STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676315	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hillcrest of North Dallas	18648 Hillcrest Rd 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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on interview and record review the facility failed to have physician orders for the resident's immediate care, at the time each resident was admitted for one (Resident #1) of one resident reviewed for admission physician orders. The facility failed to have Physician orders to provide wound care for Resident #1 who admitted on [DATE] until five days later on 03/27/24. This failure could place residents at risk for delayed wound healing and wound infection. Findings included: Review of Resident #1's undated admission record dated 03/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (Reduced circulation of blood to a body part due to a narrowed or blocked blood vessel.) and osteomyelitis (Bone infection). Review of the Resident #1's nursing admission assessment dated [DATE] revealed the resident was alert, cognitively intact, occasionally incontinent of bowel/bladder and admitted with a surgical wound to the right foot. Review of Resident #1's baseline care plan dated 03/24/24 revealed the surgical wound was identified but no interventions were listed to include wound care. Review of hospital discharge orders dated 03/21/24 revealed wound care orders for a wound vac changed three times a week. (Vacuum-Assisted Closure (VAC) is a method of decreasing air pressure around a wound to assist the healing). Review of Resident #1's physician orders dated 03/2024 revealed there was no wound care order until 03/27/24. The order dated 03/27/24 reflected, change wound vac (Vacuum-Assisted Closure (VAC) is a method of decreasing air pressure around a wound to assist the healing) to right foot/toe wound on Monday, Wednesday, and Friday. An additional physician's order dated 03/27/24 reflected a wet-to-dry dressing could be used until the wound vac was in place. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 03/27/24 at 1:12 p.m. she stated she completed the physical admission assessment for Resident #1 and another nurse (LVN D) put the hospital admission orders in the computer. She was not aware the other nurse had not put the wound care orders in the computer. Attempts to interview LVN D were unsuccessful. Interview with the DON on 03/27/24 at 4:00 p.m. he stated he had transcribed Resident #1's wound care orders into the electronic health record on 03/27/24 because he did not see any orders for wound care until after surveyor intervention on 03/27/24. He stated the ADON was responsible for completing an audit to ensure all admission orders were put into the electronic health record. The DON stated he reviewed Resident #1's admission records over the past weekend but did not notice there were no wound care orders. Interview with the DON on 03/28/24 at 4:26 p.m. he stated the facility's system was for the IDT of which he was a member of to review new admission records to ensure all admission forms, assessments and orders were in place. He stated they (the IDT) failed to follow the system to ensure admission orders were in place for Resident #1. IDT-Interdisciplinary Team-a group of different health care disciplines to help people receive the care they need). Review of the facility's P/P entitled Admission and Orientation of Residents dated revised 10/24/22 revealed the purpose was to facilitate the admission process of residents while ensuring that residents and responsible parties were properly oriented to the facility. The P/P reflected upon accepting a resident for admission, the resident's attending Physician would provide the following information to the Admissions Office: A. An order for skilled nursing care. B. The type of diet the resident requires. C. Medication orders, including a medical condition or problem associated with each medication; and D. Routine care orders to maintain or improve the resident's function. E. The Admissions Office will forward this information to the Director of Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on observation, interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest, practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one (Resident #1) of four residents reviewed for wound care. The facility failed to ensure Resident #1's physician ordered wound care was provided on 03/25/24 and 03/26/24. This failure could place residents at risk for delayed wound healing and wound infection. Findings Included: Review of Resident #1's undated admission record dated 03/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (Reduced circulation of blood to a body part due to a narrowed or blocked blood vessel.) and osteomyelitis (Bone infection). Review of the Resident #1's nursing admission assessment dated [DATE] revealed the resident was alert, cognitively intact, occasionally incontinent of bowel/bladder and admitted with a surgical wound to the right foot. Review of Resident #1's baseline care plan dated 03/24/24 revealed the surgical wound was identified but no interventions were listed to include wound care. Review of hospital discharge orders dated 03/21/24 revealed wound care orders for a wound vac changed three times a week. (Vacuum-Assisted Closure (VAC) is a method of decreasing air pressure around a wound to assist the healing). Review of Resident #1's physician orders dated 03/2024 revealed there was no wound care order until 03/27/24. The order dated 03/27/24 reflected, change wound vac (Vacuum-Assisted Closure (VAC) is a method of decreasing air pressure around a wound to assist the healing) to right foot/toe wound on Monday, Wednesday, and Friday. An additional physician's order dated 03/27/24 reflected a wet-to-dry dressing could be used until the wound vac was in place. Review of Resident #1's TARS dated 03/2024 revealed no documentation that wound care had been provided on 03/25/24 or 03/26/24. Interview with Resident #1 on 03/27/24 at 11:23 a.m. she stated she admitted with a wound infection and had received wound care only two times since admission to the facility on [DATE] but was unable to recall on what days. She stated she was told on admission that the facility did not have all of the equipment needed to provide the wound vac ordered at the hospital. Attempts to observe the resident's right foot wound were unsuccessful as she declined. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 03/27/24 at 1:12 p.m. she stated she completed the physical admission assessment for Resident #1 and another nurse (LVN D) put the hospital admission orders in the computer. She was not aware the other nurse had not put the wound care orders in the computer. Attempts to interview LVN D were unsuccessful. Interview with the DON on 03/27/24 at 4:00 p.m. he stated he had transcribed Resident #1's wound care orders into the electronic health record on 03/27/24 because he did not see any orders for wound care until after surveyor intervention on 03/27/24. He stated the ADON was responsible for completing an audit to ensure all admission orders were put into the electronic health record. The DON stated he reviewed Resident #1's admission records over the past weekend but did not notice there were no wound care orders. The DON further stated there was no wound care nurse on duty on Monday (03/25/24) or Tuesday (03/26/23) and RN A was assigned to provide wound care in the facility. Interview with RN A on 03/28/24 at 10:54 a.m. she stated she was not the facility's wound care nurse and only worked as needed (prn). She stated she was assigned as the wound nurse on 03/25/24 and 03/26/24. She stated she did not provide wound care for Resident #1 because she did not know the resident required wound care. She stated there were no orders for wound care and no wound care treatment listed on the Resident #1's TARS. Interview on 03/28/24 at 12:03 a.m. Resident #1's primary physician she stated wound care was important for healing, but she had no concerns related to the resident's wound infection as the infection was being controlled by the antibiotic the resident was receiving and the infection was improving. Interview with the DON on 03/28/24 at 4:26 p.m. he stated he was not aware that wound care had not been provided for Resident #1 on 03/25/24 and 03/26/24. He stated it was important for wound care to be provided according to physician's orders to prevent infections, pain, and possible delay in healing. He stated the facility's system was for the IDT of which he was a member of to review new admission records to ensure all admission forms, assessments and orders were in place. He stated they (the IDT) failed to follow the system that caused the omissions in wound care for Resident #1. IDT-Interdisciplinary Team-a group of different health care disciplines to help people receive the care they need). Review of the facility's current P/P entitled, Wound Management dated revised 06/2000 revealed the purpose of the P/P was to provide a system for the treatment and management of residents with wounds including pressure and non-pressure injury. The P/P reflected a resident who had a wound would receive necessary treatment and services to promote healing and prevent infection. Additionally, the P/P reflected licensed nurses would implement wound treatments per physician's orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for one (Resident #1) of 4 residents reviewed for accuracy of medical records. Findings included: 1. The facility failed to ensure staff transcribed Resident #1's wound care orders in the clinical record. 2. The facility failed to ensure staff documented the administration of Resident #1's IV (Intravenous- giving medicines or fluids through a needle or tube inserted into a vein) antibiotic on 03/23/24 and 03/24/24. These failures could place residents at risk for medication and /or treatment errors and omissions in care. Findings included: Review of Resident #1's undated admission record and physician's orders dated 03/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included peripheral vascular disease (Reduced circulation of blood to a body part due to a narrowed or blocked blood vessel.) and osteomyelitis (Bone infection). Review of the Resident #1's admission assessment dated [DATE] revealed the resident was alert, cognitively intact, occasionally incontinent of bowel/bladder and admitted with a surgical wound to the right foot. Review of hospital discharge orders dated 03/21/24 revealed wound care orders for a wound vac changed three times a week. (Vacuum-Assisted Closure (VAC) is a method of decreasing air pressure around a wound to assist the healing). Review of Resident #1's admission orders dated 03/22/24 revealed orders for the IV antibiotic Vancomycin 1 gram IV every day for 35 days. There was no order for wound care until 03/27/24. The wound care orders dated 03/27/24 reflected, change wound vac to right foot/toe wound on Monday, Wednesday, and Friday. An additional wound care order dated 03/27/24 reflected a wet-to-dry dressing could be used until the wound vac was in place. Review of Resident #1's MARS dated 03/2024 revealed no documentation that the Vancomycin had been administered on 03/23/24 and 03/24/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 03/27/24 at 11:23 a.m. she stated she admitted with a wound infection and had received wound care only two times since admission to the facility on [DATE] but was unable to recall on what days. She stated she was told on admission that the facility did not have all of the equipment needed to provide the wound vac ordered at the hospital. Attempts to observe the resident's right foot wound were unsuccessful as she declined. Interview with the DON on 03/27/24 at 4:00 p.m. he stated he had transcribed Resident #1's wound care orders into the electronic health record on 03/27/24 because he did not see any orders for wound care until after surveyor intervention on 03/27/24. He stated the ADON was responsible for completing an audit to ensure all admission orders were put into the electronic health record. The DON stated he reviewed Resident #1's admission records over the past weekend but did not notice there were no wound care orders or that the Vancomycin had not been documented as administered. The ADON was not available for interview as he was out for training. Interview with LVN B on 03/28/24 at 11:08 a.m. she stated she administered Resident #1's IV antibiotic on 03/23/24 and 03/24/24. She stated she understood the importance of documenting care provided but had just forgotten to document on the MAR. Interview with the DON on 03/28/24 at 4:26 p.m. he stated it was important to document care provided to residents to ensure residents were receiving all ordered treatments/care, to ensure continuity of care and to prevent any mishaps. Review of the facility's current P/P entitled, Documentation-Nursing dated revised 06/2000 revealed the purpose was to provide documentation of resident status and care given by nursing staff. The P/P reflected MARS would be completed with each medication administered.