

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37028</p> <p>Based on observations, interview, and record review, the facility failed to protect a resident's right to be free from abuse for 2 (Residents #1 and Resident #2) of 6 residents reviewed for resident abuse.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure Resident #1 was free from verbal and physical abuse by the Assistant Dietary Manager.</li> <li>The facility failed to ensure the Assistant Dietary Manager did not work in the facility even though Resident #1 was afraid of him.</li> <li>The facility failed to protect Resident #2, who was unable to give consent for sexual activity, from sexual abuse after Resident #3 was discovered in her bed with Resident #2 on top of her by facility staff.</li> <li>The facility failed to protect Resident #2 who was a prior victim of abuse and unable to give consent for sexual activity.</li> <li>The facility failed to follow physician's orders for Resident #3 and ensure that Resident #3 had un-monitored access to Resident #2 from 07/06/2024 to 07/11/2024 to prevent possible repeated abuse.</li> </ol> <p>An Immediate Jeopardy (IJ) was identified on 08/08/24 at 5:00 PM and 08/09/24 at 5:00PM. The IJ template was provided to the facility on [DATE] at 5:44PM and 08/09/24 at 5:24PM and signed by the Administrator. While the IJ was removed on 08/12/2024 at 7:05PM, 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 pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>These failures placed residents at risk for serious injuries, abuse, and serious harm.</p> <p>Findings included:</p> <p>(continued on next page)</p>

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
---	-------	-----------

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Record Review of Resident #1's Admission MDS Assessment, dated 05/19/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. He was cognitively intact. He did not have any behaviors. His diagnoses included stroke, heart failure, and hemiplegia (paralysis of one side of the body.)</p> <p>Review of Resident #1's Care Plans , not dated, reflected:</p> <p>Resident had a history of making false allegations/inaccurate statements as evidenced by previously accusing/stating: Makes up stories of falling, explained the same fall with different version to other nurses</p> <p>Interventions:</p> <p>If statements were determined to be inaccurate, staff will reorient and redirect as needed with reassurance and reality orientation.</p> <p>Listen openly to allegations/inaccurate statements and offer clarification as needed.</p> <p>Resident had potential to demonstrate verbally abusive behaviors related to ineffective coping skills, and poor impulse control.</p> <p>Interventions:</p> <p>Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.</p> <p>Assess resident's coping skills and support system.</p> <p>Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation.</p> <p>Evaluate for side effects of medications.</p> <p>Provide positive feedback for good behavior. Emphasize the positive aspects of compliance.</p> <p>Psychiatric/Psychogeriatric consult as indicated.</p> <p>Record review of Resident #1's Progress Notes, dated 06/15/24 at 7:20 pm reflected:</p> <p>Resident came to the nursing station to complain that he requested a double portion, but he was served with one portion of meal at dinner. He was offered another tray of dinner, but he refused and said that he was going downstairs.</p> <p>7:26 PM</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Nurse was notified by the weekend supervisor that the resident wanted to go into the kitchen, but he was prevented from going in and he started altercation with the kitchen personnel. It was reported that the resident called the police. The resident came upstairs and said get my meds ready because I'm going out. Nurse had his medication prepared but the resident never came back to take his scheduled night medication.</p> <p>8:15 PM</p> <p>A CNA came and told this nurse that the resident just left with his [family member] to the hospital. Note documented by LVN H.</p> <p>Review of Resident #1's Facility Self-Report dated 06/15/24 reflected:</p> <p>It was reported to Administrator on 6/15/24 that Resident #1 and the Assistant Dietary Manager had a verbal altercation. It was then reported to that the resident said that the Assistant Dietary Manager hit him in the chest. When the Administrator interviewed Resident #1, he said the Assistant Dietary Manager also threw his walker and grabbed him by the throat. The Assistant Dietary Manager was interviewed and he denied ever putting a hand on the resident. The Administrator interviewed staff and residents that were in the dining room and kitchen when the altercation happened. In all of the Administrator interviews, everyone stated that they never saw the Assistant Dietary Manager put his hands on Resident #1. They also all said that it was the resident who was the aggressor, yelling and cursing at the kitchen staff. Investigation findings were unconfirmed because there was no witnesses that ever saw the Assistant Dietary Manager touch or hit the resident. In all interviews the witnesses stated Resident #1 was the aggressor and the one that was yelling and cursing. The Assistant Dietary Manager was allowed to come back to work from suspension.</p> <ol style="list-style-type: none"> <li>1. Staff was in-serviced on abuse, neglect and dealing with aggressive behavior.</li> <li>2. The Assistant Dietary Manager was allowed to return to work.</li> <li>3. Resident #1 was presented a Behavior contract.</li> </ol> <p>Staff Witness Statements from the incident reflected:</p> <p>Resident #1 - The resident went to the kitchen to get double portions and the kitchen told him that they would send him another tray. He left and went back upstairs, and they could not find the tray. He came back downstairs and told them again that his tray was not up there. They told him that they would get him another tray once they finish with the other residents. He was standing in the door to the kitchen when he said the Assistant Dietary Manager came at him saying we are not going to do this Resident #1. Resident #1 then said that the Assistant Dietary Manager grabbed his walker and threw it about 10 feet. He then said that the Assistant Dietary Manager grabbed his neck and hit him in the chest. Resident #1 then stated that he took his shirt off to point at his chest that he had a pacemaker and then put his arms to his side and started saying that he did not touch anyone.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Assistant Dietary Manager - Resident #1 was cursing at the cook about getting double portions. The Assistant Dietary Manager came to the door and asked the resident to not cuss at the employees. He stepped back into the kitchen and the resident called him a bitch. The Assistant Dietary Manager stated that he asked the resident, what you just said to me? The Assistant Dietary manager then said that he never put a hand on him. The Assistant Dietary Manager then stated that the resident tried to hit him but did not hit him. The resident then took his shirt off and started yelling that people were touching him.</p> <p>Dietary Aide I - He was working in the kitchen when Resident #1 came to the kitchen and was asking for more food. He stated that the resident started yelling at the cook and stating that he did not get double portions. The Dietary Aide I got the resident another plate and the resident still kept yelling at the staff. Dietary Aide I went and got the Assistant Dietary Manager to help with the resident, so they could finish the trays for the other residents. Dietary Aide I then said the Assistant Dietary Manager asked the resident to step out of the doorway to the kitchen. Resident #1 continued to yell and cuss at the Assistant Dietary Manager. The resident was getting more aggressive, and they tried to calm him down. Dietary Aide I stated that he never saw the Assistant Dietary Manager touch or hit Resident #1.</p> <p>Dietary Aide J - He stated that he never saw the Assistant Dietary Manager hit or touch Resident #1. He then stated that Resident #1 was the aggressor during the altercation.</p> <p>CNA K - see attached statement. (No statement attached.)</p> <p>Review of Resident #1's Hospital Records, dated 06/15/24, reflected the resident was an assault victim with a right chest wall contusion (bruise), neck strain, back strain, and contusion on his left ankle.</p> <p>There was no police report for 06/15/24.</p> <p>There was no facility incident report for 06/15/24.</p> <p>There was no resident assessment for 06/15/24.</p> <p>There was no trauma assessment for 06/15/24.</p> <p>The Surveyor requested the police report on 08/09/24 at 3:45 PM from the police department.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An observation and interview with Resident #1 on 08/08/24 at 1:25 PM revealed he said he was assaulted on 06/15/24 by the Assistant Dietary Manager. He said he was supposed to get extra food and went down to get it and the Assistant Dietary Manager got in his face and threw his walker. He said it took 4-5 people to get the Assistant Dietary Manager off of the resident. Resident #1 said he was scared of him and did not feel comfortable eating food from him. The resident said he had bruises on his neck and chest on 06/15/24 and went to the hospital. He said they took images of his chest and pacemaker. He said the right side of his chest was still sore. The resident said he currently was ordering take-out food and his RP complained because it was \$100/day. The resident said his food was almost always messed up. Resident showed the Surveyor a piece of over-cooked, dry bacon and said all three of his meals were messed up. The resident said he thought his walker was messed up because the Assistant Dietary Manager threw it. The resident said when he would go to the kitchen and see him, they whispered about him. The resident said he did not feel safe getting his food from the Assistant Dietary Manager. The Administrator walked over during the conversation and the resident showed the Administrator the piece of bacon. The Administrator said, ok and walked away.</p> <p>An interview on 08/09/24 at 1:15 PM with the RP for Resident #1 revealed he arrived to the facility on [DATE] and he saw that the resident had a large red mark on his right chest and shoulder. He said the police did a scene report. The RP said following the incident the resident was afraid to eat the facility food. He said he took the resident to the hospital.</p> <p>An interview on 08/08/24 at 1:15 PM with the Assistant Dietary Manager revealed on 06/15/24 an incident occurred. He said on Resident #1's tickets he was supposed to get large portions. The resident would say he did not get them, but he did. He said on 06/15/24, Resident #1 came to the kitchen and had a tray with him. The resident also had a tray upstairs, and a 3rd one that the cook had. The Assistant Dietary Manager said when saw the resident he was arguing with the cook even though he had 3 trays. The resident was riled up, cussing, and the Assistant Dietary Manager took the tray from the resident. The resident told him he was, nothing but a bitch anyway. The Assistant Dietary Manager said he turned around, walked back to the resident and asked what he said. He repeated, you're nothing but a bitch. The Assistant Dietary Manager told Resident #1 that he was not going to call him a bitch. The Assistant Manager said he was angry and yelling back at the resident and the other staff was trying to keep both him and the resident calm. The resident ran up on the Assistant Dietary Manager and changed his mind and moved back. The Assistant Dietary Manager said he raised his voice at the resident and Resident #1 called the police. The Assistant Dietary Manager said he told the resident he was not going to be threatening his staff. The Assistant Dietary Manager said there was another incident when the resident came to the kitchen, but when he saw the Assistant Dietary Manager, the resident left. He is a headache, and he is one of a kind. The Assistant Dietary Manager said he had been trained to de-escalate behaviors and that is why he stepped into the situation. He said he did not receive any disciplinary action but was suspended pending investigation. He said [NAME] L no longer worked at the facility and the Dietary Manager was off on 06/15/24.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/08/24 at 1:35 PM with Dietary Aide J revealed he had worked at the facility for 2 months. He said on 06/15/24, he was washing the dishes and heard Resident #1 yelling and being mean to the staff. He said he went to the front and the Assistant Dietary Manager and the resident were cursing at each other and were in each other's face. Dietary Aide J aid it got to a point where the argument was dying down and then the resident called the Assistant Dietary manager a bitch. The resident started cursing at all of the kitchen staff and the Assistant Dietary Manager responded and got louder. The Assistant Dietary Manager was upset. He was standing in the doorway and they were close to each other. Dietary Aide J went to grab the resident and was told not to put his hands on him. Dietary Aide J stood by the resident's right shoulder and was facing the Assistant Dietary Manager to separate them. He said the Assistant Dietary Manager did not calm the situation, and he did not see them touch each other. Dietary Aide J said the Assistant Dietary Manager should have calmed down and let the situation go because the resident was about to leave by himself. The resident had a history of lashing out and then walking away. The police showed up 15 minutes later and the Assistant Dietary Manager left for the day. Dietary Aide J said he had to sign a paper but did not receive any in-services following the incident.</p> <p>An interview on 08/08/24 at 3:00 PM with CNA K revealed she had worked at the facility since 2022. She said on 06/15/24 Resident #1 got his tray and he said he did not get double portions. [NAME] L looked at his tray and said that he did receive double portions. The Assistant Dietary Manager came in and told the resident to step out of the kitchen. Resident #1 called the Assistant Dietary Manager the N word and stupid. The Assistant Dietary Manager was standing in the door of the kitchen. Resident #1 said he would slap the fuck out of the Assistant Dietary Manager. CNA K said she told the resident to come to her and to wait for his tray. Resident #1 reached across CNA K and tried to punch the Assistant Dietary Manager. CNA K said she told the Assistant Dietary Manager to back off and to walk away. CNA K said she got the tray for Resident #1. CNA K said the Assistant Dietary Manager escalated the situation and that she had to step in between them and back up Resident #1 from the Assistant Dietary Manager. She said the Assistant Dietary Manager should have walked away.</p> <p>An interview on 08/12/24 at 2:30 PM with LVN H revealed she was the nurse for Resident #1 on 06/15/24. She said she was told there was an incident in the kitchen and dining room and that Resident #1 went in the kitchen and was insulting staff and calling them names. She said the LVN Weekend Supervisor was handling the situation. She said when the resident came back to her following the altercation he said he needed to get his medications. Resident told her that he went to the kitchen to get food and he was attacked and insulted by staff. LVN H said she did not know if anyone attacked him because he was always making up stories. She said the resident told her he went to the hospital, but she did not assess him before he left or when he got back. She said the resident was wearing a shirt. She said she did not believe that anyone attacked him and she did not know why he was a resident in the facility. She said she did not complete an incident report because she was not there when it happened.</p> <p>An interview on 08/12/24 at 4:15 PM with the LVN Weekend Supervisor revealed she did not work the weekend of 06/15/24.</p> <p>An interview on 08/08/24 at 3:20 PM with the Psychiatrist NP revealed she had been seeing Resident #1 for a couple of months. She said he spoke to her about the incident on 06/15/24 where he was confronted by the kitchen staff for wanting food. Resident #1 said that his friend had been providing him money so that he did not have to eat at the facility. He said he did not trust the food the kitchen gave him.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/08/24 at 2:10 PM with the Administrator revealed on 06/15/24, he got a call the afternoon or evening that the Assistant Dietary Manager and the Resident #1 had the altercation. He said when he arrived, the police were wrapping up their investigation and gave him the police report number. The Administrator said he did not get the police report. He said Resident #1 left the facility with his friend. The Administrator said he interviewed the staff in the dining room and interviewed the resident when he came back. The Administrator called the Assistant Dietary Manager and suspended him. The Administrator said he found in his interviews with staff the common denominator was that Resident #1 was the aggressor. He was loud and arguing with the cook and he did not feel he got double portions. He kept trying to go in the kitchen with his walker. He said the staff got the Assistant Dietary Manager and asked him to please not go in the kitchen. Resident #1 yelled more and took his shirt off and thought he was ready to fight the Assistant Dietary Manager. The Administrator said staff did not see the Assistant Dietary Manager touch Resident #1. Resident #1 said he took his shirt off and said he had a pacemaker. The Assistant Dietary Manager denied throwing the walker and no one observed him throw the walker. Resident #1 said he was going to the hospital to have his pacemaker checked out, but he did not know if he actually went to the hospital. The Administrator said staff were supposed to de-escalate situations and re-direct residents and remove them from the situation. The Administrator said staff were not supposed to yell at residents and staff had to separate the Assistant Dietary Manager and Resident #1, because Resident #1 was being aggressive. He said he suspended the Assistant Dietary Manager but felt the Assistant Dietary Manager handled the situation appropriately. The Administrator said the resident said he was going to the hospital, but he did not think he went.</p> <p>An interview on 08/09/24 at 2:50 PM with the Medical Director revealed Resident #1 was his resident. He said he knew the resident had frequent altercations and was only aware of the resident's most recent hospitalization on [DATE]. He said he did not know what the hospital records for 06/15/24 said. He said he did not expect the facility to do an assessment on the resident following the incident on 06/15/24 if they did not know he went to the hospital. He said maybe the resident got the bruise if he went out earlier in the day. He said he did not find the facility was at fault and had no proof that a physical altercation occurred. He said he did not expect that the facility would have done a more thorough investigation if they did not know he went to the hospital.</p> <p>An interview was attempted on 08/12/24 at 6:19 PM with Dietary Aide I, but he did not return the call of the surveyor.</p> <p>Record review of the facility's policy, Abuse Prevention and Prohibition Program, revised 10/24/22, reflected:</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property.</p> <p>The Administrator was notified of the Immediate Jeopardy on 08/09/24 at 5:24PM due to the above failures and provided the IJ template to Corporate DON. A Plan of Removal was requested.</p> <p>The facility's plan of removal was accepted on 08/08/24 at 5:40 PM and included the following:</p> <p>1. The administrator submitted a self-report to HHSC regarding the incident on 6/15/2024. Intake #511237</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> <li>2. Attending Physician for involved resident was notified of the incident by the nurse on 8/9/2024.</li> <li>3. On 8/9/2024, Attending Physician was notified of medical records received on 8/9/24.</li> <li>4. Director of nursing conducted a trauma assessment with male resident on 8/10/24 , trauma assessment finding was normal. If assessment was abnormal, physician would be notified and EMR updated to reflect interventions.</li> <li>5. Assistant Dietary Manager was immediately suspended on 6/15/24.</li> <li>6. The affected resident went to the hospital for assessment and evaluation 06/15/2024.</li> <li>7. Witness statements were obtained by the Administrator 06/15/2024.</li> <li>8. Witnesses involved were reinterviewed on 8/8/24 and 8/10/24</li> <li>9. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with interview able residents on 6/17/24 and 8/9/24, 8/10/24. The non interviewable resident received a complete head to toe assessment on 8/11/2024. Any negative findings were immediately investigated, physician and responsible party notified and EMR with interventions.</li> <li>10. The affected resident was referred to [psych hospital] for psychological assessment and to be picked up on services if needed on 8/9/2024.</li> <li>11. Assistant Dietary Manager employment with the facility has been terminated on 8/8/2024</li> <li>12. Staff re-educated on abuse/neglect and how to deescalate and respond to any incidents involving residents/staff or any alleged perpetrators on 08/08/2024</li> <li>13. Staff re-educated on how to respond with incidents involving staff to resident inappropriate behaviors on 08/09/2024.</li> <li>14. Resident EMR was updated to include scanned hospital records on 8/9/24</li> <li>15. Resident care plan was updated on 8/10/24</li> <li>16. Resident Medical DX was updated 8/10/24</li> <li>17. Facility Administrator was terminated effective 8/10/2024</li> </ol> <p>In-Service conducted</p> <p>Administrator and Director of Nursing (after re-educated below) re-educated facility staff on:</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> <li>1. On 8/9/24 Director of Nursing and Administrator were re-educated by Regional Director of Operations on Abuse &amp; Neglect Policy, verbal, physical, sexual abuse and implementation of appropriate interventions to ensure residents are not afraid and feel safe. Administrator and DON were also re-educated on de-escalation of residents with behaviors.</li> <li>2. Staff in-service was initiated on 8/9/24. Staff members are being re-educated to report all allegations of abuse immediately upon notification to the Administrator who is the abuse coordinator. Re-education has an emphasis on de-escalation of residents with behaviors according to policy and resident safety with emphasis on creating an environment where residents do not feel afraid. Staff will complete an Abuse &amp; Neglect competency posttest at time of in-servicing.</li> <li>3. Staff are being re-educated by the Director of Nursing on 08/09/2024 to recognize signs of a resident being abused and early recognition of residents that do not feel safe. All such suspicions must immediately be reported to the Administrator or Director of Nursing.</li> <li>4. Staff were re-educated by the administrator/Director of Nursing or designee on de-escalation techniques when working with residents on 8/9/2024.</li> <li>5. Staff were re-educated by the administrator/Director of Nursing or designee on de-escalation techniques including employees and residents involving inappropriate behaviors on 8/9/2024.</li> <li>6. Facility nurses were re-educated 8/9/2024 to ensure residents are assessed and incident reports are completed following abuse allegations.</li> <li>7. Facility staff were also re-educated by the administrator on implementation of interventions to ensure resident safety. Re-education was initiated on 8/9/2024.</li> <li>8. The expected completion date will be 8/10/2024. Staff who have not been trained on Abuse &amp; Neglect/ De-escalation will not be allowed to work until they have completed required in-services.</li> <li>9. An interim administrator has been appointed and will start 8/12/2024. He will be educated on this Plan of removal and facility Abuse and neglect policy before he starts functioning as the facility administrator. Once a permanent facility Administrator is appointed, they will also be educated on this Plan of removal and the facility Abuse and Neglect policy.</li> </ol> <p>Implementation of Changes</p> <p>Staff will immediately inform the Administrator or Director of Nursing immediately when made aware of any abuse allegation. The administrator or director of nursing will ensure implementation of interventions for resident safety.</p> <p>A quick reference sheet of interventions has also been provided to staff and posted at the nurse's station.</p> <p>Alleged perpetrators will immediately be placed on one-on-one monitoring pending investigation and physician direction.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>If Alleged perpetrator is a staff member, Administrator, Director of Nursing or designee will immediately suspend perpetrator and will be asked to leave the facility immediately.</p> <p>All staff identified as an alleged perpetrator cannot return to work until approved by Regional Director of Operations or designee.</p> <p>The victim will be immediately assessed for injury, safety awareness, physician notification and continue to be monitored pending investigation and physician direction. Victim's Medical records will be updated to reflect any changes as needed.</p> <p>In the absence of the Administrator abuse allegations will be reported to the Director of Nursing.</p> <p>All allegations and incidents will be reviewed to the daily IDT team meeting to review for resident assessment and completion of an incident report.</p> <p>The Regional Director of Operations and Regional Nurse Consultant will be responsible for implementation of the process and will review the process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring</p> <ol style="list-style-type: none"> <li>1. Administrator/DON or designee will complete daily reviews of each incident to make sure residents are assessed, incident reports are completed, and interventions are put in place during daily IDT meetings.</li> <li>2. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents to ensure safety X2 months.</li> <li>3. 5 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week X2 months.</li> <li>4. The administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions. Findings will be documented on Abuse &amp; Neglect monitoring form X2 months.</li> <li>5. The facility Administrator/DON or designee will conduct random employee surveys on de-escalation daily x2 weeks, weekly x2 then monthly thereafter.</li> <li>6. RDO and RNC will review and monitor all allegations and incidents for proppriate implementation of interventions x4 months.</li> <li>7. RDO or RNC will review grievances weekly which are in the facility grievance binder for three months to monitor for appropriate interventions x4 months.</li> <li>8. Any adverse outcomes will be reported to the monthly QAPI Committee meeting with the Medical Director.</li> </ol> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Involvement of Medical Director</p> <p>The Medical Director was notified about the immediate Jeopardy on 8/9/2024.</p> <p>Involvement of QA</p> <p>On August 9th, 2024 an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review the plan of removal.</p> <p>Who is responsible for the implementation of the process?</p> <p>The Regional Director of Operations and Regional Nurse consultant will be responsible for the implementation of the new process.</p> <p>Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 8/9/2024.</p> <p>The facility's implementation of the IJ Plan of Removal was verified on 08/12/24 through the following:</p> <p>Record reviews of the Facility in-services started on 08/08/24 through 08/12/24 reflected in-services were given to over 50 employees prior to the start of their shift. The in-services included information on abuse and neglect, de-escalation of behaviors, keeping incidents to only a small number of people, speaking calmly during situations, protecting the resident, and validating the resident's concerns. Safe surveys, staff post-tests, the reference sheet of quick interventions posted at each nurse's station, and Resident #1's updated care plan and diagnosis list was reviewed.</p> <p>An interview on 08/12/24 at 4:50 PM with Resident #1 and his RP revealed he was happy that the Assistant Dietary Manager and Administrator were no longer working at the facility. He said it would take time for him to feel comfortable again.</p> <p>An interview with the Regional Director of Operations on 08/12/24 at 7:00 PM revealed LVN H, the Assistant Dietary Manager, and the Administrator were terminated from employment.</p> <p>Interviews on 08/12/24 from 11:05 AM to 7:00 PM with 16 staff from all shifts (Cook M, Dietary Manager, Dietary Aide N, CNA O, CNA P, CNA Q, CNA U, CNA R, CNA S, CNA T, LVN U, LVN V, LVN W, RN X, RN Y, and LVN Z) revealed they were in-serviced on the facility's abuse policy, types of abuse, de-escalation of behaviors, when to report abuse, who to report abuse to, how to protect a resident during an abusive situation, and what to do if a resident reported they did not feel safe. The staff acknowledged that they received the in-services said they also took a post-test.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview with the DON on 08/12/24 at 5:45 PM revealed his role in the Plan of Removal was to participate in all interventions for problems identified. He would be implementing interventions, educating staff, care planning, documentation, and notification. He said he had spoken with the staff and explained that they were there to help the residents and not think of them as problems. He said he was teaching the staff to listen to resident concerns and address them. The DON said he would complete daily reviews of each incident to make sure residents were assessed, incident reports were completed, and interventions were put in place. The DON said he or the Administrator would interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions. Findings would be documented on Abuse &amp; Neglect monitoring form X2 months. The DON said all incidents were reported to him so he could confirm proper steps were taken and followed. He said he read the 24-hour report daily to ensure no issues were missed with IDT. He said his plan for Resident #1 was to visit him daily. The DON said failure to follow abuse and neglect policies and failure to do investigations could put the resident's life in danger.</p> <p>An interview on 08/12/24 at 6:45 PM with the Interim Administrator revealed it was his first day as Administrator. He said his role in the POR was to be the Abuse Coordinator. He said he would make sure all in-services and all allegations were reported to him. If a resident alleges an allegation the facility was not going to just write it off. He said he would fully investigate all allegations. He said he would complete daily reviews of each incident to make sure residents were assessed, incident reports were completed, and interventions were put in place during daily IDT meetings. He said the IDT team would review all things that happened the prior day. He said he and the DON would interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions.</p> <p>Findings Included:</p> <p>2. Record review of Resident #2's Quarterly MDS with an ARD (Assessment Reference Date) of 05/24/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 diagnoses included: Alzheimer's Disease (neurological disorder that affects memory, thinking and behavior), Age-Related Physical Debility, and Alcohol Abuse. Resident #2 had a BIMS score of 11 indicating a moderately impaired cognition. Resident #2 had disorganized thinking and no potential indicators of psychosis, but did have a behavioral presence of wandering.</p> <p>Record Review of Resident #2's Comprehensive Care Plan, dated 08/08/2024, revealed the following:</p> <p>Focus- [Resident #2] had impaired cognitive function/dementia or impair [TRUNCATED]</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</b></p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of resident's, establish policies and procedures to investigate any such allegations for two (Residents #2 and #1) of eight residents reviewed for abuse.</p> <p>The facility failed to implement their abuse, neglect, and exploitation policy to ensure Resident #2 was safe from sexual abuse when Resident #3 was found by facility staff in her bed on 07/06/2024.</p> <p>The facility failed to follow their policy by not initiating criminal sexual abuse procedures when Resident #2 lacked the decision-making capacity to consent to a sexual act. The facility failed to contact law enforcement for further direction on the incident, after the incident occurred.</p> <p>The facility failed to implement their abuse, neglect, and exploitation policy to ensure Resident #1 was free from verbal and physical abuse by the Assistant Dietary Manager.</p> <p>The failed to conduct a thorough investigation for Resident #1's allegation of abuse.</p> <p>An Immediate Jeopardy (IJ) was identified on 08/08/24 at 5:00 PM and on 08/09/24 at 5:00 PM . The IJ template was provided to the facility on [DATE] at 5:44PM and on 08/09/24 at 5:24 PM and signed by the Administrator. While the IJ was removed on 08/12/2024 at 7:05PM, 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 pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>These failures could place all residents at risk for victimization, abuse, and psychosocial harm.</p> <p>Findings Include:</p> <p>Record Review of the facility's policy titled, Abuse Prevention and Prohibition Program revealed a date of 10/24/2022. Facility policy revealed that, the facility will treat allegations as criminal sexual abuse wherein the facility determines that the resident does not have the decision-making capacity to consent to the sexual act. The proper authorities and individuals are notified immediately or within two hours including but not limited to . law enforcement. The resident is provided with the medical treatment and emotional support necessary to prevent further deterioration of his/her health and wellbeing. The resident is transported to the hospital or other destination as instructed by law enforcement. Record Review of the facility's policy revealed a section titled, Prevention. This section revealed that, The facility conducts an ongoing review an analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse Resident assessments and Care Planning are preformed to monitor resident needs.</p> <p>Record Review of Resident #2's Quarterly MDS assessment with an ARD of 05/24/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 diagnoses included: Alzheimer's Disease, Age-Related Physical Debility, and Alcohol Abuse. Resident #2 had a BIMS score of 11 indicating a moderately impaired cognition. Resident #2 had disorganized thinking and no potential indicators of psychosis but did have a behavioral presence of wandering.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #2's Comprehensive Care Plan, dated 08/08/2024, revealed the following:</p> <p>Focus- [Resident #2] had impaired cognitive function/dementia or impaired thought processes r/t Dementia.</p> <p>Goal- [Resident #2] will develop skills to cope with cognitive decline and maintain safety by the review date.</p> <p>Interventions/Tasks- [Resident #2] needs assistance with all decision making.</p> <p>Focus- [Resident #2] has a communication problem.</p> <p>Goal- [Resident #2] will be able to make basic needs known on a daily basis through the review date.</p> <p>Interventions/Tasks- Anticipate and meet needs, focus on a word, or phrase that makes sense, or responds to the feeling resident is trying to express.</p> <p>Record Review of Resident #2's comprehensive care plan did not reveal any alternations or interventions that were put into place for Resident #2 after the incidents occurred on 07/06/2024 and 04/25/2024.</p> <p>Record Review of Resident #3's Admission MDS with an ARD of 06/26/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #3's diagnoses included: Alcohol Dependence with Withdrawal, Unspecified Tremors and Generalized Muscle Weakness. Resident #3 had a BIMS score of 14 indicating no cognitive impairment. Resident #3 had no potential indicators of psychosis or wandering.</p> <p>Record review of the facility's investigation report, dated 07/14/2024, revealed that the incident occurred on 07/06/2024 at 10:30 pm between two facility resident's, Resident #2 and Resident #3. Witness statements revealed that LVN A was completing her rounds when she witnessed Resident #2 on top of Resident #3. LVN A left the room and got LVN B as a witness to return to the room. Upon return to Resident #2's room, LVN A and LVN B revealed that they saw Resident #3 sitting on the side of Resident #2's bed. Resident #3 proceeded to get up from the bed, pulled up his pants, and fastened his belt. Facility investigation report revealed that Resident #3 had the capacity to make informed decisions. The facility did not indicate if Resident #2 had the capacity to make informed decisions. Provider response from the facility's investigation report revealed that the facility separated both residents and Resident #3 was asked to return to his room. A head-to-toe assessment was attempted but declined by Resident #2. MD, Family (did not indicate who), and facility Ombudsman were notified, safe survey rounds were completed by the facility. Facility investigation findings revealed the facility was unable to substantiate the findings. The facility concluded that Resident #3 was discharged to the community on 07/10/2024 and that the facility will continue to support Resident #2. Facility investigation report revealed that the local law enforcement was not notified and Resident #2 was not sent out to the hospital for a SANE (Sexual Assault Nurse Examination) at any time during or at the conclusion of the investigation.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of document titled, [Facility Name] Incidents by Incident Type dated for 08/08/2024 revealed that an incident report was initiated by the facility on 07/06/2024 for Resident #2, but not for Resident #3. Incident report for Resident #2 revealed a date of 07/06/2024 at 9:56 PM and incident category of , Other Incidents. Incident report for Resident #2 revealed to be crossed out which indicated the incident report to be deleted. Review of document revealed no other incident report initiated for Resident #2.</p> <p>Record review of a document titled, Progress Notes with a date of 07/07/2024, revealed that the nurse was going for her ward rounds during shift change and entered Resident #2's room where she observed Resident #2 and a male resident in a sexual position. The incident at that time was reported to the DON, Administrator, and Weekend Supervisor. Resident #2's sons were notified, and a message was left. Resident #2's NP (Nurse Practitioner) was notified.</p> <p>Record review of a document titled, Progress Note, dated for 07/07/2024 revealed that Resident #2 refused a skin assessment to be performed.</p> <p>Record review of a document titled, Progress Note, dated for 07/08/2024 revealed that Resident #2 refused a skin assessment to be performed.</p> <p>Record review of Resident #2's document titled, Progress Note, dated for 07/09/2024 revealed that labs were ordered. Resident #2 continued to attempt to go downstairs via elevator, staff continued to re-direct and educate.</p> <p>Record review of a document titled, Trauma Screen, dated for 07/08/2024 revealed that Resident #2 did not reveal any signs of trauma after the incident. The document revealed that during the trauma screen interview Resident #2, laughed anxiously when [she was] asked about the incident that occurred on Saturday.</p> <p>Record review of a document titled, Psychiatric Subsequent Assessment revealed a date of Service of 07/22/2024 for Resident #2. Document revealed the reason for the referral [for psychiatry services] was anxiety and worrying and the chief complaint was possible abuse. Document revealed that staff witnessed Resident #2 in an intimate position with another resident. Mental Status Examination revealed that Resident #2's thought process was illogical, associations and thought content was unable to be assessed as Resident #2 was non-verbal. Resident #2's insight and judgement were both poor.</p> <p>Record Review of Resident #3's document titled, Nurse Administration Record revealed an order that stated, Resident to be on one on one observation, every shift for observation. Order start date 07/06/24 at 2301 and D/C (Discontinue) date of 07/17/24 at 0913.</p> <p>Interview with LVN A on 08/10/2024 at 3:12PM revealed that she was the nurse for Resident #2 on 07/06/2024. LVN A revealed that she walked into Resident #2's room and observed Resident #2 on top of Resident #3 in bed. LVN A revealed that she did not witness penetration as there was not enough light in the room. LVN A revealed that she alerted LVN B for a witness. LVN A revealed that they both saw Resident #3 pulling up his pants and fastening his zipper while still in Resident #2's room. LVN A revealed that Resident #3 exited Resident #2's room and she alerted the Weekend Supervisor of the incident. LVN A revealed that Resident #2 was placed on every 15-minute checks but was unaware there was not a physician order or alternation to Resident #2's plan of care. LVN A revealed that Resident #2 did not have the capacity to consent, and wandered constantly, but was easily re-directed.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN B on 08/06/2024 at 1:14 PM revealed that she was the nurse for Resident #2 on 07/06/2024. LVN B revealed that she did not witness Resident #3 enter Resident #2's room. She revealed that LVN A alerted her during her rounds that she discovered Resident #2 on top of Resident #3. When she arrived to the room, she saw Resident #3 with his shirt unbuttoned, belt unbuckled and pants unbuttoned. LVN B revealed she alerted the Weekend Supervisor who alerted the Administrator. LVN B stated that Resident #2 was started on every 15- minute checks but could not state if Resident #3 began any enhanced monitoring that night. LVN B revealed that this behavior for Resident #2 was off her baseline. LVN B revealed that Resident #2 did not have the capacity to consent. LVN B revealed that Resident #3 resided on the first floor of the facility and Resident #2 resided on the second floor of the facility . LVN B revealed that residents had access to utilize the elevator from top to bottom floor at any time of the day and night without restriction.</p> <p>Interview with LVN C on 08/12/2024 at 11:34 AM revealed that she was the nurse for Resident #3 on 07/07/2024 from 6AM-10PM. LVN C was unsure why the one-on-one monitoring order did not start the night the incident occurred as per the NAR the order started on 07/06/24. LVN C revealed she did sign off on the one-to-one monitoring order, but no staff member was continuously monitoring Resident #3. LVN C revealed she and her CNA had other resident's they had to take care of and attend to their needs. LVN C revealed she did observe Resident #3 throughout her shift as she could. LVN C was unable to reveal documentation for Resident #3's location during her assigned shifts or reveal if Resident #3 had access to Resident #2 during her assigned shifts. LVN C revealed that residents did have access to utilize the elevator from top to bottom floor at any time of the day and night without restriction.</p> <p>Interview with RN D on 08/12/2024 at 3:42 PM revealed that she was the nurse for Resident #3 on 07/08/24, 07/09/24 and 07/10/24. RN D revealed that she was aware the order stated one-to-one monitoring and she signed off on the order during those shifts but revealed that Resident #3 was not on one-to-one monitoring during that time. RN D revealed that herself and her CNA had other resident's assigned to them during those shifts and were unable to perform one to one monitoring for Resident #3 and attend to the other resident's' needs. RN D did not reveal if she alerted the DON or physician of their inability to meet Resident #3's needs per the physician's order. RN D revealed that every time Resident #3 was in the hallway, she would monitor him. RN D was unable to reveal documentation for Resident #3's location during her assigned shifts or reveal if Resident #3 had access to Resident #2 during her assigned shifts. RN D revealed that resident's did have access to utilize elevators from the top to bottom floor at any time of the day and night without restriction. RN D revealed a risk of not following physicians' orders would be enlarging an issue already present for that resident.</p> <p>Interview with RN E on 08/09/2024 at 4:00 PM revealed that she was the nurse for Resident #3 on 07/07/2024 during the 10PM-6AM shift as indicated on Resident #3's MAR. RN E revealed that she did sign off on the one-to-one monitoring order, and that she and her CNA had multiple resident's that night and were unable to monitor the resident on a one-to-one basis throughout the shift. RN E did not reveal if she alerted the DON or physician of their inability to meet Resident #3's needs per the physician's order. RN E revealed she did check on Resident #3 periodically throughout her shift. RN E was unable to reveal documentation for Resident #3's location during her assigned shifts or reveal if Resident #3 had access to Resident #2 during her assigned shifts. RN E stated she was unaware of what the one-to-one order constituted. RN E revealed that resident's had access to utilize the elevator from the top to bottom floor at any time of the day and night without restriction.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN F on 8/12/2024 at 10:00 AM revealed that she did not remember Resident #3 or signing off on the one-to-one monitoring order. LVN F revealed that she did not remember having a resident on any type of enhanced monitoring. LVN F revealed she never worked with just one resident before or seen any other staff member be assigned to just one resident for enhanced monitoring. LVN F revealed that resident's had access to utilize the elevator from the top to bottom floor at any time of the day and night without restriction.</p> <p>Interview with the LVN Weekend Supervisor on 08/08/2024 at 12:49 PM revealed that she was the nurse supervisor on the weekends for the facility. The LVN Weekend Supervisor revealed that she was alerted by LVN A and B that Resident #2 and Resident #3 were caught having intercourse. The LVN Weekend Supervisor revealed that no staff member witnessed penetration since the room was dark at the time of discovery. Resident #3 left Resident #2's room independently but reported to staff that Resident #2 wanted to go with him to his room. The LVN Weekend Supervisor revealed she was unaware if Resident #3 was placed on enhanced monitoring on 07/06/2024 and could not remember receiving an order from the medical director for enhanced monitoring. The LVN Weekend Supervisor revealed that Resident #2's cognition varies and she had severe deficits in her short-term memory.</p> <p>Interview with RP #1 on 08/08/2024 at 10:25 am revealed that she was aware of the incident that occurred between Resident #2 and Resident #3. RP #1 revealed that she was told by staff that Resident #2 was found in bed with a male resident. RP #1 revealed that she was shocked by the event as that was not like Resident #2's baseline behavior. RP #1 revealed that she visited Resident #2 the next day, 07/07/2024 and Resident #2 did not reveal any physical markings or changes in behavior. RP #1 revealed that she was unaware Resident #2 refused to go to the hospital after the incident occurred for further examination and was not aware Resident #2 refused head-to-toe assessments after the incident occurred. RP #1 revealed she requested the facility to ensure that Resident #2 had no more contact with Resident #3. RP #1 revealed she was unsure what interventions were put into place or what the outcome of the facility investigation was. RP #1 was aware that Resident #3 discharged from the facility. RP #1 was unaware of what interventions were put into place to prevent repeated victimization of Resident #2. RP#1 revealed she was aware of the incident that occurred on 04/25/24 between Resident #2 and a male staff member, but was not aware of any interventions that were put into place to protect Resident #2 from further victimization. RP #1 revealed she was aware Resident #2 has been on psychiatric services, admitted to psychiatric services unknown by RP #1.</p> <p>Interview with RP #2 on 08/08/2024 at 10:50 am revealed that he was the Power of Attorney for Resident #2. RP #2 revealed that he was unaware of the incident that occurred between Resident #2 and Resident #3. RP #2 revealed that he was alerted of the incident back in April of 2024 between Resident #2 and a male staff member. RP #2 revealed that he was unsure of what interventions were put into place to prevent repeated victimization of Resident #2. RP #2 revealed that he would defer to Resident #2's medical team to determine Resident #2's decision making abilities and abilities to consent. RP #2 revealed he was not alerted by the facility that Resident #2 refused to go to the hospital or refused head-to-toe assessments. RP #2 revealed that he was unaware that the facility investigated the incident or what the outcome of the investigation was.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with NP #4 on 08/08/2024 at 3:22 PM revealed that she had been the Psychiatric Nurse Practitioner for Resident #2 for a year and half. NP #4 revealed that she worked with the facility and Resident #2 for medication management related to her behaviors. NP #4 revealed that she was alerted by the facility of the event that occurred between Resident #2 and Resident #3 and the facility requested an updated evaluation. NP #4 revealed that there were no medication adjustments performed or changes in behaviors for Resident #2 after the incident. NP #4 revealed that Resident #2 reacted impulsively, is not aware of the potential consequences related to her actions, and lacks the foresight to make safe and sound decisions. NP #4 was not aware of any interventions that the facility took after the incident occurred for Resident #2. NP #4 revealed that she was not referred for services for Resident #3 and was not familiar with his care.</p> <p>Interview with MD G on 08/12/2024 at 9:10 AM revealed that she had been the attending physician for Resident #2 for two years. MD G revealed that she was alerted of the incident between Resident #2 and Resident #3 by the Administrator. MD G revealed the Administrator stated to her that Resident #2 and Resident #3 were found engaging in a sexual act, but no penetration was confirmed. MD G revealed after the incident she ordered labs and requested psych services for Resident #2. MD G revealed she did not order for Resident #2 to go to the hospital for a SANE. MD G revealed she could not remember if she did order enhanced monitoring for Resident #2 after the incident, but it was her expectation of the facility to contact her or her Nurse Practitioner to receive an order for any type of enhanced monitoring before initiating. MD G revealed she was unaware the facility initiated enhanced monitoring for Resident #2 without a physician's order. MD G revealed it is her expectation of the facility to call her or her Nurse Practitioner for any changes or alterations in their resident's plan of care. MD G revealed that she spoke with the facility's psych provider for Resident #2 and confirms that Resident #2 does not have the capacity to consent or make safe and sound decisions independently. MD G revealed she did not discuss with the facility after the incident occurred about resident #2's ability to consent.</p> <p>Interview with the Facility Social Worker on 08/08/2024 at 11:27 AM revealed that she was alerted of the incident between Resident #2 and Resident #3 on the Monday following the incident as the incident occurred on a weekend. The Social Worker revealed that she interviewed Resident #2 on 07/08/24 to conduct a trauma informed screening. She revealed that Resident #2 had no alternations in behavior or physical markings after the incident. She revealed that Resident #2 had no signs of trauma, but she did indicate in the trauma screening that Resident #2 had anxious responses when asked about the incident. She revealed that Resident #2 stated, they only kissed and did not want to discuss the incident anymore. The Social Worker revealed she interviewed Resident #3 and he stated to the Social Worker that he was in love with Resident #2. The Social Worker revealed that she believed that Resident #2's cognitive and judgement abilities are related to the situation. The Social Worker confirmed that Resident #2 was on continued psychiatry and psychology services. The Social Worker revealed that she was unsure of what interventions were put into place for Resident #2 or Resident #3 after the incident occurred. She revealed that Resident #3 was issued a NOMNC (Notice of Medicare Non-Coverage) for a discharge date of [DATE] based on his therapy progress. The Social Worker revealed that Resident #2 was in a similar incident back in April 2024 with a male staff member. The male staff member was terminated from the facility and the facility's investigation revealed that the male staff member kissed the resident. The Social Worker could not reveal any interventions or alterations that were put into place for Resident #2 to prevent repeated victimization after this incident.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on 08/12/2024 at 5:47 PM revealed that he was alerted of the incident between Resident #2 and Resident #3 on 07/06/2024 by facility staff. The DON revealed that he was alerted that Resident #2 was found on top of Resident #3, there was no evidence of penetration, but suspicion of a sexual position. The DON revealed that Resident #2 and Resident #3 were separated from one another and both resident's were placed on enhanced monitoring. The DON revealed that Resident #2 was not sent out to the hospital for further examination or law enforcement was not contacted as there were no indicators of sexual coercion or force. The DON revealed that Resident #2 was in a similar incident back in April 2024 with a male staff member. The male staff member was terminated from the facility and the facility's investigation revealed that the male staff member kissed the resident. The DON could not reveal any interventions or alterations that were put into place for Resident #2 to prevent repeated victimization after this incident. The DON revealed that it was his expectation that the nursing staff would reach out to the physician for orders and direction after an incident involving possible sexual abuse occurs. The DON revealed that facility staff did not reach out to MD G for enhanced monitoring orders, but instead used nursing judgement. The DON revealed that he was unsure why Resident #3's orders were for one-to-one monitoring every shift as he was certain they were for Every 15-minute checks. The DON revealed he was unaware the nursing staff for Resident #3 was not executing the orders as written and ordered by the Medical Director. The DON revealed that he was unsure if Resident #2 and Resident #3 had contact with one another due to the order not being executed per physicians' orders. The DON revealed that there was not an additional staff member assigned to Resident #3 for one-to-one monitoring as he thought the orders were for 15-minute checks, which he revealed could be completed without an additional staffed nurse or CNA (Certified Nursing Assistant). The DON revealed that it was his expectation for staff, when, executing a one-to-one monitoring order, that the resident would be kept in proximity of that assigned staff member at all times during the duration directed in the order. The DON revealed that he was unsure why Resident #2's care plan did not reveal any alterations or interventions that were put into place after this incident and the incident that occurred on 04/25/2024 with a male staff member. The DON revealed risks for not following physicians' orders would be inadequate care delivery.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on 08/08/2024 at 2:20 PM revealed that he was first alerted of the incident on 07/06/2024 by LVN Weekend Supervisor that Resident #2 was caught in bed with Resident #3. There was an assumption of intercourse at that time, but the Administrator revealed that they only kissed based on the facility investigation. The Administrator revealed that the two residents were separated after the incident and placed on enhanced monitoring but was unsure if the physician gave the order for enhanced monitoring for either resident. Resident #2's [family members] were contacted after the incident occurred. The Administrator revealed he reported the incident to the state survey agency but did not contact law enforcement as he viewed the incident as consensual between both residents. The Administrator revealed that Resident #2 refused head to toe assessments and she was not sent out to the hospital for further examination as the incident was considered consensual. The Administrator was asked on what basis he believed the event was consensual between the two residents given MD G and NP #4's statements, the Administrator revealed it was in his opinion that Resident #2 had the ability to consent. The Administrator revealed that Resident #2 was in a similar incident back in April 2024 with a male staff member. The male staff member was terminated from the facility and the facility's investigation revealed that the male staff member kissed the resident. The Administrator could not reveal any interventions or alterations that were put into place for Resident #2 to prevent repeated victimization after this incident. The Administrator revealed that this sexual behavior for Resident #2 was typical of her baseline and labeled Resident #2 as hypersexual. The Administrator was asked on what basis of information did he conclude that Resident #2 was hyper-sexual, he directed the surveyor back to NP #4. The Administrator revealed that Resident #3 was discharged from the facility on 07/11/2024. The Administrator did not give any risks for not executing physicians' orders properly or risks for not identifying or alternating resident's plan of care after incidents of victimization occur.</p> <p>On 08/08/2024 at 5:44PM an Immediate Jeopardy (IJ) was identified. The Administrator and Director of Nursing was notified. The Administrator was provided with the IJ template, and a Plan of Removal (POR) was requested at that time.</p> <p>The facility's Plan of Removal was accepted on 08/11/2024 at 4:34 PM and included:</p> <ol style="list-style-type: none"> <li>1. Administrator submitted a self-report to HHSC regarding the incident on 7/6/24 Intake #516319</li> <li>2. Attending Physician for involved residents was notified of the incident on 7/6/24.</li> <li>3. Social Worker conducted a trauma assessment with female resident on 7/8/24.</li> <li>4. Male resident was placed on 1:1 monitoring by facility staff 7/6/24.</li> <li>5. Male resident has been discharged from facility on 7/10/24.</li> <li>6. Licensed Nurse tried to conduct a head-to-toe assessment on female resident, but she refused even after several attempts on 7/6/24 an on 7/7/24.</li> <li>7. Female resident refused to go out to the hospital for further evaluation on 7/6/24.</li> <li>8. The Director of Nursing began obtaining witness statements from staff. On 7/6/24.</li> </ol> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>9. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with interview able residents on 7/9/24.</p> <p>10. Both residents were referred to [psych provider] for psychological assessment and to be picked up on services if needed on 7/9/24</p> <p>11. Female resident was placed on 1 on 1 on 8/8/24</p> <p>12. Female resident seen by [psych provider] services on 8/9/24</p> <p>13. New Safe Surveys completed on 8/9/24 and 8/10/24</p> <p>14. Facility Administrator was terminated effective 8/10/2024</p> <p>15. Referrals for female resident's alternate placement on an all-female unit have been sent out, female resident's [family member] agreed to the plan of discharge on 8/11/24</p> <p>16. The female residents plan of care and EMR was updated on 08/08/2024 to reflect that this resident will remain on one-to-one supervision until resident is discharged .</p> <p>17. A facility wide audit on residents with dementia, PTSD or history of sexual violence was completed by Director of Nursing on 08/11/2024. No other residents were identified to be at risk for victimization at this time. A trauma assessment will be completed on all new residents to identify those at risk of victimization and alternate/appropriate placement will be immediately sought for those that are at risk.</p> <p>18. Reviewed current Abuse and Neglect Policy to ensure it is appropriate for staff to follow and protect residents from abuse and neglect on 8/8/24.</p> <p>In-Service conducted.</p> <p>The Director of Nursing/Designee (after re-educated below) re-educated facility staff on:</p> <p>1. On 8/8/24 Director of Nursing and Administrator were re-educated on Abuse &amp; Neglect Policy and implementation of appropriate interventions to ensure resident safety by Regional Director of Operations.</p> <p>2. Staff in-service was initiated on 8/8/24. Staff members are being re-educated to report all allegations of abuse immediately upon notification to the Administrator who is the abuse coordinator. Staff will complete an Abuse &amp; Neglect competency posttest at time of in-servicing.</p> <p>3. Facility staff were also re-educated by the administrator on implementation of interventions to ensure resident safety. Re-education was initiated on 8/8/2024.</p> <p>4. The expected completion date will be 8/9/2024. Staff who have not been trained on Abuse &amp; Neglect will not be allowed to work until they have completed required in-services.</p> <p>5. In - service/ ADHOC QAPI completed with Medical Director on 8/9/24 on abuse and neglect policy.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>6. An interim administrator has been appointed and will start 8/12/2024. He will be educated on this Plan of removal and facility Abuse and neglect policy before he starts functioning as the facility administrator. Once a permanent facility Administrator is appointed, they will also be educated on this Plan of removal and the facility Abuse and Neglect policy.</p> <p>7. Social worker was re-educated by Regional Director of Operations on 8/11/2024 to complete a trauma assessment on all new residents to identify those at risk of victimization and immediately seek alternate/appropriate placement for those identified to be at risk.</p> <p>8. The Regional Director of Operations and Director of Nursing re-educated facility staff on enhanced monitoring and expectations. Re-educated completed on 8/11/2024.</p> <p>Implementation of Changes:</p> <p>Staff will immediately inform the Administrator or Director of Nursing immediately when made aware of the any abuse allegation. The administrator or director of nursing will ensure implementation of interventions for resident safety.</p> <p>A quick reference sheet of interventions has also been provided to staff and posted at the nurse's station.</p> <p>In the absence of the Administrator, abuse allegations will be reported to the Director of Nursing.</p> <p>The Regional Director of Operations and Regional Nurse Consultant will be responsible for implementation of the process and will review the process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring:</p> <ol style="list-style-type: none"> <li>1. Administrator/DON or designee will complete daily reviews of each incident for proper interventions during daily IDT meetings.</li> <li>2. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents to ensure safety x 2 months</li> <li>3. 5 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week x 2 months</li> <li>4. The Administrator, Director of Nursing or designee will interview fiv [TRUNCATED]</li> </ol>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</b></p> <p>Based on observations, interview, and record review, in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to ensure alleged violations were thoroughly investigated for 2 (Residents #1 and #2) of 6 residents reviewed for resident abuse.</p> <p>The facility failed to ensure Resident #1's abuse allegation from 06/15/24 was thoroughly investigated.</p> <p>The facility failed to ensure Resident #2's abuse allegation was thoroughly investigated for 07/26/24.</p> <p>An Immediate Jeopardy (IJ) was identified on 08/09/24 at 5:00 PM. The IJ template was provided to the facility on [DATE] at 5:24PM and signed by the Administrator. While the IJ was removed on 08/12/2024 at 7:05PM, 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 pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>This failure placed residents at risk for serious injuries, abuse, and serious harm due to their allegations not being thoroughly investigated.</p> <p>Findings included:</p> <p>1. Record Review of Resident #1's Admission MDS Assessment, dated 05/19/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. He was cognitively intact. He did not have any behaviors. His diagnoses included stroke, heart failure, and hemiplegia (paralysis of one side of the body.)</p> <p>Review of Resident #1's Care Plans , not dated, reflected:</p> <p>Resident had a history of making false allegations/inaccurate statements as evidenced by previously accusing/stating: Makes up stories of falling, explained the same fall with different version to other nurses</p> <p>Interventions:</p> <p>If statements were determined to be inaccurate, staff will reorient and redirect as needed with reassurance and reality orientation.</p> <p>Listen openly to allegations/inaccurate statements and offer clarification as needed.</p> <p>Resident had potential to demonstrate verbally abusive behaviors related to ineffective coping skills, and poor impulse control.</p> <p>Interventions:</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document.</p> <p>Assess resident's coping skills and support system.</p> <p>Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation.</p> <p>Evaluate for side effects of medications.</p> <p>Provide positive feedback for good behavior. Emphasize the positive aspects of compliance.</p> <p>Psychiatric/Psychogeriatric consult as indicated.</p> <p>Record review of Resident #1's Progress Notes, dated 06/15/24 at 7:20 pm reflected:</p> <p>Resident came to the nursing station to complain that he requested a double portion, but he was served with one portion of meal at dinner. He was offered another tray of dinner, but he refused and said that he was going downstairs.</p> <p>7:26 PM</p> <p>Nurse was notified by the weekend supervisor that the resident wanted to go into the kitchen, but he was prevented from going in and he started altercation with the kitchen personnel. It was reported that the resident called the police. The resident came upstairs and said get my meds ready because I'm going out. Nurse had his medication prepared but the resident never came back to take his scheduled night medication.</p> <p>8:15 PM</p> <p>A CNA came and told this nurse that the resident just left with his [family member] to the hospital. Note documented by LVN H.</p> <p>Review of Resident #1's Facility Self-Report dated 06/15/24 reflected:</p> <p>It was reported to Administrator on 6/15/24 that Resident #1 and the Assistant Dietary Manager had a verbal altercation. It was then reported to that the resident said that the Assistant Dietary Manager hit him in the chest. When the Administrator interviewed Resident #1 , he said the Assistant Dietary Manager also threw his walker and grabbed him by the throat. The Assistant Dietary Manager was interviewed and he denied ever putting a hand on the resident. The Administrator interviewed staff and residents that were in the dining room and kitchen when the altercation happened. In all of the Administrator interviews, everyone stated that they never saw the Assistant Dietary Manager put his hands on Resident #1. They also all said that it was the resident who was the aggressor, yelling and cursing at the kitchen staff. Investigation findings were unconfirmed because there was no witnesses that ever saw the Assistant Dietary Manager touch or hit the resident. In all interviews the witnesses stated Resident #1 was the aggressor and the one that was yelling and cursing. The Assistant Dietary Manager was allowed to come back to work from suspension.</p> <p>1. Staff was in-serviced on abuse, neglect and dealing with aggressive behavior.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. The Assistant Dietary Manager was allowed to return to work.</p> <p>3. Resident #1 was presented a Behavior contract.</p> <p>Staff Witness Statements from the incident reflected:</p> <p>Resident #1 - The resident went to the kitchen to get double portions and the kitchen told him that they would send him another tray. He left and went back upstairs, and they could not find the tray. He came back downstairs and told them again that his tray was not up there. They told him that they would get him another tray once they finish with the other residents. He was standing in the door to the kitchen when he said the Assistant Dietary Manager came at him saying we are not going to do this Resident #1. Resident #1 then said that the Assistant Dietary Manager grabbed his walker and threw it about 10 feet. He then said that the Assistant Dietary Manager grabbed his neck and hit him in the chest. Resident #1 then stated that he took his shirt off to point at his chest that he had a pacemaker and then put his arms to his side and started saying that he did not touch anyone.</p> <p>Assistant Dietary Manager - Resident #1 was cursing at the cook about getting double portions. The Assistant Dietary Manager came to the door and asked the resident to not cuss at the employees. He stepped back into the kitchen and the resident called him a bitch. The Assistant Dietary Manager stated that he asked the resident, what you just said to me? The Assistant Dietary manager then said that he never put a hand on him. The Assistant Dietary Manager then stated that the resident tried to hit him but did not hit him. The resident then took his shirt off and started yelling that people were touching him.</p> <p>Dietary Aide I - He was working in the kitchen when Resident #1 came to the kitchen and was asking for more food. He stated that the resident started yelling at the cook and stating that he did not get double portions. The Dietary Aide I got the resident another plate and the resident still kept yelling at the staff. Dietary Aide I went and got the Assistant Dietary Manager to help with the resident, so they could finish the trays for the other residents. Dietary Aide I then said the Assistant Dietary Manager asked the resident to step out of the doorway to the kitchen. Resident #1 continued to yell and cuss at the Assistant Dietary Manager. The resident was getting more aggressive, and they tried to calm him down. Dietary Aide I stated that he never saw the Assistant Dietary Manager touch or hit Resident #1.</p> <p>Dietary Aide J - He stated that he never saw the Assistant Dietary Manager hit or touch Resident #1. He then stated that Resident #1 was the aggressor during the altercation.</p> <p>CNA K - see attached statement. (No statement attached.)</p> <p>Review of Resident #1's Hospital Records, dated 06/15/24, reflected the resident was an assault victim with a right chest wall contusion (bruise), neck strain, back strain, and contusion on his left ankle.</p> <p>There was no police report for 06/15/24.</p> <p>There was no facility incident report for 06/15/24.</p> <p>There was no resident assessment for 06/15/24.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>There was no trauma assessment for 06/15/24.</p> <p>The Surveyor requested the police report on 08/09/24 at 3:45 PM from the police department.</p> <p>An observation and interview with Resident #1 on 08/08/24 at 1:25 PM revealed he said he was assaulted on 06/15/24 by the Assistant Dietary Manager. He said he was supposed to get extra food and went down to get it and the Assistant Dietary Manager got in his face and threw his walker. He said it took 4-5 people to get him off of him. Resident #1 said he was scared of him and did not feel comfortable eating food from him. The resident said he had bruises on his neck and chest on 06/15/24 and went to the hospital. He said they took images of his chest and pacemaker. He said the right side of his chest was still sore. The resident said he currently was ordering take-out food and his RP complained because it was \$100/day. The resident said his food was almost always messed up. Resident showed the Surveyor a piece of over-cooked, dry bacon and said all three of his meals were messed up. The resident said he thought his walker was messed up because the Assistant Dietary Manager threw it. The resident said when he would go to the kitchen and see him, they whispered about him. The resident said he did not feel safe getting his food from the Assistant Dietary Manager. The Administrator walked over during the conversation and the resident showed the Administrator the piece of bacon. The Administrator said ok and walked away.</p> <p>An interview on 08/08/24 at 1:15 PM with the Assistant Dietary Manager revealed on 06/15/24 an incident occurred. He said on Resident #1's tickets he was supposed to get large portions. The resident would say he did not get them, but he did. He said on 06/15/24, Resident #1 came to the kitchen and had a tray with him. The resident also had a tray upstairs, and a 3rd one that the cook had. The Assistant Dietary Manager said when saw the resident he was arguing with the cook even though he had 3 trays. The resident was riled up, cussing, and the Assistant Dietary Manager took the tray from the resident. The resident told him he was, nothing but a bitch anyway. The Assistant Dietary Manager said he turned around, walked back to the resident and asked what he said. He repeated, you're nothing but a bitch. The Assistant Dietary Manager told Resident #1 that he was not going to call him a bitch. The Assistant Manager said he was angry and yelling back at the resident and the other staff was trying to keep both him and the resident calm. The resident ran up on the Assistant Dietary Manager and changed his mind and moved back. The Assistant Dietary Manager said he raised his voice at the resident and Resident #1 called the police. The Assistant Dietary Manager said he told the resident he was not going to be threatening his staff. The Assistant Dietary Manager said there was another incident when the resident came to the kitchen, but when he saw the Assistant Dietary Manager, the resident left. He is a headache, and he is one of a kind. The Assistant Dietary Manager said he had been trained to de-escalate behaviors and that is why he stepped into the situation. He said he did not receive any disciplinary action but was suspended pending investigation. He said [NAME] L no longer worked at the facility and the Dietary Manager was off on 06/15/24.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/08/24 at 1:35 PM with Dietary Aide J revealed he had worked at the facility for 2 months. He said on 06/15/24 he was washing the dishes and heard Resident #1 yelling and being mean to the staff. He said he went to the front and the Assistant Dietary Manager and the resident were cursing at each other and were in each other's face. Dietary Aide I said it got to a point where the argument was dying down and then the resident called the Assistant Dietary manager a bitch. The resident started cursing at all of the kitchen staff and the Assistant Dietary Manager responded and he got escalated. The Assistant Dietary Manager was upset. He was standing in the doorway and they were close to each other. HE went to grab the resident and was told not to put my hands on him. He stood by the resident's right shoulder and was facing the Assistant Dietary Manager to separate them. He said the Assistant Dietary Manager did not calm the situation, and he did not see them touch each other. Dietary Aide J said the Assistant Dietary Manager should have calmed down and let the situation go because the resident was about to leave by himself. The resident had a history of lashing out and then walking away. The police showed up 15 minutes later and the Assistant Dietary Manager left for the day. Dietary Aide J said he had to sign a paper but did not receive any in-services following the incident.</p> <p>An interview on 08/08/24 at 3:00 PM with CNA K revealed she had worked at the facility since 2022. She said on 06/15/24 Resident #1 got his tray and he said he did not get double portions. [NAME] L looked at his tray and said that he did receive double portions. The Assistant Dietary Manager came in and told the resident to step out of the kitchen. Resident #1 called the Assistant Dietary Manager the N word and stupid. The Assistant Dietary Manager was standing in the doorway of the kitchen. Resident #1 said he would slap the fuck out of the Assistant Dietary Manager. CNA K said she told the resident to come to her and told the resident he had to wait for his tray. Resident #1 reached across CNA K and tried to punch the Assistant Dietary Manager. CNA K said she told the Assistant Dietary Manager to back off and to walk away. CNA K said she got the tray for Resident #1. CNA K said the Assistant Dietary Manager escalated the situation and that she had to step in between them and back up Resident #1 for the Assistant Dietary Manager. She said the Assistant Dietary Manager should have walked away.</p> <p>An interview on 08/12/24 at 2:30 PM with LVN H revealed she was the nurse for Resident #1 on 06/15/24. She said she was told there was an incident in the kitchen and dining room and that Resident #1 we went in the kitchen and was insulting staff and calling them names. She said the LVN Weekend Supervisor was handling the situation. She said when the resident came back to her following the altercation he said he needed to get his medications. Resident told her that he went to the kitchen to get food and he was attacked and insulted by staff. LVN H said she did not know if anyone attacked him because he was always making up stories. She said the resident told her he went to the hospital, but she did not assess him before he left or when he got back. She said the resident was wearing a shirt. She said she did not believe that anyone attacked him and she did not know why he was a resident in the facility. She said she did not complete an incident report because she was not there when it happened.</p> <p>An interview on 08/12/24 at 4:15 PM with the LVN Weekend Supervisor revealed she did not work the weekend of 06/15/24.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/08/24 at 2:10 PM with the Administrator revealed on 06/15/24, he got a call the afternoon or evening that Resident #1 and the Assistant Dietary Manager had the altercation. He said when he arrived the police were wrapping up their investigation and gave him the police report number. The Administrator said he did get the police report. He said Resident #1 left the facility with his friend. The Administrator said he interviewed the staff in the dining room and interviewed the resident when he came back. The Administrator called the Assistant Dietary Manager and suspended him. The Administrator said he found in his interviews with staff the common denominator was that Resident #1 was the aggressor. He was loud and arguing with the cook and he did not feel he got double portions. He kept trying to go in the kitchen with his walker. He said the staff got the Assistant Dietary Manager and asked him to please not go in the kitchen. Resident #1 yelled more and took his shirt off and thought he was ready to fight the Assistant Dietary Manager. The Administrator said staff did not see the Assistant Dietary Manager touch Resident #1. Resident #1 said he took his shirt off and said he had a pacemaker. The Assistant Dietary Manager denied throwing the walker and no one observed him throw the walker. Resident #1 said he was going to the hospital to have his pacemaker checked out. The Administrator said staff were supposed to de-escalate situations and re-direct residents and remove them from the situation. The Administrator said staff were not supposed to yell at residents and staff had to separate the Assistant Dietary Manager and Resident #1, because Resident #1 was being aggressive. He said he suspended the Assistant Dietary Manager but felt the Assistant Dietary Manager handled the situation appropriately. The Administrator said the resident said he was going to the hospital, but he did not think he went.</p> <p>An interview on 08/09/24 at 12:05 PM with the DON revealed he did not know that there was no assessment or incident report for Resident #1 for 06/15/24. He said he did not know about the results of the hospital records for 06/15/24.</p> <p>An interview on 08/09/24 at 12:15 pm Administrator revealed the facility did not do an assessment because Resident #1 left, and the facility did not do incident reports for verbal aggression.</p> <p>An interview on 08/09/24 at 2:50 PM with the Medical Director revealed Resident #1 was his resident. He said he knew the resident had frequent altercations and was only aware of the resident's most recent hospitalization on [DATE]. He said he did not know what the hospital records for 06/15/24 said. He said he did not expect that the facility would have done a more thorough investigation if they did not know he went to the hospital.</p> <p>Record review of the facility policy, Abuse Prevention and Prohibition Program, revised 10/24/22, reflected:</p> <p>I. VI. Investigation</p> <p>A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts.</p> <p>i. The Facility has protocols for investigations of theft/misappropriation of resident property abuse.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>B. If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of an unknown source or crime, the Administrator or designee, may appoint a member of the Facility's management team (the Investigator) to investigate the alleged incident.</p> <p>i. If the investigation is delegated, the Administrator provides the Investigator with any supporting documents related to the alleged incident.</p> <p>C. The Investigator may take some or all of the following steps:</p> <p>i. Reviews all relevant documentation;</p> <p>ii. Reviews the resident's medical record to determine events preceding the alleged incident;</p> <p>iii. Interviews the person(s) making the incident report;</p> <p>iv. Interviews any witnesses to the alleged incident;</p> <p>v. Interviews the resident (as medically appropriate);</p> <p>vi. Interviews the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition;</p> <p>vii. Interviews Facility Staff members who have had contact with the resident during the period of the alleged incident .</p> <p>The Administrator was notified of the Immediate Jeopardy on 08/09/24 at 6:10 PM due to the above failures and provided the IJ template to Corporate DON. A Plan of Removal was requested.</p> <p>The facility's plan of removal was accepted on 08/11/24 at 4:35 PM and included the following:</p> <ol style="list-style-type: none"> <li>Administrator submitted a self-report to HHSC regarding the incident on 06/15/2024. Intake #511237</li> <li>Attending Physician for involved residents was notified of the incident by the nurse on 08/09/2024.</li> <li>Social worker conducted a trauma screen with male resident on 8/10/2024, trauma screen finding was normal. If trauma screen had been abnormal, physician would be notified and EMR updated to reflect interventions.</li> <li>Assistant Dietary Manager was immediately suspended on 6/15/24.</li> <li>A copy of the residents' hospital records has been obtained and reviewed by the Director of Nursing and residents attending physician on 8/9/2024.</li> <li>A new online request for a copy of the police report was submitted on 8/10/2024 by the administrator.</li> </ol> <p>(continued on next page)</p>

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>7. A complete head to toe assessment was completed on the resident on 8/10/2024.</p> <p>8. Witness statements were obtained by the Administrator on 6/15/2024.</p> <p>9. Witnesses reinterviewed on 8/8/24 and 8/10/24</p> <p>10. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with interview able residents on 08/09/2024. The non interviewable resident received a complete head to toe assessment on 08/09/2024. Any negative findings were immediately investigated, physician and responsible party notified and EMR with interventions.</p> <p>11. Affected resident was referred to [psych hospital] for psychological assessment and to be picked up on services if needed on 06/21/2024.</p> <p>12. Assistant Dietary Manager employment with the facility was terminated on 8/08/2024.</p> <p>13. Trauma screen completed by the social worker on 8/10/24 post record review, results were normal.</p> <p>14. Resident seen by Team Health psychologist on 8/10/24.</p> <p>15. Hospital records reviewed and uploaded on 8/8/24 by the Medical Records Director.</p> <p>16. Physician notification of hospital records received on 8/9/24 by the Director of Nursing.</p> <p>17. Care plan updated to reflect receipt of hospital records on 8/10/24, MDS coordinator.</p> <p>18. Medical dx updated to reflect hospital records on 8/10/24 , by MDS coordinator.</p> <p>19. New incident report completed on 8/10/24, the Director of Nursing.</p> <p>20. Facility Administrator was terminated effective 8/10/24</p> <p>In-Service conducted</p> <p>Director of Nursing or designee (after re-educated below) re-educated facility staff on:</p> <p>1. On 8/9/24 Director of Nursing and Administrator were re-educated by the Regional Director of Operations on Abuse &amp; Neglect Policy, verbal, physical, sexual abuse and implementation of appropriate interventions to ensure residents are not afraid and feel safe. Administrator and Director of Nursing were also re-educated on how to complete thorough investigation of incidents including completion of assessments, offering resident treatment, obtaining hospital records and obtaining police reports.</p> <p>2. Post test completed with Administrator and DON on thoroughly investigating Abuse and neglect on 8/9/24</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. Staff in-service by the Administrator, DON or designee was initiated on 8/9/24. Staff members are being re-educated to report all allegations of abuse immediately upon notification to the Administrator who is the abuse coordinator. Re-education has an emphasis on De-escalation. Preventing abuse also involving staff and resident safety with emphasis on creating an environment where residents do not feel afraid. Staff will complete an Abuse &amp; Neglect competency posttest at time of in-servicing.</p> <p>4. Staff are being re-educated by the Administrator, DON or designee to recognize signs of a resident being abused and early recognition of residents that do not feel safe. All such suspicions must immediately be reported to the Administrator or Director of Nursing on 8/9/24</p> <p>5. Facility nurses were re-educated 8/9/2024 to ensure residents are assessed and incident reports are completed following abuse allegations.</p> <p>6. Facility staff were also re-educated by the administrator on implementation of interventions to ensure resident safety. Re-education was initiated on 8/9/2024.</p> <p>7. The expected completion date will be 8/10/2024. Staff who have not been trained on Abuse &amp; Neglect will not be allowed to work until they have completed required in-services.</p> <p>8. An interim administrator has been appointed and will start 8/12/2024. He will be educated on this Plan of removal and facility Abuse and neglect policy before he starts functioning as the facility administrator. Once a permanent facility Administrator is appointed, they will also be educated on this Plan of removal and the facility Abuse and Neglect policy.</p> <p>Implementation of Changes</p> <p>The regional Director of Operations and the Regional Nursing Consultant will review all incidents and allegations to ensure thorough investigations are completed daily x3 months then weekly their after.</p> <p>Staff will immediately inform the Administrator or Director of Nursing immediately when being made aware of the any abuse allegation. The administrator or director of nursing will ensure implementation of interventions for resident safety.</p> <p>A quick reference sheet of interventions has also been provided to staff and posted at the nurse's station.</p> <p>Alleged perpetrators will immediately be placed on one-on-one monitoring pending investigation and physician direction.</p> <p>The victim will be immediately assessed for injury, safety awareness, physician notification and continue to be monitored pending investigation and physician direction. Victim's Medical records will be updated to reflect any changes as needed.</p> <p>In the absence of the Administrator abuse allegations will be reported to the Director of Nursing.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>All allegations and incidents will be reviewed to the daily IDT team meeting to review for resident assessment and completion of an incident report.</p> <p>The Regional Director of Operations and the Regional Nurse Consultant will be responsible for implementation of the process and will review the process daily X3 months then weekly their after by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring</p> <ol style="list-style-type: none"> <li>1. Administrator/DON or designee will complete daily reviews of each incident to make sure residents are assessed, incident reports are completed, and interventions are put in place during daily IDT meetings.</li> <li>2. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents to ensure safety X2 months.</li> <li>3. 5 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week x2 months.</li> <li>4. The administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions. Findings will be documented on Abuse &amp; Neglect monitoring form x2 months.</li> <li>5. RDO and RNC will review and monitor all allegations and incidents for appropriate implementation of interventions x3 months.</li> <li>6. RDO or RNC will review grievances weekly which are in the facility grievance binder for three months to monitor for appropriate interventions x4 months.</li> <li>7. Any adverse outcomes will be reported to the monthly QAPI Committee meeting with the Medical Director.</li> </ol> <p>Involvement of Medical Director</p> <p>The Medical Director was notified about the immediate Jeopardy on 8/9/2024.</p> <p>Involvement of QA</p> <p>On August 9th, 2024 an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review the plan of removal.</p> <p>Who is responsible for the implementation of the process?</p> <p>The Regional Director of Operations and Regional Nurse Consultant will be responsible for the implementation of the new process.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 8/9/2024</p> <p>The facility's implementation of the IJ Plan of Removal was verified through the following:</p> <p>Record reviews of the Facility in-services started on 08/08/24 through 08/12/24 reflected all in-services were reviewed and were given to over 50 employees. The remaining employees were to be in-serviced prior to the start of their shift. The in-services included information on abuse and neglect, de-escalation of behaviors, keeping incidents to only a small number of people, speaking calmly during situations, protecting the resident, and validating the resident's concerns, resident assessments, and completing thorough investigations. Resident #1's documentation and assessments reflected in the plan of removal were reviewed and in the electronic heal record. Safe surveys were reviewed, the quick reference sheet was posted at the nurse's station, and the QAPI meeting sign-in sheet for 08/09/24 was reviewed.</p> <p>An interview on 08/12/24 at 4:50 PM with Resident #1 and his RP revealed he was happy that the Assistant Dietary Manager and Administrator were no longer working at the facility. He said it would take time for him to feel comfortable again.</p> <p>An interview with the Regional Director of Operations on 08/12/24 at 7:00 PM revealed LVN H, the Assistant Dietary Manager, and the Administrator were terminated from employment.</p> <p>Interviews on 08/12/24 from 11:05 AM to 7:00 PM with 16 staff from all shifts (Cook M, Dietary Manager, Dietary Aide N, CNA O, CNA P, CNA Q, CNA U, CNA R, CNA S, CNA T, LVN U, LVN V, LVN W, RN X, RN Y, and LVN Z) revealed they were in-serviced on the facility abuse policy, types of abuse, de-escalation of behaviors, when to report abuse, who to report abuse to, how to protect a resident during an abusive situation, what to do if a resident reported they did not feel safe, and when to complete assessments. The said they received all in-services and completed the post-tests.</p> <p>An interview with the DON on 08/12/24 at 5:45 PM revealed his role in the Plan of Removal was to participate in all interventions for problems identified. He would be implementing interventions, educating staff, care planning, documentation, and notification. He said he had spoken with the staff and explained that they were there to help the residents and not think of them as problems. He said he was teaching the staff to listen to resident concerns and address them. The DON said he would complete daily reviews of each incident to make sure residents were assessed, incident reports were completed, and interventions were put in place. The DON said he/Administrator would interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions. Findings would be documented on Abuse &amp; Neglect monitoring form X2 months. The DON said all incidents were reported to him so he could confirm proper steps were taken and followed. He said he read the 24-hour report daily to ensure no issues were missed with IDT. He said his plan for Resident #1 was to visit him daily. The DON said failure to follow abuse and neglect policies and failure to do investigations could put the resident's life in danger.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/12/24 at 6:45 PM with the Interim Administrator revealed it was his first day as Administrator. He said his role in the POR was to be the Abuse Coordinator. He said he would make sure all in-services and all allegations were reported to him. If a resident alleges an allegation the facility was not going to just write it off. He said he would fully investigate all allegations. He said he would complete daily reviews of each incident to make sure residents were assessed, incident reports were completed, and interventions were put in place during daily IDT meetings. He said the IDT would review all things that happened the prior day. He said he and the DON would interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions.</p> <p>Findings Included:</p> <p>2. Record review of Resident #2's Quarterly MDS with an ARD (Assessment Reference Date) of 05/24/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 diagnoses included: Alzheimer's Disease (neurological disorder that affects memory, thinking and behavior), Age-Related Physical Debility, and Alcohol Abuse. Resident #2 had a BIMS score of 11 indicating a moderately impaired cognition. Resident #2 had disorganized thinking and no potential indicators of psychosis, but did have a behavioral presence of wandering.</p> <p>Record Review of Resident #2's Comprehensive Care Plan, dated 08/08/2024, revealed the following:</p> <p>Focus- [Resid [TRUNCATED]</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</b></p> <p>Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan for each resident that included measurable objectives and time frames that met the resident's medical, nursing and mental needs for two (Resident #2 and Resident #1) out of 3 residents reviewed for care plans.</p> <p>The facility failed to identify individualized interventions and objectives in the comprehensive care plan for Resident #2, after Resident #2 was involved in an alleged sexual abuse incident with a male staff member on 04/25/2024.</p> <p>The facility failed to protect Resident #2 who was a prior victim of abuse and unable to give consent for sexual activity.</p> <p>The facility failed to identify individualized interventions and objectives in the comprehensive care plan for Resident #2 after Resident #2 was involved in a sexual abuse incident with a male resident on 07/06/2024.</p> <p>This failure could place residents at risk for repeated victimization.</p> <p>After administrative review, an IJ was identified on 08/22/24. The Administrator and Regional Director of Operations were notified and an IJ template was provided on 08/22/24 at 9:54 AM. While the IJ was removed on 08/12/2024 at 7:05PM, 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 pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>Findings Included:</p> <p>Record Review of Resident #2's Quarterly MDS assessment with an ARD of 05/24/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's diagnoses included: Alzheimer's Disease, Age-Related Physical Debility, and Alcohol Abuse. Resident #2 had a BIMS score of 11 indicating a moderately impaired cognition. Resident #2 had disorganized thinking, no potential indicators of psychosis, but did have a behavioral presence of wandering.</p> <p>Record Review of Resident #2's care plan reviewed on 08/08/2024 reflected it did not include Resident #2's involvement with the incidents that occurred on 07/06/2024 and 04/25/2024. Resident #2's care plan did not include any measurable objectives or interventions that were put into place for Resident #2 after the incidents occurred.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's investigation report for the incident that occurred between Resident #2 and Resident #3, dated 07/14/2024, revealed that the incident occurred on 07/06/2024 at 10:30pm between two facility residents, Resident #2 and Resident #3. Witness statements revealed that LVN A was completing her rounds when she witnessed Resident #2 on top of Resident #3. LVN A left the room and got LVN B as a witness to return to the room. Upon return to Resident #2's room, LVN A and LVN B revealed that they saw Resident #3 sitting on the side of Resident #2's bed. Resident #3 proceeded to get up from the bed, pulled up his pants, and fastened his belt. Facility investigation report revealed that Resident #3 had the capacity to make informed decisions. The facility did not indicate if Resident #2 had the capacity to make informed decisions. Provider response from the facility's investigation report revealed that the facility separated both residents and Resident #3 was asked to return to his room. A head-to-toe assessment was attempted, but declined by Resident #2. MD, Family (did not indicate who), and facility Ombudsman were notified, safe survey rounds were completed by the facility. Facility investigation findings revealed the facility was unable to substantiate the findings. The facility concluded that Resident #3 was discharged to the community on 07/10/2024 and that the facility will continue to support Resident #2 . Facility investigation report revealed that the local law enforcement was not notified and Resident #2 was not sent out to the hospital for a SANE (Sexual Assault Nurse Examination) at any time during or at the conclusion of the investigation.</p> <p>Interview with LVN A on 08/10/2024 at 3:12 PM revealed that she was the nurse for Resident #2 on 07/06/2024. LVN A revealed that she walked into Resident #2's room and observed Resident #2 on top of Resident #3 in bed. LVN A revealed that she did not witness penetration as there was not enough light in the room. LVN A revealed that she alerted LVN B for a witness. LVN A revealed that they both saw Resident #3 pulling up his pants and fastening his zipper while still in Resident #2's room. LVN A revealed that Resident #3 exited Resident #2's room and she alerted the Weekend Supervisor of the incident. LVN A revealed that Resident #2 was placed on every 15-minute checks, but was unaware there was not a physician order or alternation to Resident #2's plan of care. LVN A revealed that Resident #2 does not have the capacity to consent, Resident #2 wanders constantly, but is easily re-directed. LVN A revealed that she was unsure of what interventions were put in place to protect Resident #2 from repeated victimization. LVN A revealed she could not recall the incident between Resident #2 and a male staff member.</p> <p>Interview with LVN B on 08/06/2024 at 1:14 PM revealed that she was the nurse for Resident #2 on 07/06/2024. LVN B revealed that she did not witness Resident #3 enter Resident #2's room, she revealed that LVN A alerted her during her rounds that she discovered Resident #2 on top of Resident #3. When she arrived to the room she saw Resident #3 with his shirt unbuttoned, belt unbuckled and pants unbuttoned. LVN B revealed she alerted the Weekend Supervisor who alerted the Administrator. LVN B stated that Resident #2 was started on every 15 minute checks, but could not state if Resident #3 began any enhanced monitoring that night. LVN B revealed that this behavior for Resident #2 was off her baseline. LVN B revealed that Resident #2 does not have the capacity to consent. LVN B revealed she was unsure of what interventions or alterations were made to Resident #2's plan of care to protect her from repeated victimization. LVN B revealed she was not familiar with the incident between Resident #2 and a male staff member and did remember any details of the incident.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with RP #1 on 08/08/2024 at 10:25 am revealed that she was aware of the incident that occurred between Resident #2 and Resident #3. RP #1 revealed that she was told by staff that Resident #2 was found in bed with a male resident. RP #1 revealed that she was shocked by the event as that was not like Resident #2's baseline behavior. RP #1 revealed that she visited Resident #2 the next day, 07/07/2024 and Resident #2 did not reveal any physical markings or changes in behavior. RP #1 revealed that she was unaware Resident #2 refused to go to the hospital after the incident occurred for further examination and was not aware Resident #2 refused head-to-toe assessments after the incident occurred. RP #1 revealed she requested the facility to ensure that Resident #2 had no more contact with Resident #3. RP #1 revealed she was unsure what interventions were put into place or what the outcome of the facility investigation was. RP #1 was aware that Resident #3 discharged from the facility. RP #1 was unaware of what interventions were put into place to prevent repeated victimization of Resident #2. RP#1 revealed she was aware of the incident that occurred on 04/25/24 between Resident #2 and a male staff member, but was not aware of any interventions that were put into place to protect Resident #2 from further victimization. RP #1 revealed she was aware Resident #2 has been on psychiatric services, admitted to psychiatric services unknown by RP #1.</p> <p>Interview with RP #2 on 08/08/2024 at 10:50 am revealed that he was the Power of Attorney for Resident #2. RP #2 revealed that he was unaware of the incident that occurred between Resident #2 and Resident #3. RP #2 revealed that he was alerted of the incident back in April of 2024 between Resident #2 and a male staff member. RP #2 revealed that he was unsure of what interventions were put into place to prevent repeated victimization of Resident #2. RP #2 revealed that he would defer to Resident #2's medical team to determine Resident #2's decision making abilities and abilities to consent. RP #2 revealed he was not alerted by the facility that Resident #2 refused to go to the hospital or refused head-to-toe assessments. RP #2 revealed that he was unaware that the facility investigated the incident or what the outcome of the investigation was.</p> <p>Record review of a document titled, Progress Notes, with a date of 04/27/2024 revealed a late entry note for 04/25/2024. Document revealed that the DON notified RP #2 for Resident #2 to notify him regarding an incident that occurred of inappropriate behavior from staff. DON notified [family member] that the employee was not in the facility at that time and the matter was pending investigation.</p> <p>Record review of a document titled, Health Status Note, with a date of 4/27/2024 revealed a late entry note from 04/25/2024. Document revealed that Resident #2 was inappropriately touched on the lips by a staff member. Resident #2 reported that the staff member, was her friend and friends do kiss.</p> <p>Interview with the Administrator on 08/08/2024 at 2:20PM revealed that Resident #2 was in a similar incident on 04/25/2024 with a male staff member. The male staff member was terminated from the facility and the facility's investigation revealed that the male staff member kissed the resident. The Administrator could not reveal any interventions or alterations that were put into place for Resident #2 to prevent repeated victimization after this incident. The Administrator revealed that the facility takes an interdisciplinary approach for care plans and no singular individual is responsible for updating each residents' care plan needs.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with Social Worker on 08/12/2024 at 10:02AM revealed that the MDS Nurse was responsible for ensuring that each care plan is personalized. The Social Worker revealed that the while the facility does take an interdisciplinary approach to care planning, the MDS Nurse is responsible for ensuring the data and information is inputted into the care plan. The Social Worker revealed that if the MDS Nurse was out of the facility, the DON or ADON would be responsible for care planning any interventions or objectives. The Social Worker revealed a risk for not personalizing or creating interventions after incidents occur for residents's would be a lapse of care for the resident.</p> <p>Interview with MDS Nurse on 08/12/2024 at 9:28AM revealed that she was the only MDS Nurse in the facility. MDS Nurse revealed that there is an interdisciplinary approach to care plans and care planning and it is the responsibility of all interdisciplinary leadership to ensure care plans are accurate and reflect the resident's current needs. The MDS Nurse revealed that she was off during the incidents that occurred between Resident #2 and Resident #3 and Resident #2 and a male staff member. The MDS revealed during the time she was off, the interdisciplinary team is responsible for updating all resident's plan of care as the facility takes an interdisciplinary approach to care plans. The MDS Nurse revealed that each resident was discussed in a weekly meeting and alterations to their plan of care are discussed during those meetings. The MDS Nurse revealed that she was unsure why Resident #2's care plan did not reflect the two incidents that occurred on 04/25/24 and 07/06/24 or any interventions that were put into place. The MDS Nurse could not reveal any alterations that were made to Resident #2's plan of care or any risks to the residents for not personalizing resident's plan of care or creating interventions after incidents occur.</p> <p>Interview with DON on 08/12/2024 at 5:47PM revealed that care plans should be personalized according to the resident's current needs. The DON revealed that the facility does take an interdisciplinary approach when it comes to care planning. The DON revealed that it is the responsibility of himself and the Administrator to ensure care plans are up to date and reflect the resident's current needs. The DON revealed he was unsure why Resident #2's care plan did not reflect the incidents that occurred on 07/06/24 and 04/25/24. The DON revealed Resident #2's care plan should have been updated to reflect all interventions that were put into place after the incidents occurred. The DON revealed a risk to not personalizing resident's plan of care or creating interventions after incidents occur are the opportunity for missed care.</p> <p>A Comprehensive Care Plan/Care Plans policy was requested by the surveyor to the RDO on 08/12/24 at 7:45AM. The facility did not present a current policy on Care Plans/Comprehensive Care Plans.</p> <p>Record Review of the facility's policy titled, Abuse Prevention and Prohibition Program revealed a date of 10/24/2024. Facility policy contained a section titled, Prevention and revealed that, The facility conducts an ongoing review and analysis of abuse incidents and implement corrective actions to prevent future occurrences of abuse Resident Assessments and Care Planning are preformed to monitor resident needs.</p> <p>Record Review of the facility's MDS Coordinator- LVN/LPN Job Description dated December 2023 revealed that the MDS Nurse will assist the DON or designee with identification of physician orders and verbal reports to assure the MDS and care plan are reflective of those changes.</p> <p>After administrative review, an IJ was identified on 08/22/24. The Administrator and Regional Director of Operations were notified. The Administrator and Regional Director of Operations were provided with the IJ template on 08/22/24 at 9:54AM.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility's Plan of Removal was accepted on 08/11/2024 at 4:34 PM and included:</p> <p>Identify responsible staff/what actions taken:</p> <ol style="list-style-type: none"> <li>1. Administrator submitted a self-report to HHSC regarding the incident on 07/06/2024. Intake #516319</li> <li>2. Attending physician for involved residents was notified of the incident on 07/06/2024.</li> <li>3. Social Worker conducted trauma assessment with female resident on 07/08/2024.</li> <li>4. Male resident was placed on 1:1 monitoring by facility staff on 07/06/2024.</li> <li>5. Male resident was discharged from the facility on 07/10/2024.</li> <li>6. Licensed Nurse tried to conduct a head-to-toe assessment on female resident, but she refused even after several attempts on 07/06/2024 and on 07/07/2024.</li> <li>7. Female resident refused to go to the hospital for further evaluation on 07/06/2024.</li> <li>8. The Director of Nursing began obtaining witness statements from staff on 07/06/2024.</li> <li>9. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with interview able residents on 07/09/2024.</li> <li>10. Both residents were referred to [psych provider] for psychological assessment and to be picked up on services if needed on 07/09/2024.</li> <li>11. Female Resident care plan was updated on 8/10/24.</li> <li>12. Female resident is on one on one as of 8/8/24.</li> <li>13. Female seen by Psychologist on 8/9/24.</li> <li>14. Orders are clarified to specify what is expected of one on one 8/10/24.</li> <li>15. Facility Administrator was terminated effective 8/10/2024.</li> <li>16. Referrals for female resident's alternate placement on an all-female unit have been sent out, female resident's [family member] agreed to the plan of discharge on 08/11/2024.</li> <li>17. The female residents plan of care and EMR was updated on 08/08/2024 to reflect that this resident will remain on one-to-one supervision until resident is discharged .</li> </ol> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>18. A facility wide audit on residents with dementia, PTSD or history of sexual violence was completed by Director of Nursing on 08/11/2024. No other residents were identified to be at risk for victimization at this time. A trauma assessment will be completed on all new residents to identify those at risk of victimization and alternate/appropriate placement will be immediately sought for those that are at risk.</p> <p>In-Service conducted:</p> <p>Administrator and Director of Nursing (after re-educated below) re-educated facility staff on:</p> <ol style="list-style-type: none"> <li>On 8/8/24 Director of Nursing and Administrator were re-education on Abuse &amp; Neglect Policy and implementation of appropriate individualized interventions to ensure resident safety by Regional Director of Operations.</li> <li>Staff in-service was initiated on 8/8/24. Staff members are being re-educated to report all allegations of abuse immediately upon notification to the Administrator who is the abuse coordinator. Staff will complete an Abuse &amp; Neglect competency posttest at time of in-servicing.</li> <li>Facility staff were also re-educated by the administrator on implementation of interventions to ensure resident safety. Re-education was initiated on 8/8/2024.</li> <li>The expected completion date will be 8/9/2024. Staff who have not been trained on Abuse &amp; Neglect will not be allowed to work until they have completed required in-services.</li> <li>An interim administrator has been appointed and will start 8/12/2024. He will be educated on this Plan of removal and facility Abuse and neglect policy before he starts functioning as the facility administrator. Once a permanent facility Administrator is appointed, they will also be educated on this Plan of removal and the facility Abuse and Neglect policy.</li> <li>Social worker was re-educated by Regional Director of Operations on 8/11/2024 to complete a trauma assessment on all new residents to identify those at risk of victimization and immediately seek alternate/appropriate placement for those identified to be at risk.</li> <li>The Regional Director of Operations and Director of Nursing re-educated facility staff on enhanced monitoring and expectations. Re-educated completed on 8/11/2024.</li> </ol> <p>Implementation of Changes:</p> <p>Staff will immediately inform the Administrator/DON or designee immediately when made aware of the any abuse allegation. The administrator/director of nursing or designee will ensure implementation of interventions for resident safety.</p> <p>A quick reference sheet of interventions has also been provided to staff and posted at the nurse's station.</p> <p>In the absence of the Administrator, abuse allegations will be reported to the Director of Nursing.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Regional Director of Operations and the Regional Nurse Consultant will be responsible for implementation of the process and will review the process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring:</p> <ol style="list-style-type: none"> <li>1 Administrator/DON or designee will complete daily reviews of each incident for proper individualized interventions during daily IDT meetings.</li> <li>2. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents to ensure safety X2 months.</li> <li>3. 5 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week X2 months.</li> <li>4. The administrator and/or Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements and appropriate interventions. Findings will be documented on Abuse &amp; Neglect monitoring form. Staff interviews will continue for x2 months.</li> <li>5. RDO and RNC will review and monitor all allegations and incidents for propriate implementation of interventions x3 months.</li> <li>6. RDO or RNC will review grievances weekly which are in the facility grievance binder for three months to monitor for appropriate interventions then monthly thereafter.</li> <li>7. RDO or RNC will review care plans post investigation to verify individualized care plans concerning allegations of abuse to prevent repeated victimization daily X4 week, then weekly X4 and monthly thereafter.</li> <li>8. Any adverse outcomes will be reported and reviewed during the monthly QAPI Committee meeting with the Medical director.</li> </ol> <p>Involvement of Medical Director:</p> <p>The Medical Director was notified about the immediate Jeopardy on 8/8/2024.</p> <p>Involvement of QA:</p> <p>On August 9th, 2024 an Ad Hoc QAPI meeting was held with the Facility Administrator, Medical Director, Director of Nursing, and Social Services Director to review the plan of removal.</p> <p>Who is responsible for implementation of process?</p> <p>The Regional Director of Operations and Regional Nurse consultant will be responsible for the implementation of the new process.</p> <p>On 08/12/2024 at 8:30AM the surveyor began monitoring the facility's Plan of Removal.</p> <p>(continued on next page)</p>

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #2's Comprehensive Plan of Care dated 08/12/2024, revealed the following:</p> <p>Focus- [Resident #2] has a psychosocial well-being problem (actual or potential) r/t alleged Sexual Assault</p> <p>Goal- [Resident #2] will demonstrate adjustment to nursing home placement by/through review date.</p> <p>Interventions- Assist/encourage/support resident to set realistic goals, Resident will be provided 1 on 1 care/supervision until discharge, continue psych services (psychology and psychiatry)</p> <p>Focus- [Resident #2] is an alleged SA victim r/t perpetrator observed kissing her. Male resident observed in [Resident #2's] room.</p> <p>Goal- [Resident #2] will be free from sexual assault through review date.</p> <p>Interventions- [Resident #2] is on 1-on-1 care until alternate placement, psych consult.</p> <p>Review of document titled, Trauma Screen with a date of 08/12/2024 revealed that a trauma screen was conducted with Resident #2. Trauma screen revealed that Resident #2 does have a history of trauma related events in her life and that Resident #2 stated the trauma experience she has is bearing five kids.</p> <p>Review of document titled, Progress Notes dated for 08/08/2024 revealed a new order was initiated for Resident #2 to monitor her on one to one monitoring.</p> <p>Review of several documents titled, Progress Notes, one note dated for 08/09/2024, three notes dated for 08/10/2024, one note dated for 08/11/2024 and one note dated for 08/12/2024 revealed that resident #2 was on one-to-one monitoring.</p> <p>Observation on 08/11/2024 at 11:45AM revealed Resident #2 in her room with a staff member stationed outside the door documenting her location.</p> <p>Observation on 08/12/2024 at 11:05AM revealed Resident #2 in the facility courtyard with a staff member close by documenting her location.</p> <p>Observation on 08/12/2024 at 1:24PM revealed Resident #2 in the facility gym with a staff member close by documenting her location.</p> <p>Interview with the Regional Director of Operations on 08/12/2024 at 10:00AM revealed that the MDS nurse was re-educated on care plans, appropriate interventions and goals.</p> <p>Interviews with 16 staff members who worked all shifts on 08/12/2024 at 11:09AM to 08/12/2024 at 5:30PM revealed:</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Staff were able to show return demonstration that they were in-serviced regarding the plan of removal, sexual abuse prevention and identification, how to identify residents who are at risk of increased victimization and plan of care alterations for Resident #2. Staff was able to verbalize that the abuse coordinator is now the Interim Administrator, and his contact number is posted around the facility. Staff was able to verbalize that the plan of care has been updated for Resident #2 to reflect 1:1 enhanced monitoring. Nursing staff was able to verbalize that after a sexual abuse incident or alleged incident occurs, they would immediately contact the abuse coordinator, physician for that resident, responsible party for that resident and the DON. Nursing staff was able to verbalize that after a sexual abuse incident or alleged incident occurs, they would ensure resident safety, report and being skin/psychosocial assessments.</p> <p>Staff Interviewed Included: [NAME] L, Dietary Manager, DA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA S, CNA T, LVN U, LVN W, RN X, RN Y, LVN Z.</p> <p>Interview with the DON on 08/12/2024 at 6:05PM revealed that his role in the plan of removal was to participate in all interventions that are associated with all the problems that have been identified. DON revealed that the interventions included, educating staff, participating to ensure the care plan was in place and followed and communicating with physicians and other providers. DON revealed that he would complete a daily audit of all incidents and accidents and that he would review the 24 hour report daily with the interdisciplinary team every morning. DON revealed that the facility has been communicating with resident #2's family daily and that the family has decided to move the resident to an all-female memory care unit. During the Plan of Removal monitoring, Resident #2 was currently still residing in the facility and remained on 1:1 enhanced monitoring.</p> <p>Interview with the Interim Administrator on 08/12/2024 at 6:25PM revealed that he was the new administrator for the facility effective 08/12/2024. The Interim Administrator revealed that his role in the Plan of Removal was to ensure, along with the Regional Director of Operations, that the plan of removal was implemented effectively and efficiently. The Interim Administrator revealed that he had been in-serviced on the facility plan of removal and the facility ANE policy. The Interim Administrator revealed that he, along with the DON would complete daily reviews of each incident report to ensure that proper individualized interventions are implemented and in place. The Interim Administrator revealed he would also complete five staff member interviews for a two-month period for return demonstration of the in-serviced topics. The Interim Administrator revealed that his work would be audited by the Regional Director of Operations and Regional Nurse Consult to ensure compliance of the plan of removal.</p> <p>Interview with the Regional Director of Operations on 08/12/2024 at 7:00PM revealed that his role in the plan of removal was to oversee alongside the Regional Nurse Consult, the implementation of the plan of removal. The Regional Director of Operations revealed that his expectation for the Interim Administrator is to follow-up on all allegations thoroughly, investigate all allegations and take action when necessary The Regional Director of Operations revealed that alongside the Regional Nurse Consult they will monitor, and review care plans post investigation to ensure individualized interventions are put into place, review grievances weekly for three months and monitor and review all allegations and incidents for three months.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Interim Administrator and Regional Director of Operations were notified the Immediate Jeopardy was removed on 08/12/24 at 7:05 PM, however 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 pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for one (Resident #4) of three residents reviewed for infection control.</p> <p>The ADON failed to do hand hygiene while providing wound care to Resident #4.</p> <p>This failure could place residents at increased risk of infection.</p> <p>Findings included:</p> <p>Review of Resident #4's Significant Change MDS assessment dated [DATE] revealed the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included heart failure, end stage renal disease, and diabetes. Her cognitive status was intact.</p> <p>Review of Resident #4's Physician Orders reflected:</p> <p>07/17/24 Wound of the left buttock: Cleanse with wound cleanser, pat dry, apply collagen powder, Anasept gel, and cover with dry dressing every shift.</p> <p>07/17/24 Wound of the right buttock: Cleanse with wound cleanser, pat dry, apply collagen powder, Anasept gel, and cover with dry dressing every shift.</p> <p>Review of Resident #4's Care Plans, not dated, reflected:</p> <p>Resident #4 has a non-pressure wound on her left thigh and right buttock.</p> <p>Facility interventions included: New orders for Collagen powder, Anasept gel, and cover with dry dressing daily.</p> <p>An observation on 08/08/24 at 11:45 AM of Wound Care by the ADON for Resident #4 revealed the resident was lying in her bed and on her left side. The ADON cleansed the left upper thigh wound. It was a macerated (process that causes skin to soften and break down due to prolonged exposure to moisture), red open area. The ADON did not change his gloves or perform hand hygiene. The ADON prepared the clean dressing and medication to apply to the wound. The ADON took the dressing and started to put it on the wound. The Surveyor asked the ADON if he was going to change gloves. The ADON stopped, changed gloves, and performed hand hygiene. The ADON cleansed the wound on the right buttock, which was also a macerated, red area. The ADON changed his gloves and performed hand hygiene. The ADON applied Nystatin cream to the resident's buttocks. Resident requested Nystatin powder, not cream. The ADON did not change his gloves or perform hand hygiene. CNA AA handed the nystatin powder to the ADON. The ADON sprinkled some powder on the resident's buttocks. The ADON assisted resident to apply a brief and clean towels without changing his gloves. He also picked up the resident's phone and handed it to the resident. The ADON then performed hand hygiene.</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 08/09/24 at 10:15 AM with the ADON revealed he was supposed to perform hand hygiene before he entered a resident's room. He said he was supposed to use hand sanitizer in-between the glove changes. He said he was supposed to change his gloves when he went from a clean area to a dirty area to prevent infection. He said he did not change his gloves or perform hand hygiene after cleansing the wound because he said he was only going to touch the back of the dressing. He said he did not remember why he did not change his gloves after applying the Nystatin cream.</p> <p>An interview on 08/09/24 at 10:30 AM with the DON revealed staff were supposed to perform hand hygiene and he often observed the care provided to residents to remind them to perform hand hygiene. He said hand hygiene and glove changes were supposed to be performed when going from a dirty area to a clean area to prevent infection. He said the ADON was in-serviced on performing hand hygiene right before survey.</p> <p>Review of the facility policy and procedure, Hand Hygiene, dated June 2020 reflected:</p> <p>V. Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too .[sic]</p> <p>A. Wash hands with soap and water:</p> <p>i. Before eating;</p> <p>ii. After using the bathroom;</p> <p>iii. When soiled with visible dirt or debris;</p> <p>iv. After unprotected (ungloved and damaged gloves) contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings;</p> <p>v. After contact with intact and non-intact skin, clothing and environmental surfaces of residents with active diarrhea even if gloves are worn;</p> <p>vi. Before and after food preparation</p> <p>vii. Upon starting of the shift</p> <p>viii. After removing personal protective equipment PPE and before moving to another resident in the same room or exiting the room.</p> <p>ix. Before putting on sterile gloves for the purpose of performing procedures for which aseptic technique is required (e.g., insertion of vascular access devices,</p> <p>(continued on next page)</p>		

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  08/12/2024
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>urinary catheters, etc.)</p> <p>B. Alcohol-based hand hygiene products can and should be used to decontaminate hands:</p> <p>i. Immediately upon entering a resident occupied area (single or multiple bed room, procedure or treatment room) regardless of glove use;</p> <p>ii. Immediately upon exiting a resident occupied area (e.g., before exiting into a common area such as a corridor) regardless of glove use;</p> <p>iii. Before moving from one resident to another in a multiple-bed room or procedure area regardless of glove use;</p> <p>VI. Hand hygiene is always the final step after removing and disposing of personal protective equipment.</p> <p>VII. The use of gloves does not replace hand hygiene procedures .</p>