

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/30/2025
NAME OF PROVIDER OR SUPPLIER The Highlands Guest Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to be treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #38) reviewed for respect and dignity in that: The facility failed to ensure RN A provided privacy by leaving the door open and not pulling privacy curtain, exposing Resident #38's abdomen while administering the medications through gastroenterology tube (feeding tube). This failure could place residents at risk of emotional distress and low self-esteem. Findings included: Record review of Resident #38's significant change MDS assessment, dated 12/19/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included: Cancer (destroying tissue), multiple sclerosis (neuromuscular disease), aphasia (unable to speak), dysphagia (unable to swallow), and hypertension (high blood pressure). Resident #38 was cognitive impaired and unable to make decisions and required assistance from one staff for activities of daily living. Record review of Resident #38's physician orders dated 10/29/2025 reflected, all medications are to be given by the feeding tube. Record review of Resident #38's care plan dated 09/28/2025 reflected that the resident had problems with swallowing from Multiple Sclerosis and required receiving medications through the feeding tube to maintain nutritional status. An observation on 12/29/2025 at 12:23 p.m., revealed RN A entered room of Resident #38 while she was in her bed. RN A did not close the door or pull the privacy curtain of Resident #38's room during the entire process of administering medications through her feeding tube. Resident #38's abdomen was visible to the hallway and to her roommate, who was in the room eating her lunch. Further observation revealed the floor technician outside of the room in the hallway cleaning the floors and a CNA wheeling a male resident down the hallway to his room after eating his meal. In an interview on 12/28/2025 at 1:15 p.m., RN A revealed she forgot to close the door or pull the privacy curtain. RN A stated she did guess she was more nervous than she thought and did not think about it, until she had completed her task. When asked about the training she received on resident's rights, RN A stated, by not closing the door and the curtain, the privacy and dignity of Resident #38 was compromised as the roommate could see her abdomen and anyone who passed by the room could see the abdomen of the resident. RN A was fully aware of resident rights to have privacy, dignity, and respect and received in-service on resident's rights at least once a year. In an interview on 12/29/2025 at 7:45 a.m., Administrator revealed that the nursing staff should always provide privacy when providing care to the residents. The Administrator stated that it means shutting the door and closing the blinds in the room and pulling the privacy curtain. In an interview on 12/29/2025 at 9:15 am Resident #38 revealed the staff usually does close the door and close the curtain. Resident #38 stated RN A had told her she was nervous because the surveyor was in the room with her. Resident #38 stated she liked RN A and she always talks to her and she is very nice and helps her, but she would have liked the door to be closed and the curtain pulled. In an interview on 12/29/2025 at 9:30 a.m. the roommate, Resident #68, revealed that Resident #68 never looked when they were taking of her roommate, and they almost always pulled the curtain, and closed the door. (continued on next page)		

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

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

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #68 stated her biggest concern was getting past the curtain and opening the door when she wanted to leave the room. During an interview on 12/30/2025 at 11:51 a.m., the DON stated privacy and dignity must be provided during nursing care and the door and privacy curtain to Resident #38's room should have been closed completely and the curtain pulled by RN A. He said the training was an ongoing process and resident rights was one of them. The DON stated the facility ensured all the new hires had gone through skill checks. Every nursing staff member also had to complete an annual evaluation to ensure their nursing skills and knowledge including competency in respecting residents' rights. Review of facility's policy Resident Rights revised dated February 2021, reflected: It is the policy of this facility that all residents be treated with kindness, respect, and dignity Policy Interpretation and Implementation. a, a dignified existence. b. be treated with respect, kindness, and dignity.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to post the daily nurse staffing information with the current date, resident census, and numbers of staff actual hours worked at the beginning of each shift for 1 of 1 facility reviewed for nurse staffing. The facility failed to update and post the daily nurse staffing information from 12/27/2025-12/28/2025. This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding the numbers of staff caring for the residents each shift and the facility census. The findings included: During an observation on 12/28/25 at 9:00 a.m., the daily staffing posting was hanging at the receptionist desk dated 12/26/2025. During an interview on 12/29/2025 at 10:42 a.m., the Staffing Coordinator stated that she created the staff posting on Friday and placed it in the 24-hour turnover binder for the Weekend Supervisor to post on weekends. The Staffing Coordinator said the night shift nurses completed the daily staffing posting. Record review of the 24-hour turnover binder revealed there was daily staff posting for 12/27/25 and 12/28/25. During an interview on 12/30/25 at 11:45 a.m., the DON stated that the Staffing Coordinator was responsible for filling out the facility's daily posting. The Weekend Supervisor was in charge to put up the staff posting on Saturday and Sunday. The DON was not aware that the staff posting had not been posted. The DON stated that the purpose of the daily staff posting was for the transparency of the facility to family members. The DON said the staff posting informs each family member how many staff members are assigned each shift to provide care for their loved one. The DON stated the negative effect of not posting would be that visitors would not have the nursing staff hours for that day. During an attempted interview on 12/30/2025 at 11:55 a.m., the Weekend Supervisor did not answer the phone. Record review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised August 2022, indicated, Our facility will post on a daily basis for each shift staffing data, including the number of nursing personnel responsible for providing direct care to residents. 1. Within two hours of the beginning of each shift, the number of licensed nurses (RN, LPNs, LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in clear and readable format.		