

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 09/16/2024
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 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49837</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one of six residents (Resident #1) reviewed for range of motion.</p> <p>The facility failed to implement interventions to prevent further decline of Resident #1's contracture to her left hand after discharge from occupational therapy on [DATE].</p> <p>This failure could result in a decline in range of motion and worsening of contractures to the residents.</p> <p>Findings included:</p> <p>Record review of Resident #1's quarterly MDS assessment, dated [DATE], reflected a [AGE] year-old female with an admitted [DATE]. Resident #1 was unable to participate in the brief interview for mental status and staff had assessed her to be severely cognitively impaired. The Resident had upper and lower extremity impairment on one side. Resident #1 had not received OT or PT services in the seven days look back period. Resident #1 had not received restorative care, splints, or braces. Resident #1 was dependent for all ADLs and had no history of refusing care. Active diagnoses included cerebral vascular accident (stroke), hypertension, diabetes mellitus, and aphasia (language disorder).</p> <p>Record review of Resident #1 Orthotic Caregiver Training dated [DATE] reflected, Nursing staff to safely donn (sic) and doff (take on and off) R resting hand splint to R hand and L hand palmar guard (hand cushioned glove) daily or as tolerated.</p> <p>Record review of Resident #1 Focus on Function .Range of Motion/Contracture Tool, created by OT H dated [DATE] reflected . Resident #1 demonstrate decreased ROM in left and right wrists and fingers .patient has a splint for that specific joint .resident appear to be at risk for decreased joint mobility due to inactive or any other reasons .it has been 3 months since the current joint protection or contracture management program has been reviewed .</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
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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #1 Occupational Therapy Discharge Summary created by OTA and OT H dated [DATE] reflected, .Dates of Services: [DATE]-[DATE] .Short-Term Goals .Patient will safety wear a resting splint R hand and a palmar guard on left hand for up to 2 hours w/minimal signs and symptoms of redness, swelling, discomfort or pain .</p> <p>Record review of Resident #1's Nursing Restorative Care Program created by OT H, undated reflected, Patient will tolerate resting hand R hand and palmar guard L hand daily or as tolerated. Nursing staff will safely donn and doff R hand resting hand and L hand palmar guard daily or as tolerated.</p> <p>Record review of Resident #1's Telephone physician order dated [DATE] reflected, Patient to wear R hand resting hand splint and L hand palmar guard daily or as tolerated.</p> <p>Record review of Resident #1's Treatment administration record for [DATE], [DATE] did not reveal any notation of splint application to right hand and palm guard application to left hand. Review of [DATE] treatment administration record reflected on [DATE] Place carrot sponge on the left palm to prevent resident's nails from digging into skin. Check for skin integrity every shift.</p> <p>Record review of Resident #1 Documentation Survey report for [DATE], [DATE] reflected no documentation for application of splints or palm guards to the resident's hand contractures. Review of the [DATE] report reflected, splint program: left hand was first documented on [DATE] on the evening shift (3:00 PM-11:00 PM).</p> <p>Record review of Weekly Skin Check V,d+[DATE] dated [DATE] reflected, The assessment was completed using direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members.</p> <p>Record review of Weekly Skin Check V,d+[DATE] created by LVN B dated [DATE] reflected, G-tube site/stoma with no signs of infection, unable to assess patient's contracted hands because pt was resistant to assessment/care. MD notified. Family member aware.</p> <p>Record review of Weekly Skin Check V,d+[DATE] created by LVN B dated [DATE] reflected, G-tube site/stoma with no signs of infection. Family member here, able to open her left hand, wound noted to the left palm. Wound cleansed with wound cleanser, dry dressing applied, and a rolled face towel put in place to keep the contracted hand open.</p> <p>An observation of Resident #1 on [DATE] at 1:22 p.m. revealed left hand drawn into a fist. Resident #1 hand was wrapped in white bandage. Resident #1 was unable to open hand or move fingers. Resident #1 had a contracture to right hand and had no splints or hand rolls in place.</p> <p>An observation of Resident #1 with LVN A on [DATE] at 3:05 p.m. revealed a wound in the center of Resident #1 left hand. The wound was bright red and smaller than the size of a dime. The palm of Resident #1's hand was light brown in color.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Nurses progress note dated [DATE] by LVN B reflected , Resident's Family Member 2 asked to see the nurse. This nurse went in the room and seen Family Member 2 repeatedly trying to ask the resident to allow her look at the contracted left hand as resident kept on resisting. Family Member 2 was able to see what appeared to be a wound on the contracted hand that the resident will historically not let the nurses assess. MD notified, new orders to clean the wound and apply triple antibiotic and keep a rolled face towel to keep the contracted hand open, Pain and skin assessment completed, pain medication administered as ordered, wound consult in progress and wound nurse to review on the next visit. Treatment immediately started. will continue to monitor.</p> <p>In an interview with LVN A on [DATE] at 3:52 p.m. she stated Resident #1's wound was odd looking. She stated it could be a pressure ulcer, but it looked weird. She stated the wound looked like a stoma (an opening in the body) and appeared perfectly round. She stated the edges weren't raised. She stated she is unsure how the resident got the wound. She stated if the wound was caused by a fingernail, it would have more of crescent moon shape. In progress notes dated [DATE], the MD was notified by LVN B.</p> <p>In an interview with Family Member #2 on [DATE] at 4:11 p.m. revealed she walked into Resident's #1 room on [DATE] and smelled a stench . Family Member #2 stated she opened Resident #1's left hand and smelled a decomposing smell, like someone had died . She stated she saw blood draining from Resident #1 left hand. She stated she opened Resident #1 left hand more and saw blood and a wound. She stated the wound was red and bleeding and looked like Resident #1's finger was digging into Resident #1 skin. She stated Resident #1 pinky and ring finger were stuck to Resident #1 palm. She stated she immediately called for LVN B. LVN B came to assess the resident. She stated she told LVN B that she got Resident #1's nail out of Resident #1's flesh. Family Member #2 stated she asked LVN B to cut Resident #1 nails. She stated LVN B cleaned Resident #1 wound and came back 25 minutes later and cut and filed Resident #1 nails. She stated she took pictures of Resident #1 wound and text the DON to report the wound and her concerns. Family Member #2 stated she had previously asked the facility to cut Resident #1 nails and the facility reported not having the instruments to cut Resident #1's nails. She stated the family purchased and provided the facility with the instruments to cut Resident #1 nails. She stated Resident #1 had a carrot to increase the range of motion to Resident #1's hand, but it was not being used. She stated she complained to the DON back in [DATE] about Resident #1's nails not being cut. Family Member #2 stated LVN B did respond to the complaint and cut resident nails. She stated LVN B could only cut three out of the five Resident #1's fingernails as LVN B told her that Resident #1 would not allow her to get to the other fingernails.</p> <p>In an interview on [DATE] at 1:21 p.m. she stated she was unsure if Resident #1 had a splint or a roll. She stated Resident #1 had received restorative nursing services and the CNAs were to assist Resident #1 with ROM. She stated Resident #1 had received therapy but did not know why it ended. She stated Resident #1 used a splint or handroll as tolerated. CNAs are responsible for applying handroll/splints to the resident. They are to document the information in the CNA Kardex. She stated it was the responsibility of the nurses to ensure the services were being provided to the residents.</p> <p>In an interview with DOR on [DATE] at 9:42 a.m. she stated Resident #1 received therapy from [DATE]-[DATE] for contracture management. She stated Resident #1 was discharged on [DATE]. She stated the CNAs were trained to apply the splint and palmar guard to Resident #1 hands.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA C on [DATE] at 10:16 a.m. she stated Resident #1 had a carrot and a blue splint. She stated she just started back working with Resident #1 last week. She stated the last time she put the splint on Resident #1 left hand was Thursday. She stated she did not notice a wound to Resident #1 left hand but did notice a smell. She stated she did not know where the smell came from . She stated she informed the nurse on duty about the smell. She stated the splint was to be applied to Resident #1's left hand when Resident #1 is out of bed. She stated the carrot, which is used to increase range of motion, is to be used when Resident #1 is in bed. She stated when she came on duty Friday, Resident #1 did not have the carrot in her left hand. She stated a couple of times during that week she did not see Resident #1 with anything on her hand. She stated she had not seen a palmar guard on Resident #1 since she started back working with Resident #1 last week. CNA C stated she received training on how to put on and take off splints and [NAME] guards. She stated there is list printed out daily of all residents with contractures. She stated it was the responsibility of both the CNA's and nurses to ensure the residents received services.</p> <p>In a telephone interview with LVN D on [DATE] at 10:36 a.m. she stated she was responsible for trimming Resident #1 nails. She stated she is supposed to check Resident #1 nails weekly. She stated Resident #1 sometimes resisted care and would not open her hand. She stated the splint is to be applied to Resident #1 when Resident #1 is out of bed. She stated it is the responsibility of the nurses to assess Resident #1 and to assure the splint and palmar guard are being applied. She stated Resident #1 was to wear the palmar for two hours daily if tolerated.</p> <p>In an interview with OT H on [DATE] at 10:55 a.m. he stated he worked with Resident #1 back in [DATE]. He stated he recommended a resting splint for Resident #1 right hand. He stated Resident #1 had good a good passive ROM in the right hand. He stated the issues were more of Resident #1 clinching her fist. He stated he recommended the palmar guard daily for Resident #1 left hand for two hours as tolerated.</p> <p>In the OTR H's observation of Resident #1 on [DATE] at 11:00 a.m. he stated Resident #1's wound had pressure and moisture to her left hand and the nail is the possible cause for the wound. He stated the palmar guard is less harsh on Resident #1's hand than the carrot.</p> <p>In the RN G's observation of Resident #1 on [DATE] at 11:00 a.m. she stated the cause of Resident #1's wound looked like a nail had dug in Resident #1's hand.</p> <p>In an interview with the MDS on [DATE] at 11:16 a.m. she stated restorative care is provided by the CNAs. She stated CNA C and E received training on how to apply the splint and [NAME] guard to Resident #1 hands. She stated the therapy department was responsible for the training. CNA C and CNA E received Orthotic Caregiver Training on [DATE]. Both CNA C and CNA E signed the training log where they acknowledged they received the training.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN B on [DATE] at 11:25 a.m. she stated the nurses are responsible for putting palmar guards on Resident #1. She stated sometimes Resident #1 would not have the splint on when she comes on duty. She stated Resident #1 does not use the splint. She stated when she would be on duty, Resident #1 would not have anything on her hands. She stated last Friday, Family Member #2 alerted her about Resident #1 wound. She stated she observed the wound. She stated the wound was bright red and bleeding. She stated Resident #1's fingernails were long on her left hand. She stated in the past she tried to assess Resident #1's left hand but Resident #1 would [NAME] her hand making it difficult for her to assess her hand and skin. She stated she would notify the DON weekly when she could not assess Resident #1 left hand. She stated she had not tried to soak or massage Resident #1's hand to gain access. She stated no other options were attempted to gain access to Resident #1's hand for assessment. She stated she had not cut Resident #1's nails on her left hand since the end of [DATE].</p> <p>In an interview with the DON on [DATE] at 11:48 a.m. he stated the CNAs are responsible for providing restorative care to Resident #1. He stated it is the nurse's responsibility to ensure the CNAs are applying the splint and palmar guard. He stated Resident #1 should have had the palmar guard applied to Resident #1's left hand and right resting splint to her right hand as ordered. He stated it is the responsibility of the nurses on each shift to do a skin assessment of Resident #1 skin when using the splint or palmar guard.</p> <p>In a telephone interview with CNA E on [DATE] at 12:53 p.m. she stated she only put the blue splint on Resident #1 left hand when Resident is in her chair. She stated she was able to get Resident #1 hand opened twice. She stated she last worked with Resident #1 three weeks ago. She stated she did not put anything on Resident #1 right hand. She stated she was not aware that she was supposed to put the splint on Resident #1 right hand and the palmar guard on Resident #1 left hand . She stated there was a list printed out daily of residents with contractures. She stated Resident #1 never refused to have the splint apply to her hand. She stated if she could not get Resident #1 hand open to apply the splint, she would get the nurse.</p> <p>Record Review of Occupation Therapy assessment dated [DATE] reflected, #1 Short-Term Goals .Patient will demonstrate good tolerance with use of hand roll in L hand to facilitate extension of digits for contracture. (Target: [DATE]). #2 Provide PROM to L hand/digits into extension to facilitate decreased joint tightness and improved placement and fit of hand roll for contracture management. (Target: [DATE]). #3 Improve L hand hygiene and nail care to good to facilitate prevention of further skin breakdown. (Target: [DATE]).</p> <p>Record review of Resident #1's comprehensive care plan dated [DATE] revealed the facility initiated a care plan on [DATE] (after surveyor entered) and revised on [DATE] for . Alteration in musculoskeletal status r/t contracture left hand. Trial L hand palmar guard splint/roll with therapy only. Apply left hand splint/handroll. Trial L hand palmar guard splint/roll with therapy only. Ensure site is clean, nails are trimmed</p> <p>Record review of Resident #1 Kardex report dated as of [DATE] reflected, Therapy .Apply left hand splint/handroll. Trial L hand palmar guard splint/roll with therapy only. Ensure site is clean, nails are trimmed, and monitor how resident tolerates the procedure. Notify nursing for pain, redness and swelling to left hand. PT/OT evaluation and treatment as per MD orders.</p> <p>(continued on next page)</p>		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Restorative Nursing Program Guidelines dated [DATE], reflected, A resident may be started on a Restorative Nursing Program .When a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy .The Restorative Nurse's Aide (RNA) carries out the restorative program according to the care plan and document daily. In addition, the RNA completes a written weekly summary for residents on a Restorative Nursing Program .Licensed Nurses reflect participation in and progress of residents in the Restorative Nursing Program in their weekly/monthly summaries .General restorative nursing care is that which does not require the use of a qualified professional therapist to render such care. The basic restorative nursing categories include Splinting or bracing .		