RN B stated x-rays were ordered, and Resident #1 did have a fracture. RN B reported he ordered the x-ray before he left around 2pm and gave report to the oncoming nurse. RN B stated the x-ray results came on the next shift, and the night nurse called the NP. RN B stated he was told in report that the resident had a fracture and he also followed up with the NP. RN B stated the NP told him to send her to the emergency room , and he sent her to the hospital. RN B stated he does not remember exactly when the x-ray results were received or when Resident #1 was sent to the hospital. RN B stated he knows he got an order for an orthopedic consult and an order to send to the emergency room . RN B stated he was unsure when he notified the NP or when he received new orders. In an interview and observation on 4/09/2025 at 2:02 p.m., the DON reported Resident #1 told her she hit her foot when she was transferred from the shower chair to the bed on 2/21/2025. The DON reported she did not remember what happened concerning the x-ray results and would have to check the notes. The DON reported Resident #1 complained of pain after the incident on 2/21/2025, but Resident #1 did have pain medicine. The DON reviewed Resident #1's notes on her computer and confirmed x-rays were ordered for Resident #1 on 2/21/2025, and the NP was notified on 2/22/2025 by RN II, but no response was received. The DON reported RN B received an order for an orthopedic consult on 2/25/2025, but an order to send Resident #1 to the hospital was not received until 2/26/2025. The DON stated she was confused about the incident and did not know why Resident #1 was not sent to the hospital until 2/26/2025. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/10/2025 at 1:11 p.m., the DON reported the nurses should call NP JJ 24 hours a day, 7 days a week with lab results and x-ray results. The DON stated if she did not answer then they would call the answering service. The DON stated NP JJ had never given them instructions not to call her after hours. The DON stated they stopped using the answering service about six months ago, and just started calling NP JJ. The DON stated she expected the nurses to call her depending on the emergency and how many times they had called the NP. The DON stated she did not know how many times they should call the NP before calling her and that the nurses should use their own judgement. The DON stated she did not know what happened with Resident #1's x-ray results, and why the doctor was not followed up with. The DON stated a fractured leg was painful, and she was aware of the x-rays were obtained for Resident #1 on 2/21/2025. The DON stated she did not remember if she knew about the results and thought maybe she was off work at that time. 2. Record review of Resident #1's progress note dated 4/07/2025 at 1:07 p.m. by RN B revealed Resident #1 had reported that she hit her right foot against the shower chair when transferred from the shower chair to the bed and an x-ray had been ordered. Record review of Resident #1's incident report dated 4/07/2025 completed by RN B revealed Resident #1 reported right foot pain and had reported she hit her right foot against the shower chair when being transferred from the shower chair to the bed. Record review of Resident #1's x-ray dated 4/07/2025 revealed an oblique fracture (a bone break that occurs at an angle to the bone's long axis) to the right distal diaphysis of the tibia (lower area of the shin bone) that was reported to the facility on [DATE] at 11:17 p.m. Record review of Resident #1's progress notes dated 4/08/2025 at 12:47 a.m. by LVN J revealed the x-ray results from 4/07/2025 had been sent to NP JJ, and LVN J was still awaiting response. In an interview on 4/09/2025 at 11:19 a.m., LVN J reported she received the x-ray results for the x-ray performed on 4/07/2025 and sent a text message to NP JJ. LVN J stated she did not receive a response from NP JJ, so she told the oncoming nurse in report to follow up. LVN J reported staff always notified NP JJ of changes and that it did not matter what day or time it was. LVN JJ reported she did not attempt to call NP JJ when she did not receive a response. Record review of Resident #1's progress note dated 4/08/2025 at 10:18 a.m. by RN B revealed an order was received from NP JJ to send Resident #1 to the hospital. Record review of Resident #1's progress note dated 4/08/2025 at 10:36 a.m. by RN B revealed Resident #1 was transported to the hospital via ambulance. In an interview on 4/09/2025 at 12:59 p.m., RN B stated that on 4/07/2025 Resident #1 reported to him that her right leg hurt. RN B reported that x-rays were ordered, and the results were received later that night. RN B reported the night nurse told him that she texted NP JJ and did not get a response. RN B stated he called NP JJ after receiving report, and NP JJ said she was on her way. RN B stated NP JJ came to the facility, checked Resident #1, and gave the order to send Resident #1 to the hospital. RN B stated he sent Resident #1 to the hospital as ordered on 4/08/2025. RN B reported Resident #1 did have pain and was given pain medicine until she was sent to the hospital. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview and observation on 4/09/2025 at 11:04 a.m., Resident #1 reported that both of her legs had been broken. Resident #1 stated that her left leg had been broken over a month ago when CNA A transferred her from the shower chair to the bed. Resident #1 reported that her right leg had been broken a few days ago when she was transferred again by CNA A from the shower chair to the bed. Resident #1 stated that both times her foot had gotten caught between the shower chair and the bed. Resident #1 reported that she was not sent to the hospital immediately after fracturing the first leg and did not remember how long it took before she was sent to the hospital. Resident #1 stated she was in pain after both fractures until she was sent to the hospital because the facility was not able to administer strong enough pain medications. Resident #1 stated they did not send her to the hospital until the next day after the second fracture. Resident #1 reported when she fractured her right leg a few days ago that she had felt it pop in the right leg when CNA A transferred her from the shower chair to the bed. Resident #1 reported her right leg got caught behind the shower chair, and CNA A transferred her from the shower chair to the bed by herself. Resident #1 reported the facility sent her to the emergency room the next day after breakfast. Resident #1 stated she was in pain before they sent her to the hospital, and they gave her pain medication. Resident #1 reported the pain medication did not work, and she was still in pain. Resident #1 stated before her legs were fractured that she only got out of bed for therapy and showers but was unable to do therapy since the injuries occurred. Resident #1 lifted her blanket and revealed both of her legs were wrapped with soft gauze and ACE wrap. The right leg appeared bigger than the left. Resident #1 reported her pain was currently well managed. In an interview and observation on 4/09/2025 at 2:02 p.m., the DON confirmed by looking at her computer that LVN J had notified NP JJ of the x-ray results just after midnight on 4/08/2025 but had not received a response. The DON reported the nurses should call the NPs if a response was not received. The DON reported they were still investigating the incident that occurred on 4/07/2025 and did not know why staff did not call NP JJ or the MD. In an interview on 4/09/2025 at 3:56 p.m., NP JJ reported she was on-call Monday thru Friday from 8am to 5pm. NP JJ stated any calls or messages after 5pm should have been called in to their call system. NP JJ stated she did not remember waiting days to send Resident #1 to the hospital and did not remember when she was notified by the facility of the x-ray results from 2/21/2025. NP JJ stated she did remember giving an order for an orthopedic consult but did not remember waiting to send Resident #1 to the hospital. NP JJ stated she would have sent Resident #1 to the hospital if she had a fracture because a broken bone in the elderly could delay their healing. NP JJ stated she expected staff to notify her immediately of changes when she was on-call, and they could send a text if it was not critical. NP JJ stated if a critical result was received in the middle of the night, then they should call the on-call provider. NP JJ stated the risk to the residents if she was not notified timely was that it could jeopardize the residents' health or life. In an interview on 4/10/2025 at 9:25 a.m., the DON reported staff notified NP JJ of changes or diagnostic results via text 24 hours a day, every day. The DON reported staff always notified NP JJ via text and did not have an on-call system. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's policy titled Lab and Diagnostic Test Results - Clinical Protocol, dated 2001, revealed 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility . a. if staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure . 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 . Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: . whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison . Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification . If the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. A record review of the facility's policy titled Change in a Resident's Condition or Status, revised 02/2021, revealed Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . The nurse will notify the resident's attending physician or physician on call when there has been a (an): . significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; . g. need to transfer the resident to a hospital/treatment center . a significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff. The ADM, the DON, ADON D, ADON E, and the MDS Nurse were provided the IJ template on 4/10/2025 at 3:13 p.m. and notified that an Immediate Jeopardy situation had been identified due to the above failures. The plan of removal was approved on 4/12/2025 at 3:19 p.m. and reflected: Interventions: On 4/10/2025 at 7:00pm the DON; ADON D; ADON E immediately completed a change of condition assessment focusing on pain on each resident to determine if they are not at their baseline. Each resident was documented on the outcome of their assessment in their progress note in Point Click Care. For any residents that were found not to be at their baseline their physician was be notified and documented on. Any conditions noted after this immediate assessment, and it was found that the physician was not notified a re-education of physician notification will be completed. On 4/12/2025 either DON; ADON D; ADON E; and LVN CC; will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/10/2025 at 7:00pm the following in-services were initiated by the Chief Nursing Officer: Any nurse not present or in-serviced by 4/12/2025 by 12pm, will not be allowed to assume their duties until in-serviced. The ADM and human resources will ensure these team members are removed from the time clock and PCC access removed, this will be monitor until 100% complete or the team members are terminated. On going in-service will be completed by the DON; ADON D; ADON E until all staff, Weekend, and PRN are completed by 4/12/2025 at 12:00pm. Post Test will be completed to evaluate team members understanding of in-services covered. The passing score will be 80% - 100%. (See Post-test POR-1) The following in-services were immediately initiated by Chief Nursing Officer: Licensed Nurses: - Notifying physicians during a change of condition in a resident. (See Inservice 580-I1). - Physician on-call schedule (See Inservice 580-I2). - Process on what to do if a physician cannot be reached. (See Inservice 580-I3). - Comprehensive Pain Management Treatment Plan for each resident. (See Inservice 580-I4). The medical director was notified of the immediate jeopardy situation on 4/10/2025 by the DON. The Ombudsmen was notified of this Immediate Jeopardy situation on 4/10/2025 by the ADM. Monitoring as of 4/10/2025: On 4/11/2025 the Corporate Nurse immediately audited the 24-hour facility resident summary to determine if there were any changes of conditions focusing on pain that were noted, and the physician was notified. These findings were sent to the DON; ADON D; ADON E for follow-up. On 4/12/2025 the chief nursing officer reviewed the administrative nurse's follow-up to ensure follow-up happened and will do this daily for 7 days. DON; ADON D; ADON E will monitor daily resident's current electronic records for a change of condition utilizing the Point Click Care Clinical Dashboard which includes resident's Change of Condition, 24 Hour Resident Report, Progress notes, Incidents & Accidents, Weights & Vitals, and Diagnostic reports on all residents daily. To ensure accuracy DON; ADON D; ADON E will round the center and observe each resident every 12 hours looking for indications of pain or change of conditions, these rounds will be documented on the resident 24-hour report for the next 7 days. The ADM will monitor this process daily for the next 7 days. Monitoring of the plan of removal included: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observation and interview the facility failed to ensure all patient care equipment was in safe operating condition for three (Resident #1, Resident #2, and Resident #3) of eight residents reviewed for safe operating patient care equipment. 1. The facility failed to ensure Resident #3 had brakes on the foot of his bed. 2. The facility failed to ensure one brake on Resident #1's bed was able to lock. 3. The facility failed to ensure Resident #2's bed had a working remote control. These failures could place residents at risk of living in an unsafe and un-homelike environment. Findings included: 1. Record review of Resident #3's Annual MDS revealed Resident #3 was a [AGE] year-old male admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 12 (indicated mildly impaired cognition). Section I of the MDS revealed Resident #3 had diagnoses of muscle weakness, morbid obesity (overweight), and anxiety disorder. Record review of Resident #3's care plan with a revision date of 4/09/2025 revealed Resident #3 had limited mobility and required extensive assistance with bed mobility. 2. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 15 (indicated no cognitive impairment). Section GG of the assessment revealed Resident #1 was dependent on staff to provide all the effort when toileting, showering, and when changing positions from sitting to standing. Section I of the MDS indicated Resident #1 had diagnoses of a left tibia (shin bone) fracture, multiple sclerosis (a disease that affects the nervous system and causes muscle weakness), and lack of coordination. Record review of Resident #1's care plan with a revision date of 4/08/2025 revealed Resident #1 sustained a fracture to the lower left extremity (left leg) on 2/26/2025 and sustained an additional fracture to the right lower extremity (right leg) on 4/07/2025. Resident #1's care plan was updated on 4/08/2025 and indicated a mechanical lift should be used for transfers. 3. Record review of Resident #2's Annual MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Section C of the MDS assessment revealed a BIMs score of 12 (indicated mildly impaired cognition). Section I of the MDS revealed Resident #2 had diagnoses of muscle weakness, severe morbid obesity (overweight), and anxiety disorder. Record review of Resident #2's care plan with a revision date of 3/31/2025 revealed Resident #2 indicated she was a fall risk and had poor safety awareness. (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	04/14/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 4/09/2025 at 10:44 a.m., Resident #3 reported his bed did not work when he first admitted there a few weeks ago. Resident #3 stated the wheels on his bed did not lock. Resident #3 denied a history of falls and reported staff were aware that the brakes on his bed did not lock. Resident #3 stated he did not remember which staff knew that his brakes on his bed did not work. Observed bed easily moved and wheels rolled when minimal force was applied. In an interview and observation on 4/09/2025 at 11:04 a.m., Resident #1 reported her bed did not lock. Resident #1 stated she was unsure if staff knew her bed did not lock and denied any falls. Observed bed easily moved and wheels rolled when minimal force was applied. In an interview and observation on 4/10/2025 at 9:46 a.m., Resident #2 stated her remote control to her bed did not work. Observed Resident #2 press buttons on the bed remote, and the bed did not move except when Resident #2 pressed the button that indicated the bed would be lowered. When Resident #2 pressed that button, the head of the bed raised. Resident #2 stated staff were aware her bed did not work but was unsure who the staff were. In an interview and observation on 4/11/2025 at 10:30 a.m., the Maintenance Supervisor reported he was not aware of any issues with any beds, and if he had been then he would have fixed them. Observed the Maintenance Supervisor check Resident #3's bed, and the Maintenance Supervisor reported Resident #3's bed did not have locks on the wheels on the foot of the bed. The Maintenance Supervisor reported Resident #3's bed was not made to have brakes on the foot of the bed. Observed the Maintenance Supervisor move the foot of the bed with one hand. The Maintenance Supervisor reported he would change out the bed. The Maintenance Supervisor then went to Resident #1's room and checked the bed. The Maintenance Supervisor reported one brake on the foot of the bed would not lock and the other brake on the foot of the bed was not locked when he checked it. The Maintenance Supervisor reported he would change out the bed now since Resident #1 was at the hospital. The Maintenance Supervisor then went to Resident #2's room and checked the remote control for the bed. The Maintenance Supervisor pressed several buttons and checked the wires underneath the bed. The Maintenance Supervisor stated he was unable to fix the remote and would change out Resident #2's remote control to their bed. The Maintenance Supervisor stated he was responsible for monitoring the residents' bed and ensuring they worked properly. The Maintenance Supervisor stated the risk to the residents would be that the beds could move if the brakes did not work and that the residents would not be able to control their bed if the remotes did not work. The Maintenance Supervisor stated he expected staff to tell him when there were problems with equipment so he could fix them.