STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676315	A. Building B. Wing	04/04/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one resident (Resident #1) of three residents reviewed for discharge planning. -The facility failed to provide or document sufficient preparation for an orderly discharge of Resident #1. This failure could place residents at risk of not receiving care and services to meet their needs upon discharge, which could cause physical and emotional harm. Findings included: Record review of Resident #1's face sheet, dated 04/04/2025, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and discharged on 03/13/2024 with diagnoses that included: cerebral ischemia (a condition where the brain does not receive enough blood flow, resulting in a lack of oxygen and nutrients. This can lead to brain damage.), Generalized Anxiety Disorder (a mental health condition characterized by excessive, persistent, and often unrealistic worry about everyday things, which can significantly impact daily life and cause distress.), hypertensive urgency (is a condition where blood pressure is significantly elevated but there is no evidence of acute organ damage.) Lack of coordination, Cognitive communication deficit (difficulties in communication skills from cognitive impairments, attention, memory .). Record review of Resident #1's Quarterly MDS assessment, dated 03/12/2025, reflected in Section A0310 G was left blank for unplanned or planned discharge. Section A1010 was left blank for race. the resident had a BIMS score of 15 which indicated no cognitive impairment. The MDS assessment reflected Resident #1 was independent with most ADLs; however, the resident required moderate assistance and/or supervision with hygiene, and upper body dressing. Further review reflected Resident #1 had a mood of feeling down, depressed, or hopeless several days at a time. Resident #1 had a behavior of physical behavioral symptoms toward others and rejecting assessments care 1 to 3 days. Resident #1 was occasionally incontinent for urine and frequently incontinent with bowel. Section Q participation in assessment and goal setting .Q0610 referral to Local contact agency indicated no. Section I0620 Reason referral to local contact agency (LCA) not made reflected 5 (discharge date more than 3 months away. The MDS did not address resident returning to the community, due to this being his quarterly MDS. The quarterly MDS signature included LMSW signature for completion of Sections B, C, D, E, Q. However, section A was completed with entry discharge reporting (none of the above). The facility had not completed a discharge MDS for Resident #1. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 03/12/2025, reflected Resident #1 wishes to return/ discharge to home. Encourage resident to discuss feelings, and concerns impeding discharge, monitor for and address episodes of anxiety, fear, distress, establish a pre-discharge plan with the resident/family/caregivers) and evaluate progress and revise plan, evaluate residents' motivation to return to the community. Resident has potential for an ADL Self Care Performance Deficit r/t Cerebral ischemia, Degenerative disease of the nervous system and diabetes Monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of Resident #1's MD orders reflected no discharge orders for the resident. Record review of Resident #1's electronic documents dated 02/27/2025 revealed a 30 day discharge notice that reflected this letter is written in notification to [Resident #1] will be discharged from [facility] effective 30 days from the date of this letter March 28, 2025, this discharge is based on failure to pay the facility staff will work with you to make the preparations needed to ensure a safe and orderly transition .should you prefer to be discharged to another facility we will assist with relocating an appropriate alternate placement .you have a right to appeal this decision . signed by the ADM Further review Resident #1's MD orders reflected that there was not a discharge order. Record review of the facility discharge report dated 04/04/2025, reflected [Resident #1] was discharged on 03/13/2025 at 5:15 PM . discharge status: discharged /transferred to SNF. Record review of Resident #1's progress note dated 3/13/2025 at 05:07 AM Communication with Resident/Family Late Entry: The ADON and Administrator met with the resident regarding his discharge. The resident stated he did not want to be transferred to a group home or another nursing facility; instead, he requested to be discharged to a motel of his choosing. The facility van driver transported him to his selected location. The resident has a BIMS score indicating decision-making capacity and was educated on the risks associated with discharging to a motel. While the facility is currently in the process of finding an alternative placement, the resident insisted on being discharged to the motel. The family and attending physician have been made aware. Record review of Resident #1's progress note dated 03/13/25 at 5:59 AM by RN P, indicated the resident was alert and oriented x 4 . can let all needs be known, no s/s of distress or discomfort noted, resident discharge to shelter. Record review of Resident #1's progress notes 03/13/25 at 9:18 AM by RN P reflected Resident discharge home. Record review of Resident # progress note on 03/13/2025 at 10:22 PM by RN P reflected the discharge GG evaluation was completed and indicated: *Reason for evaluation is discharge (stand-alone or combination). *Eating: Discharge Performance: Setup or clean-up assistance. *Oral hygiene: Discharge Performance: Partial/moderate assistance. *Toileting hygiene: Discharge Performance: Independent. *Shower/bathe self: Discharge Performance: Partial/moderate assistance. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Personal hygiene: Discharge Performance: Independent. *Upper body dressing: Discharge Performance: Independent. *Lower body dressing: Discharge Performance: Independent. *Putting on / taking off footwear: Discharge Performance: Independent. *Roll left and right: Discharge Performance: Independent. *Sit to lying: Discharge Performance: Independent. *Lying to sitting on side of bed: Discharge Performance: Independent. *Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed: Discharge Performance: Independent. *Chair / bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair): Discharge Performance: Independent. *Toilet transfer: The ability to get on and off a toilet or commode: Discharge Performance: Independent. *Tub/shower transfer Tub / shower transfer: The ability to get in and out of a tub/shower: Discharge Performance: Independent. *Car transfer: The ability to transfer in and out of a car or van on the passenger side: Discharge Performance: Independent. *Walk 10 feet: Discharge Performance: Independent. *Walk 50 feet with two turns: Discharge Performance: Independent. *Walk 150 feet: Discharge Performance: Independent. *Walking 10 feet on uneven surfaces: Discharge Performance: Independent. One step (curb): Discharge Performance: Independent. *Four steps: Discharge Performance: Independent. *Twelve steps: Discharge Performance: Independent. *Picking up object: Discharge Performance: Independent. *Indicate the type of wheelchair/scooter used. - Discharge Performance: Manual. The Resident uses a wheelchair and/or scooter. *Wheel 50 feet with two turns: Discharge Performance: Independent. Wheel 150 feet: Discharge Performance: Independent. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This note was entered at 10:22 PM after the resident was discharged from the facility on 03/13/2025 at 5:15 PM. Record review of progress note dated 03/12/2025 at 3:17 PM, by the SW reflected [facility] AL discussed admitting the resident tomorrow under private pay. Record review of progress note dated 03/12/2025 at 2:45 PM, by the SW reflected onsite complete with [facility] pending. Record review of progress note dated 03/12/2025 at 2:40 PM, by the SW reflected met with [Resident #1] of notice to discharge. [Resident #1] was content with SW sending referrals to other SNF's in order to prevent him from losing his AL benefits. Referral sent to [facility] and [facility]. Record review of progress note dated 03/12/2025 at 2:28 PM, by the SW reflected relocation specialist). She reports she will send information for a group home. Note Text: [NAME] House pending accepting transfer. DC date and wait time pending. Record review of Resident #1's progress note dated 03/12/2025 at 1:58 PM by SW, reflected Referral sent to [facility]. Record review of Resident #1's psychological services progress note dated 03/13/2025 from 10:40 AM to 10:58 AM by Ph D reflected a DX of generalized anxiety disorder .top target symptoms: Somatic concerns Mild (excessive worrying .leading to significant distress/or functional impairment .not fully explained by a medical condition). Depression Moderate (clinical disorder characterized by a sustained feeling of sadness and loss of interest). Anxiety moderate (a mental health condition where excessive and persistent worry or fear about everyday situations interferes with daily life, causing distress and difficulty functioning). Patient's Response to Intervention: The therapist was informed by staff of patient being spotted engaging in inappropriate behavior with another resident. He explained the other patient is his friend and he sat on her bed, and they ate cinnamon rolls together. He feels he is being falsely accused and denied all wrongdoing. He feels the 1:1 is currently just as much to keep the other patient out of his room as she keeps going into his room so they can talk as they did prior to the incident. He is hopeful to transfer soon and spoke of going back to [city] as soon as he is able. Plan For Next Session: Continue individual psychotherapy to build rapport and improve interactions with others. During an interview with TPS D on 04/03/2025 at 11:00 AM he stated that he was asked by the Administrator on 03/13/2025 at approximately 5:00 PM to transport resident #1 to a shelter. TPS D stated he loaded resident personal property in the van and proceeded to transport Resident #1 to the homeless shelter. TPS D stated that Resident #1 wanted to be transported to a nearby hotel instead the homeless shelter. TPS D stated that he transported Resident #1 to the nearest hotel, and remained with the resident until a key and room was assigned. TPS D said he assisted the resident with moving all personal items to the room. He returned to the facility and notified the Administrator of the location. TPS D was unable to provide any information on the resident's current cognitive status. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 04/04/2025 at 2:15 PM, she said that Resident # 1 was discharged on 03/13/2025 to a homeless shelter after refusing three facility placement referrals. The DON said that once TPS D returned to the facility, he informed the DON and ADM that Resident #1 asked TPS D to take him to a nearby hotel, instead of the homeless shelter. The DON said that the facility did not attempt to contact Resident #1 after discharge to the hotel and check on his wellbeing or safety. During an interview with the ADM on 04/04/2025 at 2:40 PM, Resident #1's was discharged on 03/13/2025, after an incident with another resident on 03/12/25. Resident was placed on one-on-one staff supervision until discharge. The resident was his own RP and did not want to transfer to another nursing facility. She stated the SW contacted three other facilities and the resident refused placement. She stated he was discharged to a homeless shelter. However, upon being transported by facility staff TPS D, Resident #1 requested to be taken to a hotel nearby. Resident paid for his room with his own money. The ADM stated she nor her staff followed up with Resident #1 after discharge to confirm his whereabouts or safety. In an interview with the ombudsman on 04/11/2052 at 9:01 AM she stated that she would have to review facility notes to confirm that she was contacted about the discharge of Resident #1. This surveyor requested a return call upon reviewing the information. Record review of Resident #1's record did not reveal any contact information for Resident #1 to follow up on discharge or interview. Review of the facility's policy title Transfer and Discharge, operational manual - admission and Discharge, revised 06/2020, revealed in part the following: Nursing facility must complete discharge planning when you anticipate discharging a resident to a private residence, another nursing facility or skilled nursing facility, or another type of residential facility. Purpose: To ensure that residents are transferred and discharged from the Facility in compliance with state and federal laws and to provide complete, safe, and appropriate discharge planning and necessary information to the continuing care provider. Policy: The Facility may transfer or discharge a resident for the following reasons: residents are transferred/discharged based on physician order unless the sign themselves out against medical advice. See Policy Discharge Against Medical Advice. Discharge Planning begins with the pre-admission process by identifying and assessing the resident's living and social support network prior to admission. Discharge planning continues throughout the stay. includes: Assessing the resident's continuing care needs, including: Consideration of the resident's and family/caregiver's preferences for care; How services will be accessed; Developing an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver education needs To facilitate a smooth transition of care, the Facility will utilize Continuity of Care Checklist to provide the following information to the receiving entity: If the resident is transferred because his/her needs cannot be met, the Facility must document attempts to meet the resident's needs and the service available at the receiving facility to meet the need(s). The medical record will contain written documentation from a physician if the resident is transferred/ discharged because: The safety of individuals in the facility was endangered by the resident's presence.