| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676315 | A. Building<br>B. Wing | 02/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Hillcrest of North Dallas | 18648 Hillcrest Rd<br>Dallas, TX 75252 |

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) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152<br><br>Based on observation, interview and record review the facility failed to treat each resident with respect, 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 two (Residents #1 and #2) of thirteen residents reviewed for dignity.<br><br>LVN A failed to maintain Resident #1 and #2's dignity and respect by standing between the residents while feeding both of them.<br><br>The failure could negatively affect the mental and psychological well-being of all residents who required the assistance of staff with eating.<br><br>The findings were:<br><br>Record review of Resident #1's face sheet dated 02/28/2024 reflected, she was an [AGE] year-old female initially admitted to the facility on [DATE] with primary diagnosis of Alzheimer's disease with early onset (most common type of dementia), lack of coordination, dysphasia (language disorder marked by deficiency in the generation of speech), and cognitive communication deficit (difficulty thinking and how someone uses language).<br><br>Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS of 99, which indicated she was not able to complete the interview. Staff assessment for mental status indicated short and long-term memory problem. Functional abilities indicated she was dependent on staff for eating.<br><br>Record review Resident #1's care plan dated 12/16/2023 reflected a potential for nutritional problem/unavoidable weight loss due to on hospice care/end of life, dx of Alzheimer's. Interventions: Invite the resident to activities that promote additional intake, monitor/document/report to MD PRN for s/sx of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat .<br><br>Record review of Resident #2's face sheet dated 02/28/2024 reflected, she was an [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses of coronary artery disease (plaque buildup in arteries impacting blood flow to the heart), hypertension (high blood pressure), hyperlipidemia (elevated level of lipids in blood), aphasia (loss of ability of understand or express speech), and dementia (loss of cognitive functioning impacting daily life and activities).<br><br>(continued on next page) |



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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS of 4, which indicated severely impaired cognition. Functional abilities indicated she was partially/moderately dependent on staff for eating.<br><br>Record review Resident #2's care plan dated 12/16/2023 reflected an ADL Self Care Performance Deficit r/t pain. Interventions: requires limited 1 person assistance with meals.<br><br>An observation on 02/28/2024 at 9:40 AM, revealed LVN A assisting Residents #1 and #2 to eat in the Main Dining room. LVN A stood between the two residents and alternately fed them from their respective plates of food.<br><br>An interview on 02/28/2024 at 2:00 PM, with Resident #1 revealed she was treated well. She was not able to recall if LVN A was standing while feeding her but preferred her to be seated.<br><br>An attempted interview on 02/28/2024 at 2:05 PM, with Resident #2 revealed she was not interviewable and did not answer questions.<br><br>In an interview on 02/28/2024 at 9:55 AM, LVN A stated she had worked in the facility for seven years and knew she should have been sitting when assisting Residents #1 and #2 to eat. She said she did not know why she was standing but should have known better because residents had a right to her full attention when she assisted them. She said not doing so was a dignity concern.<br><br>In an interview on 02/28/2024 at 10:04 AM, the DON stated staff should be sitting next to residents when assisting them to eat. He said this respected their dignity by promoting a respectful environment. He said staff needed to be mindful of resident's dignity. He said staff were in serviced on resident rights and dignity but did not recall when the last in-service was.<br><br>In an interview on 02/28/2024 at 11:39 AM, the ADON stated he expected staff to be seated next to residents while assisting them to eat. He said they needed to be sure they paid attention to the residents to ensure their needs were met while eating. He said staff had been in serviced on resident dignity and the last time was about four months ago.<br><br>In a telephone interview on 02/28/2024 at 2:24 PM, the Administrator said LVN A should have known better. He said standing while assisting residents to eat was inexcusable and compromised the resident's dignity. He said staff needed to be seated and provide eye contact with the residents they were assisting to eat.<br><br>Record review of the facility's policy titled, Resident Rights, revised 08/2020, reflected, All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident 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, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's policy titled, Privacy and Dignity, revised 06/2020, reflected, To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity, and overall quality of life . V. The Facility promotes independence and dignity in dining . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152<br><br>Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #3) of thirteen residents reviewed for accidents.<br><br>CNA B failed to have assistance from another staff member when transferring Resident #3 via a mechanical lift.<br><br>This failure place residents at risk for accidents and injuries.<br><br>Findings included:<br><br>Review of Resident #3's face sheet, dated 02/28/2024, reflected a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included transient cerebral ischemic attack (blood clot blocks the blood supply to part of the brain), dysphasia (impairment in the production of speech), need for assistance with personal care, and hyperlipidemia (an elevated level of lipids in the blood).<br><br>Review of Resident #3's quarterly MDS assessment, dated 11/05/2023, reflected a BIMS score of 3 indicating a severe cognitive deficit. Resident #3 required substantial/maximal assistance for bed to chair transfers. The MDS did not indicate the use of a mechanical lift.<br><br>Review of Resident #3's care plan, dated 12/07/2023, reflected, an ADL Self Care Performance Deficit r/t Stroke. Interventions: Requires limited 1-2-person assistance with transfers. Bed Mobility: requires extensive 2-person assistance to reposition and turn in bed. The use of a mechanical lift was not care planned.<br><br>An observation on 02/28/2024 at 11:36 AM, revealed CNA B exit Resident #3's room with a mechanical lift. No other staff was observed in the room.<br><br>In an interview on 02/28/2024 at 11:39 AM, the ADON said he also observed CNA B exit Resident #3's room with the mechanical lift. He said he did not see any other staff enter or exit the room and when he asked CNA B who assisted her with lifting Resident #3, CNA B told him she used the mechanical lift on her own. He stated CNA B told him she was weighing Resident #3 and lifted Resident #3 from her bed to a wheelchair to do so. He said Resident #3 was a 1-2 person assist for transfers and did not need a mechanical lift for transfer. He stated any mechanical lifts should be done with two people to ensure safety of the resident and prevent accidents. He stated staff were recently in serviced on using mechanical lifts.<br><br>In an interview on 02/28/2024 at 11:43 AM, CNA B said she did transfer Resident #3 form her bed to a wheelchair, by herself, using a mechanical lift. She stated Resident #3 did not require a mechanical lift but because Resident #3 told her she was in pain, CNA B said she decided to use the mechanical lift. She said she knew mechanical lifts required two staff to operate safely. She said she had received training on how to safely operate mechanical lifts but did not remember when.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An attempted interview on 02/28/2024 at 11:55 AM, with Resident #3 revealed she was not able to answer questions.<br><br>An interview on 02/28/2024 at 11:55 AM, with Resident #3's roommate revealed CNA B did use the mechanical lift to lift Resident #3 from her bed to her wheelchair. She said there was no other staff in the room.<br><br>In an interview on 02/28/2024 at 12:30 PM, the DON stated Resident #3 did not require a mechanical lift and was not sure why CNA B used one. He stated two staff were required to operate a mechanical lift to ensure the safety of residents.<br><br>In a telephone interview on 02/28/2024 at 2:24 PM, the administrator stated two staff were required to transfer anyone with a mechanical lift to ensure the safety of residents.<br><br>Record review of the facility's in-service training, titled, Total transfers, Lifts, Sit-to Stand, reflected the ADON present the in-service on 02/02/2024.<br><br>Record review of the facility's policy titled, Transfer, revised 06/2020, reflected, .VII. Mechanical Lift Transfer: . Safe and secure mechanical lift transfers may require the help on one, two, or three caregivers depending on the resident's condition . B. Be aware of and follow the manufacturer's recommendations for the particular lift being used. |