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	06/14/2024

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of seven residents reviewed for improper transfers. The facility failed to ensure Resident #1 was transferred according to his Care Plan using a Hoyer. An Immediate Jeopardy (IJ) was identified on [DATE] at 03:56 PM. The IJ template was provided to the facility on [DATE] at 3:58 PM and signed by the Administrator. While the IJ was removed on [DATE] at 12:26 PM, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. These failures resulted in hospitalization due to an improper transfer whereas Resident #1 received a fracture and underwent surgery to repair the fracture. Findings included: Review of Resident #1's quarterly MDS assessment, dated [DATE], revealed he was an [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included Age-related Osteoporosis (bone disease that develops when bone mineral density and bone mass decreases,), Osteopenia (loss of bone density), Muscle Weakness (decrease in muscle strength), Lack of Coordination, Congestive Heart Failure (heart muscle does not pump blood well), Acute Respiratory Failure (he lungs can't release enough oxygen into your blood), etc. The MDS reflected Resident #1 had a BIMS (a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 13 indicating cognition was intact. The functional abilities and goals section indicated Resident #1 required extensive assist with bed mobility and transfers, mechanical lift with 2 persons. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan revised on [DATE] revealed Resident #1 had an ADL Self Care Performance Deficit r/t Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe), Impaired balance (Loss of balance or unsteadiness), Limited Mobility (any physical impairment that impacts a person's ability to move around freely, easily, and without pain), Musculoskeletal impairment (conditions that can affect your muscles, bones, and joints), chronic pain (pain that lasts for over three months), COPD (chronic obstructive pulmonary disease), CHF (heart failure), abnormal posture (rigid body movements and chronic abnormal positions of the body), lack of coordination (problems coordinating how your muscles work), difficulty in walking, muscle wasting (thinning of muscle mass). Interventions included lying to sitting on bed side substantial/maximal assistance; sit to stand (not attempted due to medical condition or safety concerns); chair/bed-to-chair transfer dependent: Hoyer lift times 2 person assist, etc. Review of Resident #1's PT Sessions and Evaluations dated [DATE] under the Functional Mobility Assessment Section revealed, Transfers: Sit to stand and Chair/bed-to-chair transfer = Not attempted due to medical conditions or safety concerns. It also revealed, Amount of assist needed to sit at edge of bed: Current Value changed from Max (A) times 2 to Unable and Time patient can sit unsupported: Current Value changed from 20 seconds to Unable. Review of Resident #1's PT Encounter Summary dated [DATE], it revealed, We started our day as we usually do. Checked on the evaluations for the day, and reviewed notes as appropriate. After which, PT-student said she would go to round up patients to treat. I stayed at the gym to look over other documents due for the day. At 10:21am, PT-student called me saying she needed help. I asked where she was and said she's in [Resident #1]'s room. When I arrived in the room, PT-student was sitting on the floor beside [Resident #1]'s bed with Resident #1 beside her, laying on his back. I immediately alerted LVN A about [Resident #1]'s fall. LVN A went to the room with me to assess Resident #1. Resident #1 reported that his right hip hurts, there was also a scratch/abrasion on [Resident #1]'s right middle toe - but other than that, no other injuries were noted. I saw another staff member walk past and alerted her as well that we need help to get Resident #1 off the floor and then three male nurses arrived. The three male nurses attempted to get Resident #1 off the floor but was unable to. They put a Hoyer sling underneath and was able to use the Hoyer machine to lift Resident #1 off the floor. Resident #1 was positioned in bed, and I handed him the bed control so he can comfortably position himself. The bolster was put back in place, along with the 2 pillows underneath his calf, and the fall mat was returned beside his bed. We spoke to Resident #1 and made sure he was comfortable on his bed and asked if he needed anything else. We left the room and made sure his bedside table, bed control, and call light was within reach. I spoke to PT-student on the stairwell to clarify what happened. I have read her statement and it was what she told me as well. I educated PT-student on the indicators on how this particular patient was not appropriate for a 1-person transfer (PT-student has demonstrated good clinical judgement in the past that did not indicate anywhere near any kind of this incident happening or her missing these signs) 1) on ocular inspection, the patient was at least 6 feet tall, weighing at least 200 lbs; 2) There was no goal for transfers; 3) Patient required 2 person assist with supine side-lying activity due to poor trunk control and 2-/5 manual muscle testing of bilateral lower extremities - which we had always done together when treating him/we evaluated the patient together; and 4) There was a Hoyer sling on top of his wheelchair indicating patient was a Hoyer transfer. Review of Resident #1's Pain Evaluation dated [DATE] at 1:00 PM revealed his pain level was at a 3 and described as intermittent aching and he was given one HYDROcodone-Acetaminophen Oral Tablet 7XXX, d+[DATE] mg. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress notes revealed: [DATE] at 10:35 AM eINTERACTS BAR Summary for Providers Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Falls - At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:35Position: Sitting l/arm - Pulse: P 61 - [DATE] 10:39 Pulse Type: Regular - RR: R 16 - [DATE] 12:36 - Temp: T 97.7 - [DATE] 12:36 Route: Forehead (non-contact) - Weight: W 222.0 lb - [DATE] 17:07 Scale: Wheelchair [DATE] at 11:25 General Progress Note: Resident alert and oriented, doing therapy session, including strengthening and mobility. unable to transfer from bed to w/c resident was ease down to the floor on his back. resident with history of pain on right hip call out pain on right knee and discomfort on his right hip; MD called immediate X-Ray obtained; Mar Updated. [FAM A] called with information; FAM A talked to [Resident #1] and resident stated that I did not have a fall, but I was put down in front on the Bed. Resident resting in bed with eyes opened. [DATE] at 11:35 General Progress Note: This nurse was alerted to room by Therapy Staff that resident was on the floor, upon entering room resident was lying on the floor on his back, head to toe assessment was performed, resident call out of pain to right hip and right knee, resident was transferred safely to bed, MD notified, order was given for immediate X-Rays to right hip, right knee, and right tibia and right fibula, PRN Medication Norco was administered, Responsible Party was notified. [DATE] at 12:34 Lab Note Text: X-Ray called immediately to [Company]: Order Number: 42947239 [DATE] at 2:27 PM General Progress Note: Notified NP of resident's X-Ray results which indicated acute fracture to right lower leg. Order given by NP to transfer resident to ER for further evaluation and treatment. Responsible Party was made aware. Review of the facility's Ad Hoc QAPI dated [DATE] revealed, Resident #1 sustained an assisted fall during a transfer with PT-student which resulted in a fracture to his right leg. An X-Ray was ordered, pain assessment completed, pain medication was given, and Resident #1 was sent to the ER. In an interview with FAM A on [DATE] at 01:15 PM, she stated she had a video of the PT-student in Resident #1's room and she attempted to pick him up without any help, a gait belt, nor a Hoyer. FAM A stated the PT-student dropped her father on the floor and he yelled out, he broke his leg, and she dismissed what he was saying. FAM A stated the PT-student told Resident #1 his leg was not broken; you are okay. The PT-student then moved his broken leg and kept telling him it was okay. FAM A stated the PT-student reported it as a minor incident. FAM A stated the facility called and told her what happened. FAM A stated she started reviewing the video and she could hear Resident #1 in the video and the transfer procedures were not followed. FAM A stated Resident #1 was scheduled for surgery tomorrow on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of FAM A's video recording on her phone on [DATE] at 01:15 PM, revealed the PT-student attempted multiple times to pull Resident #1 to a standing position. The PT-student counted to three and attempted to pull Resident #1 up. On the fifth attempt, Resident #1 and the PT-student fell on to the floor. The PT-student used her cell phone and called the CI and informed her they had fallen and requested assistance. In an interview with ADON A on [DATE] at 02:30 PM, he stated during the morning meeting yesterday ([DATE]), he received a call from LVN A. LVN A informed him Resident #1 had fallen. ADON A stated he arrived upstairs Resident #1 had been placed back in bed. ADON A stated Resident #1 said it was a little incident. ADON A stated the roommate, Resident #2 chimed in and said, No one was going to move me because she just dropped him on the floor. ADON A stated LVN A told him a PT-student tried to transfer Resident #1 and in the middle of the transfer Resident #1 could not make it, so the PT-student eased him onto the floor. ADON A stated he called the DOR for a report and to come upstairs with the PT-student. ADON A stated three of the PT staff arrived at the room, and they explained it was a student that tried to transfer Resident #1 by herself. ADON A stated he called the MD and explained when he touched Resident #1's right foot he called out in pain. ADON A stated the doctor ordered an X-Ray on Resident #1's hip, knee and ankle. ADON A stated he told FAM A to review the camera and she came to the facility and spoke with the DON. ADON A stated the DON called him and said he just reviewed the video camera and to call 911 right away. ADON A stated he called the doctor back and informed her they would be sending Resident #1 out opposed to waiting on the X-Ray results. ADON A stated Resident #1 received a broken bone of the tibia going towards the ankle. In an interview with the ADM on [DATE] at 03:50 PM, he stated the fracture was confirmed the same day. The ADM stated it was a witnessed incident, nothing was mentioned of neglect and Resident #1 had a BIMS of 13. The ADM stated Resident #1 said he did not fall, but that is the great thing about videos because it can help cut through inconsistencies. The ADM stated Resident #1 lost his balance while the PT-student was trying to assist him. Review of Resident #1's hospital paperwork revealed, on Tuesday, [DATE] at 3:09 pm, patient presented with RLE (right lower extremity) pain. Patient was being transferred at his nursing facility when he was dropped. He has a deformity to the right anterior tibia. He denies hitting his head and LOC (level of consciousness). In an interview with Resident #2 on [DATE] at 11:00 AM, he stated he did not see anything due to the curtain being pulled. Resident #2 stated he heard Resident #1 crash on the floor, and he could see Resident #1 a little beneath the curtain. Resident #2 stated he did not see the staff that entered the room, but he heard all the commotion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on [DATE] at 11:25 AM, he stated the ADON reported to him on [DATE] that Resident #1 sustained a fall. The DON stated the ADON said it was an assisted fall on a failed transfer from Resident #1's bed to chair. The DON stated he instructed the ADON to assess Resident #1 properly and report it to the MD. The DON stated FAM A walked into his office and showed him a video. The DON stated he watched the video of the transfer, which was really an assisted fall. The DON stated he did not have the heart to watch the video and it broke him to see what he saw. The DON stated it was a difficult position for the resident. The DON stated he stopped the conversation with FAM A and had his staff call 911. The DON stated EMS arrived before FAM A left his office. The DON stated an X-Ray had already been completed in-house. The DON stated after Resident #1 arrived at the hospital, the results of the in-house X-Ray confirmed a fracture which was reported to FAM A and the doctor. The DON stated after the incident, they had started in-servicing and training on transfers, gait belt use, fall prevention and renewing competencies. The DON stated they had an Ad Hoc QAPI and addressed the concerns with the monitoring of transfers in place for 7 days, once a week for one month, and once a month for 3 months. The DON stated that Resident #1 was a Hoyer transfer. The DON stated the DOR reported the PT-student had gone to the floor to get different residents to bring down for therapy, but they were not ready. The DON stated the PT-student had entered Resident #1's room because he was on her schedule. The DON stated the PT-student started her field work at the facility on [DATE]. In an interview with the DOR on [DATE] at 11:50 AM, she stated the PT-student started her field work at the facility on [DATE]. The DOR stated the PT-student had already completed two 3-month rotations in Outpatient Care. The DOR stated universities sent students enrolled in this type of program anywhere within the United States. The DOR stated this had been the PT-student's first rotation in a long-term care setting. The DOR stated therapy followed the school's syllabus and the facility's Competency Checklist. The DOR stated the CI supervised and checked off the PT-student's completed tasks. The DOR stated after a student started, they received a tour of the facility and started shadowing their instructor (documentation, evaluations, treatments, etc.). The DOR stated the PT-student started treating Residents alongside the CI and each week they progressively increased her caseload. The DOR stated the PT-student saw half of the Residents and the CI tended to the other half. The DOR stated she observed the PT-student and the CI during Week 2 with less-complexed residents. The DOR stated the PT-student was never assigned to treat Resident #1 alone. The DOR stated Resident #1 was on the PT-student's schedule, but the PT-student and the CI had always provided services to him together in his room. The DOR stated the PT-student told them she had gone to get two different residents across the hall from Resident #1, but they were not ready. The DOR stated the PT-student had gone to see Resident #1, trying to salvage her day. The DOR stated the PT-student informed her Resident #1 said he wanted to get up and she said, Let's do it. The DOR stated the PT-student retrieved Resident #1's wheelchair and placed it at the edge of his bed and the goal was to stand Resident #1 up and place him in the wheelchair. The DOR stated the PT-student said Resident #1 could not make it and since the wheelchair was close, the goal was the wheelchair, and they went down. The DOR stated the PT-student participated in Resident #1's Therapy Care Plan and Goals on her second day. The DOR stated Care Plans were part of the PT-student's first evaluation. The DOR stated she did not foresee anything worse than a fracture due to the mechanics of the fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:25 PM, the RDOT stated PT-students were assigned via their recruiter. The RDOT stated after the student started, they followed a Competency Checklist. The RDOT stated the first couple of days was a lot of observations. The RDOT stated when the CI felt the PT-student was ready, they allowed them to participate in treatments and documentation. The RDOT stated the PT-student assisted with evaluations, progress notes, and discharges. The RDOT stated the PT-student was scheduled to graduate in [DATE]. The RDOT stated based on the CI's observation, she could give the PT-student as much work as the PT-student could handle. The RDOT stated they started with simpler cases and there were never any concerns with the PT-student. The RDOT stated they completed bed mobility, sitting on the edge of the bed, and worked on strengthening. The RDOT stated the PT-student got Resident #1 to the edge of the bed, got him ready, attempted to get him up with a lack of clinical judgement for sure, and it went south. The RDOT stated she did not know why the PT-student did it, especially if she tried multiple times without success. The RDOT stated Resident #1's transfer status was part of his PT evaluation. The RDOT stated the PT-student wrote a statement and was dismissed from the facility. The RDOT stated they reported the incident to the PT-student's school. In an interview on [DATE] at 01:00 PM with the CI, she stated she was not in the room when it happened. The CI stated the PT-student was supposed to round residents up and bring them down to therapy. The CI stated the PT-student entered Resident #1's room and attempted to complete his therapy in the room alone. The CI stated previously when she and the PT-student treated Resident #1, it was always the two of them and she was surprised the PT-student attempted to do it by herself. The CI stated the PT-student had been doing good and the PT-student thought she could do it on her own. The CI stated her, and the PT-student completed Resident #1's sessions in bed. The CI stated Resident #1 was a Hoyer transfer even when transferred to his wheelchair, the Hoyer would be used. The CI stated Resident #1's treatment was for him to sit on the side of the bed and that was why there was always two therapists present because he was just that weak. The CI stated she had worked at the facility over 5 years, and she never completed Resident #1's therapy by herself. The CI stated she spoke with the PT-student after the incident, and the PT-student stated she lowered the resident down to ease the fall. The CI stated the PT-student called her on the phone and said she needed help. The CI stated she arrived at the room and called out for nurse's assistance. The CI stated after a student started field training at the facility, the student would shadow her for one week to get oriented to paperwork, assessments, evaluations, etc. The CI stated she would complete a Competency Skills Checklist to make sure the PT-student was able to complete all tasks. The CI stated she would gradually give a PT-student more complex cases with less supervision. The CI stated the PT-student had already accomplished these tasks. The CI stated the PT-student was trained on gait belt use, proper transfer techniques, assessment of a resident, how to complete evaluations and treatments. The CI stated PT-students are not trained on Hoyer use due to it not being a skilled service, it was a Nursing task. The CI stated the PT-student was proactive with her learning and took on cases easily in which she demonstrated good clinical judgement. The CI stated they were flabbergasted by this incident. The CI stated the PT-student had trained at the facility for 5 weeks. The CI stated the PT-student related her [NAME] with real treatment well. The CI stated this had been a lapse in the PT-student's judgement. The CI stated the worse that could had happened was the resident could have received a head injury and died . Observation on [DATE] at 10:00 AM at [Hospital], Resident #1 was observed to be sleeping peacefully and not in pain. HRN awakened Resident #1 to speak with Surveyor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:03 AM at [Hospital], Resident #1 stated he was okay and not in pain. Resident #1 stated the PT-student entered his room and attempted to stand him up. Resident #1 stated he was too heavy for the PT-student. Resident #1 stated he told the PT-student he weighed 220 lbs. Resident #1 stated the PT-student kept trying to stand him. Resident #1 stated they fell ed to the floor, and the PT-student had him twisted up. Resident #1 stated the PT-student dropped him, and it was painful. Resident #1 denied he told the PT-student he wanted to sit in his wheelchair. Resident #1 stated he never discussed his wheelchair with the PT-student. In an interview on [DATE] at 10:25 AM at [Hospital], the HRN confirmed Resident #1 was admitted on [DATE] at 3:09 pm. HRN stated Resident #1 had a fall at the nursing home and received a right ankle fracture. HRN stated Resident #1 had surgery on [DATE]. HRN stated there were no concerns listed by the doctor, nor the ER. HRN stated there was nothing medically going on except treatment of the fracture. HRN stated there was no timeframe for discharge because they were waiting for PT to evaluate Resident #1. HRN stated Resident #1 was unable to tolerate a lot of PT and required care when discharged . HRN stated she had been Resident #1's nurse since he admitted 3 days ago. HRN stated Wednesday morning ([DATE]), she told Resident #1 she needed to turn him to provide incontinent care and he was afraid and told her, Please do not drop me. HRN stated Resident #1 said she looked small like the girl that dropped him so he was scared she would drop him too. HRN stated she informed Resident #1 PT was going to stop by and was panicked because he feared being dropped. HRN stated the doctor notes from ,d+[DATE] stated [Resident #1] had been bed-bound status for almost one year. The Nursing Facility staff tried to get him to stand up and get into his wheelchair. During the past one year, the facility had used a Hoyer. [Resident #1] could not hold his balance, fell on the floor, and broke his right ankle. In an interview on [DATE] at 11:15 AM, the MD stated she was made aware Resident #1 fell . The MD stated Resident #1 had not experienced a recent change in condition. The MD stated she understood a PT-student was trying to do a transfer by herself. The MD stated Resident #1 was usually non-ambulatory and required extensive assistance due to weakness. The MD stated the PT-student should have requested assistance. The MD stated Resident #1 fell , received a fracture, and required surgery. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	

II. Residents must be lifted or transferred according to the determined procedure.

III. Residents who require assistance in transferring will be transferred using a gait/transfer belt or with a

lift.

V. Mechanical lift procedures are used on any resident unable to independently pivot or transfer.

Procedure

II. Assisting to Chair

A. One Person Pivot Transfer (resident must be able to bear weight)

An Immediate Jeopardy (IJ) was identified on [DATE] at 3:56 PM. The IJ template was provided to the facility on [DATE] 3:58 PM and signed by the Administrator. A plan of removal was requested at that time.

The facility's plan of removal was accepted on [DATE] at 12:26 PM and reflected:

Summary of Details which lead to outcomes.

F689 Free of Accident Hazards/Supervision/Devices

On [DATE] during a complaint survey at The Hillcrest of North Dallas at 18648 Hillcrest Road, Dallas, TX 75252. On [DATE] the HHSC surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The facility allegedly failed to provide supervisory services. When resident #1 was being transferred at his nursing facility he was dropped. Has a deformity to the R anterior tibia.

The notification of the alleged immediate jeopardy states as follows:

An [AGE] year-old male with a BIMS of 13 admitted to the facility on [DATE]. His diagnoses include Age-related Osteoporosis, Osteopenia, Muscle Weakness, Lack of Coordination, Dementia, Acute Respiratory Failure, etc. He required a Hoyer when transferring and two therapists at bedside during therapy. An in-house Stat X-Ray was performed, and he was sent out prior to the results. EMS transferred the resident to Medical City [NAME] where the hospital paperwork states he presented with RLE pain. Patient was being transferred at his nursing facility when he was dropped. Has a deformity to the R anterior tibia. Denies hitting his head and LOC.

Identify residents who could be affected.

All Residents who require assistance to be transferred have the potential to be affected.

Identify responsible staff/ what action taken.

1. Physical Therapist Student was immediately removed from the facility.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 18648 Hillcrest Rd Dallas, TX 75252	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. We contacted the school and informed them that the Physical Therapist Student was being removed from the student fieldwork program and could not return to the facility. In-Service conducted. 1. Therapy staff was re-educated on mechanical lifts and gait belts appropriate transfer training, transfer status and protocol for falls which include do not move residents, call for assistance and have nurse to assess on [DATE]. 2. Education is being provided to nursing staff on fall prevention, and transfers with mechanical lifts and gait belts on [DATE]. 3. Education is being provided to nursing staff to check the KARDEX to know plan of care and transfer technique [DATE]. Implementation of Changes Change of policy for student supervision - Clinical supervisor must provide close, direct supervision and oversight to student clinicians Providing patient care in the following circumstances: To make an initial determination of competence. When a student clinician is performing assigned treatment or activity with a patient for the first time. When the student clinician is learning a new skill or technique. When the student clinician's performance assessment/evaluation identifies issues (e.g. conduct, clinical performance, capacity) with potential to interfere with delivery of competent, quality and ethical rehabilitative care. In all other treatment circumstances, the student clinician must be in line of sight of the clinical supervisor when providing direct patient care. The clinical supervisor should be available to intervene and/or correct student performance, as necessary. Director of Rehabilitation has been in-service on the new policy change [DATE]. Clinical Instructors have been in-serviced on the new policy change [DATE]. Audit of fall assessments and care plans are being completed and appropriate interventions will be put in place as needed by [DATE]. Therapy staff was re-educated on mechanical lifts and gait belts appropriate transfer training, transfer status and protocol for falls which include do not move residents, call for assistance and have nurse to assess on [DATE]. Education is being provided to nursing staff on fall prevention, and transfers with mechanical lifts and gait belts on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Education is being provided to nursing staff to check the KARDEX to know plan of care and transfer technique [DATE]. Monitoring DOR/Designee will monitor staffing to ensure that any student therapist will be closely monitored to follow the new policy. DOR/Designee will review the effectiveness of this daily X 7 days and weekly X 4 weeks, then X 3 monthly, continued monitoring will be ongoing and report any adverse findings to the QAPI committee. All concerns noted will be addressed at the time of discovery. The Administrator/DON/Designee will be responsible for monitoring the implementation and effectiveness of in-service conducted on [DATE] and ongoing. The Administrator/DON will review the effectiveness of this daily X 7 days and weekly X 4 weeks, then X 3 monthly, continued monitoring will be ongoing and report any adverse findings to the QAPI committee. All concerns noted will be addressed at the time of discovery. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on [DATE] [TRUNCATED]