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	05/01/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of six residents reviewed for care plan. The facility failed to ensure Resident #1's care plan was revised to reflect person centered interventions for pain and physical therapy. This failure could place the resident at risk of current needs not being met. Findings included: Record review of Resident #1's Admission Record dated 5/1/25 reflected a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15 indicating he was cognitively intact. He had been receiving scheduled pain medications including opiates. His diagnoses included Hypertension (high blood pressure); spinal stenosis (tight spaces between bones of the spine that can cause pressure on the spinal cord causing pain, tingling, or weakness in extremities); low back pain and other reduced mobility. Record review of Resident #1's Order Recap Report dated 5/1/25 reflected the following orders: PT clarification order: Patient to be seen 5x/period 30 days for presence of left artificial knee joint, and generalized muscle weakness. Order dated 4/5/25 and discontinued 4/10/25. PT Clarification: Patient to be seen 5x/week for 30 days for spinal stenosis and generalized muscle weakness. Order dated 4/10/25. Oxycodone Hcl 10 mg. Give two tablets every 4 hours for pain. Order dated 4/6/25. Pregabalin 300 mg three times a day for neuropathy (nerve pain). Order date 4/5/25. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's hospital records dated 4/22/25 reflected he had received a left total knee arthroplasty (knee replacement) and hardware removal on 3/26/25. His discharge recommendations included: multimodal pain management per attending [physician] .PT/OT/CM: Encourage OOB to chair and ambulate daily with nursing and/or therapy . Record review of Resident #1's Progress noted reflected the following: An entry dated 4/6/25 at 12:03 AM: Note Text: 4/5/25 @ 12:47 [PM], readmitted res to facility from [hospital name] via stretcher accompanied by three attendants, Dx; left knee replacement. a/ox4 [alert and oriented to person, place, time, and situation], vs; BP 109/95, HR 98, Resp 18, Temp 97.6, 02 sat 96%RA, c/o left knee pain, prn oxycodone given as ordered, resp even and unlabored. no s/s of distress noted at this time. surgical wound to left knee, r/t left knee replacement, wound dressing dry, clean and intact. no s/s of infection noted at this time. per hospital report received over the phone, cleanse wound to left knee with wound cleanser, and apply dry dressing daily until 4/8/25, then may left [sic] open to air. Medication list verified with HCP and updated in EMAR/ETAR for pharmacy delivery. Weekend RN supervisor aware of res arrival, DON, and MD notified. nursing staff will continue to monitor res for any changes. Record review of Resident #1's Care Plan Report retrieved 5/1/25 reflected the following entries: Entry initiated 4/14/25 and Revised 4/28/25, Focus: The resident is resistive to care r/t anxiety/pain. Interventions/Tasks included: Allow the resident to make decisions about treatment regime, to provide sense of control . Educate resident on risks of not obtaining weight as ordered .Explain the risks of refusing wound care . Give clear explanation of all care activities prior to and as they occur during each contact . Entry initiated 4/29/25, Focus: Patient has diagnosis of narcotic dependence. Interventions/Tasks included: Educate resident on risks of narcotic abuse .Pain Management consult .Psych consult . No entries were located with a focus on pain management or physical therapy. During an observation and interview on 4/29/25 at 11:18 AM, Resident #1 was observed lying in bed. He stated he was upset the facility had not increased his pain medication doses following his recent knee surgery. He stated he was unhappy with his pain management physician and Nurse Practitioner for refusing to increase his medication doses. He stated they had offered other medications, and he did not wish to take them. Resident #1 stated he was exploring his other options including moving to another facility or getting a new pain management physician. Resident #1 stated he had not received any physical therapy since returning to the facility after surgery. He stated he had returned to the hospital twice over the past month for other issues related to his knee but did not know why he had not received any therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/25 at 11:36 AM, LVN C stated Resident #1 was unhappy with his pain medication regimen. She stated he received scheduled pain medications every 4 hours and had initially received a higher dose upon return from the hospital and he wanted to continue it. She stated the pain NP, (NP D) saw him regularly and had explained to him why they could not increase his dose. She stated he had also met with the Pain Management physician as well as the Medical Director about the issue and they were also giving him other medications such as muscle relaxers for his pain. LVN C stated she believed he had received physical therapy but could not say whether he was receiving any at that time. She stated she was unsure whether either issue had been care planned but knew the pain was addressed frequently. During an interview on 4/30/25 at 11:06 AM, the Director of Therapy reviewed Resident #1's notes and stated he had received physical therapy. She stated he had initially been declined by his insurance company but the Administrator approved therapy payment for him. She stated he had received a full evaluation and received services five times before leaving to go back to the hospital. She stated the facility continued to work with his insurance company to approve coverage, but the process had been stalled by repeated trips to the hospital and had to be restarted. She stated she was scheduled that day for another evaluation and re-initiation of therapy. During an interview on 5/1/25 at 4:00 PM, with the Administrator and Regional Nurse Consultant, the Administrator stated care plans were typically initiated within 48 hours of admission or readmission. The Administrator reviewed Resident #1's medical record during the interview. She stated she did not know why pain did not trigger as a focus area for his care plan and noted pain management was included as an intervention for a previous fall he had had. She stated she was unsure whether it was important for his therapy to be included in his nursing care plan as he was receiving therapy services. The Regional Nurse Consultant stated his assessments and care planning had been complicated a bit due to the fact he had returned to the hospital twice since his readmission. The Administrator stated she was responsible for ensuring Resident Care Plans were completed as well as the interdisciplinary team. She stated they met as a team to review all aspects of the resident's care. The Administrator stated the risk for insufficient care plan included the potential for insufficient care, but she felt Resident #1 was having his pain and therapy needs met as he was followed by a pain management group and was receiving physical therapy. Record review of the facility's policy titled, Care Planning, dated revised 6/2020 reflected the following: Purpose To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. Policy: I. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines. II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs . Procedure: The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. The Baseline Care Plan will include at least the following information: A. Initial goals based on admission orders B. Physician orders C. Dietary orders D. Therapy services . IV. The Baseline Care Plan will be updated to reflect changes in the resident's condition or needs (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurring prior to the development of the Comprehensive Care Plan .VIII. A comprehensive person-centered Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. A. In the event that the Comprehensive Care Plan identified a change in the resident's goals or functioning that was not identified in the Baseline Care Plan, these changes will be incorporated into an updated summary and provided to the resident and/or resident's representative. B. Changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the resident's stay. These subsequent changes will not need to be reflected through updates to the Baseline Care Plan XI. The Comprehensive Care Plan must be prepared by the IDT team. The IDT team includes the following individuals: A. The Attending Physician; B. The Resident Assessment Coordinator; C. The Licensed Nurse who has responsibility for the resident; . G. Therapists as applicable; H. Consultants (as appropriate) .