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	06/10/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plan development. The facility failed to ensure Resident #1's comprehensive care plan included a plan of care for ADLs. This failure could place residents at risk of not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. The findings included: Record review of the MDS dated [DATE] indicated Resident #1 was a 70-years-old female and was admitted on [DATE] with diagnoses including hypertension (elevated blood pressure), non-Alzheimer's dementia (a broad group of progressive brain disorders that cause cognitive decline severe enough to impact daily life, but are not caused by Alzheimer's disease), stroke, and muscle weakness. Resident #1 had BIMS score of 00/15, indicating her cognition was severely impaired. Section GG (Functional Abilities) reflected Resident #1 required partial/moderate assistance for personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, washing/drying face and hands (excludes baths, showers, and oral hygiene). Record review of Resident #1's care plan last reviewed 04/28/26 revealed there was no plan of care that identified measurable objectives, goals, interventions and time frames for ADLs. During an interview on 06/10/26 at 11:21 AM, the DON stated every resident should have a plan of care that reflected their likes, dislikes, everyday routine, and anything that affected the residents. She stated the absence of ADLs in the care plan diminished staff communication and knowledge of resident preferences. She stated it was the responsibility of the nursing staff, (charge nurses, ADON, MDS Coordinator nurse and DON) to update residents care plan. The DON stated that since the aides (CNAs) follow care plans to do their task, if the care was not care planned, the aides would not know what to do for the resident. During an interview on 06/10/26 at 12:02 PM, ADON A stated every resident should have a plan of care that reflected their needs, everyday routine, and anything that affected the residents. She stated the absence of ADLs in the care plan diminished staff communication and knowledge of resident preferences. She stated it was the responsibility of the nursing staff, (charge nurses, ADON, MDS Coordinator nurse and DON) to update residents care plan. The ADON stated the care plan was not updated if would place residents at risk of not receiving care and services to meet their needs. During an interview on 06/10/26 at 12:48 PM, the MDS nurse stated the residents' care plan update was the responsibility of all IDT (nurses, ADON, physical therapy, SW) according to their discipline. She stated the care plan was to be generated so everyone will know how to collectively care for the residents. The MDS nurse deflected questions regarding the missing plans or risk to residents. Record review of the facility policy titled Care Plans-Baseline) revised on March 2022 revealed: The base line care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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

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