

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	

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. (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames that met the residents clinical and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #14) out of 5 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure that Resident #14's Comprehensive Care Plan included the following:1. The facility failed to ensure that Resident #14's Comprehensive Care Plan included physician orders for hip precautions.2. The facility failed to ensure that Resident #14's Comprehensive Care Plan included physician orders for her toe-touch weight bearing status.3. The facility failed to ensure that Resident 14's Comprehensive Care Plan included physician orders for Full Code Advanced Status. These failures could place residents at risk of having received inadequate interventions not individualized to their care needs and diagnoses. Findings Included:Record review of Resident #14's admission face sheet dated 10/06/25 reflected she was an [AGE] year-old female was originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: aftercare following joint replacement surgery, pain in right hip, aftercare following explanation of hip joint prosthesis, and inflammatory reaction due to internal right hip prosthesis with subsequent encounters effusion of the right hip, generalized muscle weakness, chronic pain syndrome, and abnormalities of gait and mobility, lack of coordination, and COPD (a group of lung diseases that cause ongoing airflow obstruction and breathing difficulties). Record review of Resident #14's readmission MDS assessment dated [DATE], reflected a BIMS score of 15 indicating that her memory was cognitively intact. Resident #14's MDS Assessment reflected that she had an impairment on one side of her lower extremity (hip, knee, ankle, foot). Resident #14 required assistance with her ADL's for eating (Setup or clean-up assistance), Oral Hygiene (Supervision or touching assistance), Shower/bath (Substantial/maximal assistance), Upper body dressing (Supervision or touching assistance), Lower body dressing (Substantial/maximal assistance), Putting on/taking off footwear (Substantial/maximal assistance), Roll left and right (Substantial/maximal assistance), Sit to lying (Substantial/maximal assistance), Lying to sitting on side of bed (Substantial/maximal assistance). Resident #14 Urinary and Bowel Continence was always incontinent. Resident #14 had active diagnoses of Other Orthopedic Conditions. Resident #14's Pain Assessment Interview revealed that she had frequent pain or hurting with occasional pain during sleep. Record review of Resident #14's Care Plan dated 09/16/2025 reflected, Special Instructions: Max assist x 2 with transfers Problem: The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t Physical Limitationsdaily routine needs.Date Initiated: 09/18/2025Revision on: 09/18/2025 Goals: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date.Date Initiated: 09/18/2025Target Date: 09/24/2025 Interventions: Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals.Date Initiated: 09/18/2025 Invite the resident to scheduled activities.Date Initiated: 09/18/2025 Provide with activities calendar. Notify resident of any changes to the calendar of activities.Date Initiated: 09/18/2025 Thank resident for attendance at activity function.Date Initiated: 09/18/2025. Record review of Resident #14's Care Plan reflected no information regarding Advanced Directives. Record review of Resident #14's Discharge from the hospital dated 09/16/2025 reflected, TTWB, Partial Weight Bearing, Physical Therapy and Occupational Therapy. Record review of Resident #14's Physician Orders reflected an Active Phone Order on 09/16/2025 of Full Code. Record review of the facility's Admission/Discharge Report for 4/6/2025 to 10/6/2025, revealed that Resident #14 was originally admitted to the facility from an acute care hospital on [DATE]. Resident #14 was discharged from the facility to an acute care hospital on [DATE]. Resident #14 was readmitted to the facility from an acute care hospital on [DATE]. In an interview and Observation of Resident #14 on 10/06/25 at 11:14 AM, revealed that she was alert and oriented and lying in bed. Resident #14 stated that she had been a resident at the facility for 3 weeks. Resident #14 stated that she was originally admitted to the facility after having surgery on her left hip. Resident #14 stated that she was originally admitted to the facility sometime during the first week of September 2025. She stated that during her 1st stay at the facility, she had been at the facility about 1 week and was in pain and told the staff that she needed to go to the hospital because she was in a lot of pain. Resident #14 stated that she informed staff that she was in pain and they notified her physician who told the staff to have her sent to the ER because of her pain. Resident #14 stated that she had</p>		