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	10/10/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for five (Resident #13, Resident #39, Resident #49, Resident #70, and Resident #71) of twenty-seven residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light was in reach and accessible for Resident #13, Resident #39, Resident #49, Resident #70, and Resident #71. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Resident #13 Review of Resident #13's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13's pertinent diagnoses included paraplegia (paralysis of the legs and lower part of the body) and muscle weakness. Review of Resident #13's Quarterly MDS Assessment, dated 07/10/2024, reflected the resident had an intact cognition with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was dependent on staff for toileting hygiene, shower, dressing, and personal hygiene. Review of Resident #13's Comprehensive Care Plan, dated 08/27/2024, reflected the resident had an actual fall and the goal was the resident will resume usual activities without further incident. In an interview with Resident #13 on 10/08/2024 at 11:06 AM, Resident #13 stated she was looking for her call light earlier but was not able to find it. She said she had been waiting for somebody to come and give the call light to her. She said her call light should be secured beside her so she did not have to yell if she needed something. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN D on 10/08/2024 at 11:15 AM revealed LVN D was about to provide wound care to Resident #13. LVN D went inside the room and told the resident she would be cleaning her wound to her right heel. She picked-up the foam wedge that was on the floor. She did not notice the resident's call light was also on the floor. After the wound care, LVN D saw the call light, picked it up, and handed it over to Resident #13. She said the call light should be in a place accessible to the residents because the residents needed them to call the staff. LVN D said if the call lights were not within reach, the residents would not be able to call the staff and their needs would not be met. Resident # 39 Review of Resident #39's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #39 was diagnosed with muscle weakness and muscle spasm. Review of Resident #39's Comprehensive MDS Assessment, dated 08/27/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. Resident #39 was dependent on staff for toileting, shower, and personal hygiene. Review of Resident #39's Comprehensive Care Plan, dated 07/03/2024, reflected the resident had an actual fall last 04/03/2024 and the goal for the resident would resume usual activities without further incident. Observation and interview with Resident #39 on 10/08/2024 at 10:01 revealed the resident was in his bed awake. His call light was observed on the floor. When asked where his call light was, the resident looked for his call light and said he could not find it. Resident #49 Review of Resident #49's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #49 was diagnosed with dizziness and cerebrovascular disease (blood supply to the brain was interrupted). Review of Resident #49's Comprehensive MDS Assessment, dated 09/30/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 06. Resident #49 required moderate assistance in toileting, dressing, and personal hygiene. Review of Resident #49's Comprehensive Care Plan, dated 10/07/2024, reflected the resident had a risk for fall and one of the interventions was to be sure the call light was within reach. Observation and interview with Resident #49 on 10/08/2024 at 9:30 AM revealed the resident was in his bed, awake. It was observed that Resident #49's call light was on the floor. Resident #49 stated he was trying to look for his call light because he wanted to get up but cannot find it. He said he cannot even find the cord of his call light. He said several staff already went inside his room and did not notice his call light was on the floor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN A on 10/08/2024 at 10:06 AM, LVN A stated call lights should be with the residents all the time, because they use the call lights to call for help or assistance if needed. He said the residents used the call lights to communicate to the staff that they needed something. He added that if the call lights were not with the residents, the residents might fall trying to do things by themselves or get frustrated because they could not call the staff. He said all the staff were responsible in making sure the call lights were within reach of the residents. LVN A said the call light were for all residents, whether dependent or independent. LVN A went inside Resident #39's room, picked up the call light and placed it where the resident could reach it. LVN A then went to Resident #49's room, picked up the call light, and handed it to Resident #49. Resident #70 Review of Resident 70's Face Sheet, dated 10//08/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #70 was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side. Review of Resident #70's Comprehensive MDS Assessment, dated 08/16/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 02. Resident #70 required substantial assistance in transfer, bed mobility, shower, dressing and personal hygiene. Review of Resident #70's Comprehensive Care Plan, dated 08/29/2024, reflected the resident had an actual fall on 07/25/2024 and one of the goals was the resident will have no complications related to fall. Observation on 10/08/2024 at 9:16 AM revealed that Resident #70 was in his bed with eyes closed. His call light was observed to be on the floor under the bed. Observation and interview with Resident #70's 10/08/2024 at 12:34 PM revealed Resident #70 was still in his bed. His call light was still on the floor. The resident did not respond when asked if he had his call light. Resident #71 Review of Resident #71's Face Sheet, dated 10/10/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #71 was diagnosed with muscle weakness and lack of coordination. Review of Resident #71's Comprehensive MDS Assessment, dated 08/21/2024, reflected the resident had a severe cognitive impairment with a BIMS score of 00. Resident #71 required set-up assistance for eating, toileting, shower, and dressing. Review of Resident #71's Comprehensive Care Plan, dated 08/11/2024, reflected the resident had potential for falls and the goal was the resident will be free of minor injuries. Observation on 10/08/2024 at 9:20 AM revealed Resident #71 was sitting in his bed. It was observed that the resident's call light was on the floor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #71 on 10/08/2024 at 12:38 PM revealed the resident came back from lunch and went straight to his bed. His call light was still on the floor. The resident did not respond when asked if he had his call light. Observation and interview with CNA G on 10/08/2024 at 12:44 PM, CNA G stated the call light was accessible to the residents in case they needed something. She said the call lights were important because the resident use them to let the staff know that they need assistance. Without the call light, the needs of the resident will not be known. CNA G went inside Resident #70's room and tried to pull the call light from beneath the resident's bed. CNA G said the call light was stuck under the bed. CNA G looked for the remote, raised the bed, and pulled the call light from beneath the bed. CNA G then went to Resident #71's room, picked-up the call light from the floor, and clipped it on Resident #71's bed. In an interview with the Administrator on 10/10/2024 at 7:36 AM, the Administrator stated the call lights should not be on the floor because the residents needed them to call the staff. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should be make sure the call lights were within reach. The Administrator said he would coordinate with the DON regarding call lights and would constantly remind them that before leaving the room, make sure the call lights were with the resident. The Administrator concluded that they would re-educate the staff about privacy, monitor them closely weekly for four weeks and monthly thereafter. In an interview with the DON on 10/10/2024 at 8:12 AM, the DON stated call lights were important for the residents and they should be placed where the residents could access them without difficulty. The DON said the call lights were the residents' mode of communication so they could tell the staff they needed something. She said even if the residents seldom use them, the call lights should still be placed somewhere accessible. She said the call lights were for the dependent residents, as well for the independent residents. She said all the staff, from nurses, CNAs, therapy, housekeeping, and management, were responsible in ensuring that the call lights were within reach. The DON said the expectation was for the staff would be mindful that every time they leave the residents' room, the call lights were within reach. The DON said she would conduct an in-service and check-off about the call lights for all the staff of the facility. She said she would personally monitor that all the residents' call lights were within reach. Record review of facility's policy Call Lights: Accessibility and Timely Response revealed Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside . to allow residents to call for assistance . Policy Explanation and Compliance Guidelines . 5. Staff will ensure the call light is within reach of resident and secured.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to provide the right to personal privacy which includes accommodations during personal care for one (Resident #13) of thirteen residents reviewed for Privacy. The facility failed to ensure LVN D closed Resident #13's door while performing wound care. This failure could place the residents at risk of not having their personal privacy maintained during medical treatment. Findings included: Review of Resident #13's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13's pertinent diagnoses included paraplegia (paralysis of the legs and lower part of the body) and injury to Achilles tendon (connective tissue that connects the calf to the heel bone). Review of Resident #13's Quarterly MDS Assessment, dated 07/10/2024, reflected the resident had an intact cognition with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had an injury to Achilles tendon. Review of Resident #13's Care Plan, dated 08/27/2024, reflected the resident had potential for pressure ulcer development r/incontinence, obesity, limited mobility and paraplegia. Review of Resident #13's Physician Order, dated 10/03/2024, reflected STAGE 3 PRESSURE WOUND OF THE RIGHT, lateral HEEL full THICKNESS-clean with wound cleanser, pat dry apply Santyl calcium alginate, ABD pad and wrap with kerlix (white gauze dressing) every day shift for Wound care. Review of Resident #13's Physician Order, dated 10/03/2024, reflected Stage 2 pressure wound OF THE RIGHT, medial HEEL partial THICKNESS-clean with wound cleanser, pat dry apply skin prep ABD pad and wrap with kerlix every day shift for Wound care. Observation and interview with LVN D on 10/08/2024 at 11:15 AM revealed LVN D was about to provide wound care to Resident #13. LVN D said the resident had wounds to the medial and lateral aspect of the right heel. She said treatment to the outward wound would be Santyl and calcium alginate while treatment for the inner wound would be skin prep. LVN D went inside the room and told the resident she would be cleaning her wound to her right heel. She washed her hands, put on a pair of gloves, prepared the things needed for wound care, and then removed her gloves. She then took the overbed table from inside the room, sanitized it, put paper towels on top of it, and transferred the items for wound care on the overbed table. LVN D went back inside the room and placed the table at the end of the bed. She washed her hands and put on a pair of gloves. LVN D proceeded with wound care. LVN D did not close the door or pulled the privacy curtain while doing wound care. LVN D stated she forgot to close the door before she did wound care. She said the door should be closed every time wound treatment was done to provide privacy and give dignity to the resident. She said she would make sure she would close the door or pull the privacy curtain every time she would do wound care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #13 on 10/08/2024 at 11:31 AM, Resident #13 stated she did not notice the door was open during wound care. She said, not that I mind, but it would be decent if the door was closed if they were treating me. In an interview with the Administrator on 10/10/2024 at 7:36 AM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care to prevent embarrassment. He said the expectation was for the staff to close the door, not only during wound care, but during all care provided. He said he would collaborate with the DON to do an in-service about privacy during treatment. The Administrator concluded that they would re-educate the staff about privacy, monitor them closely weekly for four weeks and monthly thereafter. In an interview with the DON on 10/10/2024 at 8:12 AM, the DON stated the door should be closed or the privacy curtain should be drawn during wound care to provide privacy. She said providing privacy was true as well in the provision of any treatment to avoid other residents, staff, or visitors in seeing what treatment were being done to a particular resident or what the resident's wounds look like. The DON said all the staff, including her, were responsible in providing privacy to the residents. The DON said the expectation was for the staff to make sure that when they were providing care, the residents' door should be closed, or the privacy curtain should be pulled. She said she was made aware by LVN D about the issue and she already made a one-on-one in-service with LVN D. She said she would also do an in-service to all staff to continually remind the staff the importance of providing privacy and dignity through an in-service. Record review of facility's policy, Dignity 2001 MED-PASS, Inc. revised February 2021 revealed Policy Statement: Each resident shall be cared for a manner that promotes and enhances his or her sense of well-being feelings of self-worth and self-esteem . Policy implementation . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #13) of eight residents reviewed for Respiratory Care. The facility failed to ensure that Resident #13's BiPAP (Bilevel Positive Airway Pressure: machine used to deliver pressurized air through a mask to keep airways open) mask was stored properly. This failure could place the resident at risk for respiratory infection and not having her respiratory needs met. Findings included: Review of Resident #13's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13 was diagnosed with acute respiratory failure and obstructive sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep). Review of Resident #13's Quarterly MDS Assessment, dated 07/10/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #13's Quarterly MDS Assessment indicated the resident was on non-invasive mechanical ventilation. Review of Resident #13's Comprehensive Care Plan, dated 08/27/2024, reflected the resident was wearing Bi-pap r/t respiratory failure and sleep apnea and one of the interventions was use BiPAP as ordered. Review of Resident #13's Physician Order, dated 01/26/2024, reflected BIPAP ON AT 2100 (9PM) OFF AT 0900(9AM) Attach O2 @ 2 LPM via (through) BIPAP MACHINE two times a day. Observation and interview with Resident #13 on 10/08/2024 at 10:56 AM revealed resident was in her bed, awake. The resident had a BiPAP machine mounted on a mobile BIPAP stand. A full mask BiPAP mask was attached to the BiPAP machine. The mask was not bagged. Resident #13 stated the nurses were the one putting the mask on at night and taking it off in the morning. She said sometimes the nurses put it on a bag but sometimes they do not. She said she would put it on a bag if she could but she said her movements were limited. Observation and interview with LVN C on 10/10/2024 at 12:08 PM, LVN C stated Resident #13 was using a BiPAP at night. She said the BiPAP mask should not be exposed nor touching anything because it could cause cross contamination and respiratory infection. She went inside the room and saw the BiPAP mask was hanging beside the BiPAP machine and was not bagged. LVN C looked for a plastic bag, found one on top of the resident's left-side table, and put the mask inside the bag. She said she did not notice that the mask was not bagged when she made her morning round. LVN C said she would clean the BiPAP mask and put in a new plastic bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 10/10/2024 at 7:36 AM, the Administrator stated the mask for BiPAP should be bagged to prevent infection. He said he would coordinate with the DON on how to go forward about the issue of respiratory care. The Administrator concluded that they would re-educate the staff about privacy, monitor them closely weekly for four weeks and monthly thereafter. In an interview with the DON on 10/10/2024 at 8:12 AM, the DON stated the BiPAP mask should be bagged when not in use to keep it clean. She said if the BiPAP mask was exposed or touching surfaces that were not clean, there could be a probability of cross contamination, respiratory infection, and oxygen administration could be compromised. The DON said the staff taking it off should put it in a bag. She said the expectation was for the staff to be mindful in making sure that the BiPAP mask of the resident would be bagged when not in use. The DON said she would conduct an in-service and check-off about the respiratory care and would personally monitor if the staff were bagging BiPAP mask. She also said the policy only stated to bag the nasal cannula but the policy also applied to the BiPAP mask. Record review of facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection MED-PASS, Inc. revised November 2011 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy . Steps . 8. Keep the oxygen cannula and tubing . in a plastic bag when not in use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for eight (Resident #10, Resident #13, Resident #44, Resident #49, Resident #56, Resident #61, Resident #80, and Resident #84) of eighteen residents observed for Infection Control. 1. The facility failed to ensure that CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #49. 2. The facility failed to ensure that CNA E changed her gloves and performed hand hygiene while providing incontinent care to Resident #80. 3. The facility failed to ensure that LVN B sanitized the blood pressure cuff in between Resident #44, Resident #56, Resident #61, and Resident #84. 4. The facility failed to ensure that LVN C sanitized the blood pressure cuff in between Resident #10 and Resident #13. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #49's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #49 was diagnosed with cerebrovascular disease (blood supply to the brain was interrupted) and kidney failure. Review of Resident #49's Comprehensive MDS Assessment, dated 09/30/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 06. The Quarterly MDS Assessment indicated the resident was always incontinent for bladder and bowel. Review of Resident #49's Comprehensive Care Plan, dated 10/07/2024, reflected Resident #49 was incontinent for bladder and bowel r/t kidney failure and one of the interventions was clean peri-area with each incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with CNA D on 10/08/2024 at 9:39 AM revealed CNA D was about to provide incontinent care to Resident #49. CNA D raise the bed and lowered the head of the bed. She washed her hands, put on a pair of gloves, put a brief on the resident's right-side table, and positioned the wipes beside the resident. She reached for the trash can and placed it near her. She did not change her gloves after touching the trash can. CNA D unfastened the brief on both sides and pushed the front part of the brief between the legs of the resident. CNA D pulled some wipes and started to clean the front part of the resident. She did it four times. CNA D rolled the resident towards the wall and cleaned the bottom of the resident. After cleaning the resident's bottom, CNA D rolled the soiled brief and the bed padding altogether towards the middle of the bed, pulled them, and put them in the trash can. After putting the soiled brief and padding on top of the trash can, CNA D took the new brief and put it at the bottom of the resident and fixed it. CNA D did not change her gloves nor sanitize her hands before touching the new brief. CNA D rolled the resident back, fixed the new brief, and taped the brief on both sides. CNA D went to the bathroom and washed her hands. CNA D stated she washed her hands before and after doing incontinent care. She said she did roll the soiled brief and padding altogether and put it on top of the trash can. CNA D said she did not change her gloves nor did hand hygiene before touching the new brief. She said she should have changed her gloves after pulling the soiled brief and padding because her gloves were considered soiled after they came in contact with the soiled brief. She also said she should have changed her gloves after touching the trash can. She said not doing hand hygiene and not changing the gloves could cause transfer of contaminants from dirty to clean. She said cross contamination could eventually cause infection. She said she had an in-service for hand hygiene and incontinent care but still forgot to do the right procedure. 2. Review of Resident #80's Face Sheet, dated 10/08/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #80 was diagnosed with muscle weakness and kidney failure. Review of Resident #80's Quarterly MDS Assessment, dated 10/02/2024, reflected the resident was cognitively intact with a BIMS score of 15. Resident #80's Quarterly MDS Assessment indicated the resident was incontinent for bowel and bladder. Review of Resident #80's Comprehensive Care Plan, dated 07/13/2024, reflected the resident was incontinent of bowel and bladder r/t kidney failure and one of the interventions was clean peri-area with each incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with CNA E on 10/08/2024 at 2:43 PM revealed CNA E was about to provide incontinent care to Resident #80. After letting the resident know that she would change her, CNA E started to prepare the items needed for incontinent care. She put on a pair of gloves, opened a brief and put it on the side of the resident's pillow, and put the wipes near the brief. CNA E pulled the hospital gown of the resident up, unfastened the brief on both sides, and pushed the brief on both sides. CNA E pulled some wipes and cleaned the resident from front to back. After cleaning the front part of the resident, the resident was instructed to roll to her left side. CNA E cleaned the bottom of the resident, pulled the soiled brief, and threw it on the trash can. CNA E grabbed the brief near the resident's head, put it under the resident, and fixed it. CNA E took did not change her gloves after pulling the soiled brief or before touching the new brief. After fixing the brief, CNA E lowered the resident's gown and pulled up the light blanket up to the resident's chest. She did not wash her hands after incontinent care. CNA E stated she should do hand hygiene before and after doing incontinent care for a resident. She said she was not aware that she did not wash her hands before and after cleaning Resident #80. She said she should have changed her gloves after cleaning the bottom of the resident because her gloves were already dirty. She said she was not aware she needed to sanitize her hands in between changing of the gloves. She said, if it was mandatory to sanitize her hands when she changed her gloves, she would do it. She said they had in-services and check-off about hand hygiene but cannot recall about sanitizing in between changing the gloves. 3. Review of Resident 61's Face Sheet, dated 10/09/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #61 was diagnosed with hypertension. Review of Resident #61's Quarterly MDS Assessment, dated 07/16/2024, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated hypertension as one of Resident #61's active diagnosis. Review of Resident #61's Comprehensive Care Plan, dated 09/09/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #61's Physician's Order for amlodipine, dated 07/23/2024, reflected Amlodipine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN HOLD IF SBP <100 OR HR <60. Review of Resident #61's Physician's Order for lisinopril, dated 07/23/2024, reflected Lisinopril Tablet 20 MG. Give 1 tablet by mouth one time a day for HTN. Hold if SBP < 100 or DBP < 60. Observation on 10/09/2024 at 7:07 AM revealed LVN B was preparing Resident #61's medication. He picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #61's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #61. He did not sanitize the blood pressure cuff. Review of Resident 84's Face Sheet, dated 10/09/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #61 was diagnosed with hypertension. (continued on next page)

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	675447	A. Building B. Wing	10/10/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #84's Quarterly MDS Assessment, dated 09/27/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated hypertension as one of Resident #84's active diagnosis. Review of Resident #84's Comprehensive Care Plan, dated 09/30/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #84's Physician's Order for lisinopril, dated 09/30/2024, reflected Lisinopril Oral Tablet 10 MG (Lisinopril). Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if SBP <110 or DBP <60. Observation on 10/09/2024 at 7:15 AM revealed LVN B was preparing Resident #84's medication. He picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #84's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #84. He did not sanitize the blood pressure cuff. The cuff was the same one used on the previous resident(s) which was not sanitized. Review of Resident 56's Face Sheet, dated 10/09/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #56 was diagnosed with hypertension. Review of Resident #56's Quarterly MDS Assessment, dated 09/30/2024, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated hypertension as one of Resident #56's active diagnosis. Review of Resident #56's Comprehensive Care Plan, dated 09/30/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #56's Physician's Order for amlodipine, dated 10/01/2024, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if SBP <100 or DBP <60. Review of Resident #56's Physician's Order for metoprolol, dated 10/01/2024, reflected Metoprolol Succinate ER Tablet Extended Release 24 Hour 100 MG. Give 1 tablet by mouth one time a day for HTN Hold for SBP <100, DBP <60, or HR <60. Observation on 10/09/2024 at 7:59 AM revealed LVN B was preparing Resident #56's medication. He picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #56's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart. He said the resident's blood pressure was low so he would re-check Resident #56's blood pressure before the resident go to her appointment. He did not sanitize the blood pressure cuff. The cuff was the same one used on the previous resident(s) which was not sanitized. Review of Resident 44's Face Sheet, dated 10/09/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #44 was diagnosed with hypertensive heart disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's Quarterly MDS Assessment, dated 09/30/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated hypertension as one of Resident #44's active diagnosis. Review of Resident #44's Comprehensive Care Plan, dated 08/09/2024, reflected the resident had hypertension (HTN) r/t hypertensive heart disease and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #44's Physician's Order for tadalafil, dated 07/27/2024, reflected Tadalafil Oral Tablet 20 MG (Tadalafil). Give 2 tablet by mouth one time a day for Hypertension Hold if SBP <100 or DBP <60. Observation and interview with LVN B on 10/09/2024 at 7:59 AM revealed LVN B was preparing Resident #44's medication. He picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #44's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #44. He did not sanitize the blood pressure cuff. The cuff was the same one used on the previous resident(s) which was not sanitized. LVN B stated he obtained the blood pressure of the residents before giving the medication for hypertension to know if the medication needed to be held or not. LVN B said he sanitized his hands after he gave the medications of a resident. LVN B said the blood pressure cuff should be sanitized as well after using it or before using it on another resident. LVN B said he forgot to sanitize the blood pressure cuff in between residents when he passed the medications. LVN B stated not sanitizing the blood pressure cuff in between residents could cause infection to transfer from one resident to another. LVN B added if a resident already had an infection, that infection could be transferred to another resident because the reusable item was not sanitized. He said he would make sure that he sanitized the blood pressure cuff everytime he would use it. 4. Review of Resident 13's Face Sheet, dated 10/08/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #13 was diagnosed with hypertension. Review of Resident #13's Quarterly MDS Assessment, dated 09/30/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated hypertension as one of Resident #13's active diagnosis. Review of Resident #13's Comprehensive Care Plan, dated 08/27/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #13's Physician's Order for amlodipine, dated 10/01/2024, reflected Amlodipine Besylate Tablet 10 MG. Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold if SBP <100 or DBP <60. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/09/2024 at 8:25 AM revealed LVN C was preparing Resident #13's medication. She picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #13's arm. After the blood pressure reading was completed, LVN C placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #13. She did not sanitize the blood pressure cuff. The cuff was the same one used on the previous resident(s) which was not sanitized. It was observed that a container of sanitizer was on top of the nurse's cart, beside a laptop. Review of Resident 10's Face Sheet, dated 10/09/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #10 was diagnosed with hypertension. Review of Resident #10's Quarterly MDS Assessment, dated 09/17/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated hypertension as one of Resident #10's active diagnosis. Review of Resident #10's Comprehensive Care Plan, dated 09/17/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #10's Physician's Order for lisinopril, dated 09/17/2024, reflected Lisinopril Oral Tablet 20 MG (Lisinopril). Give 1 tablet by mouth one time a day for hypertension related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD SBP LESS THAN110 DBP LESS THAN 60. Observation and interview with LVN C on 10/09/2024 at 8:57 AM revealed LVN C was preparing Resident #10's medication. She picked up the blood pressure cuff from the medication cart, went inside the resident's room, and placed the blood pressure cuff on Resident #10's arm. After the blood pressure reading was completed, LVN C placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #10. She did not sanitize the blood pressure cuff.This was the same one used on the previous resident(s) which was not sanitized. LVN C stated she forgot to sanitize the blood pressure cuff after using it for Resident #13 and before using it for Resident #10. She said the blood pressure cuff should be sanitized after using it or before using it to another resident to prevent cross contamination and infection. In an interview with the Administrator on 10/10/2024 at 7:36 AM, the Administrator stated not washing the hands nor sanitizing them could contribute to cross contamination. He said not changing the gloves after touching soiled items could contribute to the development of infection as well. He said if the blood pressure cuff was used for a resident, it should be sanitized before using it to another resident to prevent transfer of germs. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said he would collaborate with the DON to in-service the staff about infection control. The Administrator concluded that they would re-educate the staff about privacy, monitor them closely weekly for four weeks and monthly thereafter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 10/10/2024 at 8:12 AM, the DON stated she always do in-services for infection control, hand washing, and infection control. She said the hands should be washed before and after incontinent care, or any care for that matter. She said gloves should be changed after touching any soiled items, like the trash can and the soiled brief. She said gloves should be changed after cleaning the resident's bottom. She said hands should be sanitized in between changing of gloves. She said the blood pressure cuff should be sanitized after every use. She said not washing the hands, not sanitizing the hands, not changing the gloves after touching soiled items, and not sanitizing the blood pressure cuff after each use could result to cross contamination and infection. She said the expectation was for the staff to be mindful in following the procedures pertaining to infection control. The DON said she would do a one-on-one in-service with the concerned staff and then would do an in-service about infection control for all the staff. She concluded that he would continually remind the staff to be attentive to the procedures for infection control and that she would personally monitor infection control. Review of facility policy, Perineal Care Nursing Policy and Procedure Manual for Long-Term Care rev. February 2018 revealed Purpose: the purpose of this procedure are to provide cleanliness . to prevent infection . Steps in the procedure . 2. Wash and dry hands thoroughly . 7. Put on gloves . 8. Female resident . e. Wash rectal area . Male resident . e. Wash rectal area . 10. Remove gloves . 11. Wash and dry hands . 12. Make resident comfortable . 16. Wash and dry hands thoroughly. Record review of facility policy Routine Cleaning and Disinfection Centers of Disease Control updated July 2019 revealed It is the policy of this facility to ensure the provision of routine cleaning and disinfection . c. Clean and disinfect any equipment that enters the room before use in another. Review of facility policy Hand Washing/Hand Hygiene Nursing Policy and Procedure Manual for Long-Term Care rev. August 2019 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 2. All personnel shall follow the hand-washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . b. Before and after direct contact with residents . After contact with a resident's intact skin . j. After contact with blood or bodily fluids . m. After removing gloves.