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	07/31/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his quality of life for 1 of 2 residents (Resident #61) observed for care in that: The facility failed to ensure Resident #61's urinary drainage bag (a bag at the end of an indwelling catheter that drains urine from the bladder) had a privacy cover in place on 07/29/25. This failure could affect residents in the facility who received care and could result in residents not being treated with dignity and respect.Finding included: Record review of Resident #61's MDS assessment dated [DATE] reflected Resident #61 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted [DATE]. His diagnoses included hypertension (elevated blood pressure), neurogenic bladder, type 2 diabetes (elevated blood sugar), quadriplegia (paralysis of all four limbs), and schizophrenia (a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucination). Resident #61 had a BIMS score of 15/15 which indicated Resident #61's cognition was intact. Review of Resident #61's Comprehensive Care Plan, created date 06/16/25, reflected the following: Focus: [Resident #61] has indwelling Catheter r/t Neurogenic bladder (a condition where nerve damage affects the bladder's ability to store and release urine, leading to various urinary problems). Goal: [Resident #61] will show no signs/symptoms of Urinary infection through review date. Intervention. TOILET USE: [Resident #61] is totally dependent on staff for toilet use . Further review revealed Focus: Enhanced Barrier Precautions R/T G tube. Goal: Reduce transmission of pathogens. Interventions: Monitor for signs/symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. [Resident#61] will have catheter change every month and as needed.Observation and interview on 07/29/25 at 2:31 PM revealed Resident #61 was observed up in a wheelchair in the lobby by the dining room entrance. He was observed with a urinary drainage bag on the right side of his chair with no privacy cover in place. Resident#61 stated he got up every day in his wheelchair between breakfast and dinner, and he stayed in the lobby, because he was a smoker, so he could go outside to smoke during the smoking time. Resident#61 did not say anything related to the drainage bag without privacy bag.In an interview on 07/29/2025 at 2:42 PM LVN G looked at Resident#61's foley catheter drainage bag and stated it needed a privacy bag. She stated not having drainage bag covered with privacy bag could affect Resident#61 dignity.In an interview on 07/31/25 at 10:34 AM the Administrator said privacy bags needed to be in place for resident's dignity. During an interview on 07/31/25 at 11:35 AM the DON said she expected her staff to ensure privacy bags were in place for residents with a urinary drainage bag. She said it was a dignity issue for the residents. She said she would be monitoring to ensure they were used going forward. Record review of a facility policy titled Notice of Resident Rights with revised date 08/2020, read To ensure that residents are fully informed of their rights during stay at the facility.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 8 residents (Residents #8, #31, & #54) reviewed for care plans.1. The facility failed to develop a comprehensive person-centered care plan that reflected Resident #8 had broken teeth and required dental follow up.2. The facility failed to develop a comprehensive person-centered care plan that reflected Resident #31's behavior of hiding cigarettes. 3. The facility failed to develop a comprehensive person-centered care plan that reflected Resident #54's diet order for large portions dated 07/10/25. These deficient practices could place residents at risk of not receiving the necessary care or services.Findings included:1. Record review of Resident #8's Quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male, admitted to the facility on [DATE], with the diagnoses of heart failure, diabetes (high blood sugar), osteoarthritis (breakdown of cartilage) and a BIMS score of 13 (intact cognition). Record review of Resident #8's care plan, dated 07/28/25, revealed there were no care areas regarding Resident #8's teeth or dental services. Record review of Resident #8's dental assessment dated [DATE] reflected Resident #8 was seen for an assessment exam and there were 7 teeth that needed to be extracted due to broken root tips and abscessed. Record review of Resident #8's progress notes from 05/01/25-07/31/25 reflected the following physician follow up progress note, dated 05/13/25: .Diagnosis, Assessment, and Plan. Tooth decay.refer to dentist In an interview and observation on 07/29/25 at 2:09 PM with Resident #8, he stated he needed to see a dentist since March 2025 because he had broken teeth and an infection that needed to be addressed; observation revealed broken and missing teeth on the top and bottom of his mouth. He stated he thought he had been seen by the dentist twice and they looked at his teeth but he had not heard any information about a follow up exam or treatment. He stated he was not sure who was scheduling the follow up visits and the facility was aware because he mentioned it to the physician and the social worker.In an interview on 07/31/25 at 10:19 AM with the Regional Social Services Consultant revealed she was one of the social workers who covered the facility while a full-time social worker was being onboarded. She stated she was not familiar with Resident #8. She reviewed Resident #8's dental assessment dated [DATE] and stated she did not think his dental concerns were care planned because every resident needed to see the dentist. In an interview on 7/31/25 at 11:30 AM with the Administrator she stated the resident's dental issues should have been care planned. She stated care plans were important to guide the plan of care for a resident.An interview on 07/31/25 at 3:13 PM with the Regional MDS Coordinator revealed it was the responsibility of the clinical team to update acute needs. She reviewed Resident #8's care plan and noted he did not have any care areas related to dental. She stated Resident #8's dental issues, such as the ones noted in the dental visit on 3/13/25, should have been added to the care plan. She stated care plans ensured staff knew what residents' needs were and a new staff member should be able to look at a care plan and know exactly what the residents' needs were. She stated there was no risk to residents for not listing the dental concerns because the care should have been provided regardless if it was in the care plan or not. In an interview on 07/31/25 at 3:53 PM with the DON she stated she was not familiar with Resident #8 because she recently began working at the facility. 2. Record review of Resident #31's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE], with the diagnoses of sepsis (systemic infection), neuralgia (nerve pain), cellulitis (bacterial infection of the skin), and a BIMS score of 15 (intact cognition).Record review of Resident #31's care plan, dated 07/18/25, reflected she was a smoker and interventions included to provide assistance to the smoking area, monitor for unsafe smoking such as dropping cigarette or holding close to body and report to the nurse, and assess smoking ability quarterly. The care plan did not reflect Resident #31 had hidden cigarettes on 06/18/25 and 07/29/25.Record review of Resident #31's smoking violations dated 6/18/25 reflected cigarettes were found in Resident #31's room and were removed, Resident #31 refused to sign the smoking violation form. A smoking violation dated 07/30/25 reflected cigarettes were found in Resident #31's room and were removed with re-education provided, Resident #31 refused to sign the smoking violation form and physician and family were notified, signed by

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of seven residents (Resident #25) reviewed for quality of care. 1. The Facility failed to ensure CNA N provided safe transport for Resident #25 when she walked forward pulling the resident's wheelchair backwards down the hallway and running the wheelchair footrest into the wall on 07/29/25. 2.The Facility failed to ensure CNA U and RN C used a gait belt and instead lifted Resident #25 under his arms when transferring him from his wheelchair to the bed on 07/29/25. 3. The Facility failed to ensure CNA U and RN C performed a correct gait belt transfer when they lifted the resident under his arm when transferring him from the bed to his wheelchair on 07/29/25. These failures could affect the residents by placing the residents at risk for falls, injuries, and skin tears. Findings included: Record review of Resident #25's Face sheet dated 07/31/25 reflected an admission date of 10/27/23. Record Review of Resident #25's quarterly MDS assessment, dated 07/08/25 reflected a [AGE] year-old male who had a BIMS score of 1 which indicated he was severely cognitively impaired. He was dependent for all activities of daily living and required the assistance of 2 persons to complete most activities. He was always incontinent of bladder and bowel. Diagnoses included dementia, cerebral vascular accident (stroke) and aphasia (language disorder that affects a person's ability to communicate). Review of Resident #25's care plan revised on 07/29/25 reflected, [Resident #25] had an ADL Self Care Performance Deficit related to dementia. Intervention.Transfer: The resident requires x 2 staff participation with transfers. In an observation on 07/29/25 at 11:35 a.m. Resident #25 was observed sitting in the common/dining room area in a reclining wheelchair. Attempts to interview the resident were made, but he was unable to carry on a conversation. In an observation on 07/29/25 at 2:25 p.m. CNA N was observed walking forward and pulling Resident #25 backwards in his wheelchair from the common/dining room area toward the nurses' station and down the hallway to his room. When CNA N rounded the corner at the nurse's station, the foot of the wheelchair bumped into the wall. RN C followed CNA N down the hallway and instructed CNA N to push the resident forward instead of pulling him down the hall backwards. CNA N then turned the resident around and stopped in the hallway in front of his room. She stated he was not her resident and was not sure who was coming to put him to bed. In an interview with CNA N on 07/29/25 at 02:28 p.m. she stated she was not supposed to pull the resident backward because it was a safety risk. She stated she was not aware she bumped the wall with his wheelchair. In an observation on 07/29/25 at 02:30 p.m. CNA U, CNA L and RN C came and pushed Resident #25 into his room and positioned his wheelchair next to the bed with the resident facing the head of the bed. CNA U and RN C placed their arms under the resident's arm pits and lifted him from the wheelchair to the bed without the use of a gait belt. Resident #25's legs were not extended, and his feet were not touching the ground. A gait belt was observed laying on top of the chest of drawers by the resident's bed. CNA U and CNA L rolled the resident onto his back and removed his pants. CNA U completed the peri-care and both staff placed a clean brief and clean pants onto the resident. RN C and CNA U then positioned the resident on the side of the bed and both CNA U and RN C placed the gait belt around the resident's waist. Both staff placed one of their hands on the gait belt and placed their other arm under the residents' armpits, lifting him from the bed to wheelchair. Again, his feet did not touch the ground. In an interview with RN C on 07/29/25 at 03:00 p.m. he stated Resident #25 was a 2-person transfer. He stated sometimes he can stand a little but other times he cannot. He stated he was not sure if he had been evaluated for a mechanical lift transfer but stated that would be better. He stated all two persons assist transfers which were not mechanical lift should have a gait belt. He stated they should not have lifted him by his arms because it could cause injury to the resident's shoulders. He stated he did not see the gait belt in the room and should have stopped and looked before they transferred the resident. In an interview with CNA U on 07/29/25 at 03:05 p.m. she stated they were supposed to use a gait belt anytime they assisted with a transfer. She stated a gait belt was used to help steady a resident and help prevent a fall and injury to the resident and to themselves. She stated she was not aware they could not place their arms under the residents' arm pits when using the gait belt. In an interview with PT W on 07/30/25 at 03:45 p.m. she stated she had done some new employee training with gait belts and mechanical lift transfers, but it was not something they did on a routine basis. She stated the facility's expectation for safe transfers was any resident who needed contact assistance with a transfer would need a gait belt to assist with fall recovery and or prevent falls. She stated it was never

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #3) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #3's oxygen was administered at the correct setting of 2 liters per minute on 7/29/25 as ordered by the physician. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #3's admission record dated 7/29/25 reflected a [AGE] year-old female with an original admission date of 1/25/23 and readmission date of 10/2/24. Pertinent diagnoses included Acute or Chronic Heart failure, Acute Kidney Failure, End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and Morbid Obesity. Record review of Resident #3's Order Summary Report dated 06/29/2025, and a physician order on 7/1/25 reflected O2 (oxygen) @ 2 liters per minute via Nasal Cannula every shift.Record review of Resident #3's person-centered care plan, initiated date 7/12/25 reflected .resident has Oxygen Therapy related to Ineffective gas exchange Date Initiated: 09/14/2023 Revision on: 09/08/2024.CHANGE respiratory tubing mask, bottle water q 7 days, and prn (as needed) -clean oxygen concentrator filter with soap and water, and air dry 7 days, and prn (as needed) -check o2 (oxygen) saturation qshift (every shift) and prn (as needed) (may titrate oxygen flow rate 2-5 lpm (liters per minute) Date Initiated: 05/29/2024 Revision on: 11/01/2024 LVN O2 (oxygen) @ 2 liters per minute via Nasal Cannula as needed for To maintain 02>90 Date Initiated: 09/14/2023 Revision on: 11/07/2024 CNA LVN RN. Record review of Resident #3's Quarterly MDS assessment, dated 7/2/25 in section O-C1 reflected resident required oxygen while residing at the facility. Her BIMS score was 13 which indicated little to no impairment to cognition. In an interview and observation with Resident #3 on 07/29/2025 at 10:58 AM the resident was heard yelling from her room she needed her call light and oxygen because she couldn't breathe. The Staffing Coordinator entered the room immediately and left shortly after. The Surveyor entered the room to check on Resident #3 after the Staffing Coordinator had left. Resident #3 was observed with oxygen on via nasal cannula. The oxygen tank read 4.5 liters. Resident #3 reported she needed her oxygen on because she was having difficulty breathing and felt better now that it was on. Resident #3 stated she did not know the oxygen level her machine should have been at and had not adjusted it herself, as she could not reach it. During and interview and observation with the Staffing Coordinator on 7/29/25 at 11:13am revealed she responded to Resident #3 yelling and turned on the oxygen tank for the resident. She stated she was unsure of the oxygen orders, but the oxygen machine was usually set to where the resident needed it. She stated oxygen was typically ordered at 1 or 2 liters. She was asked to read the oxygen level on the tank and she stated it was at 4.5 liters, and she then stated oh I need to slow it down. She was observed adjusting the oxygen level and left the room to check Resident #3's orders. When she returned, she stated Resident #3's order was for 2 liters via nasal cannula and did not make any adjustments to the oxygen tank. She stated the risk to the resident of incorrect oxygen administration was administration of oxygen may not be as ordered by the physician. She stated the resident had too much oxygen going in before she adjusted it but did not know the risk for that resident of getting too much oxygen and would have to check. An observation of Resident #3 in her room on 7/29/25 at 11:15am revealed the oxygen tank was set at 3.5 liters and the resident continued to receive oxygen via nasal cannula. In an observation and interview with ADON A in Resident #3's room on 7/29/25 at 11:47am she confirmed the oxygen tank was set at 3.5 Liters. She stated she did not know what it should be at but would get a nurse from the floor and check the order. She stated she knew it was set incorrectly as she walked out of the room. ADON A returned and stated the physician order was 2 liters via nasal cannula. The Staffing Coordinator and ADON A entered the room again and corrected Resident #3's oxygen to 2 liters. The Surveyor observed the oxygen tank to be set at 2 liters. ADON A stated she was unsure of the risk to Resident #3 getting too much oxygen but stated if her oxygen had been administered 8 to 10 liters, she could become disoriented. She stated oxygen can usually be titrated between 2 and 4 liters; however, the physician order must be followed. An interview with LVN H on 7/30/25 at 3:09pm revealed if a resident was asking for their oxygen and had as needed oxygen, she would look at the physician order, verify how many liters the order stated and would place them on oxygen. She stated if the resident was on continuous

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	676315	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for 1 of 8 residents (Residents #8) reviewed for dental services.The facility failed to provide and coordinate dental services for Resident #8 after a dental assessment on 03/13/25 indicated he needed 7 teeth extracted. This failure could place residents at risk of oral complications, dental pain, and diminished quality of life.Findings included:Record review of Resident #8's Quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male, admitted to the facility on [DATE], with the diagnoses of heart failure, diabetes (high blood sugar), osteoarthritis (breakdown of cartilage) and a BIMS score of 13 (intact cognition). Record review of Resident #8's face sheet, dated 07/30/25, reflected his primary payor source was Medicaid.Record review of Resident #8's care plan, dated 07/28/25, did not reflect and care areas regarding Resident #8's teeth or dental services. Record review of Resident #8's dental assessment dated [DATE] reflected Resident #8 was seen for an assessment exam and there were 7 teeth that needed to be extracted due to broken root tips and having an abscessed. Record review of Resident #8's progress notes from 05/01/25-07/31/25 reflected the following physician follow up progress note, dated 05/13/25: . Diagnosis, Assessment, and Plan. Tooth decay.refer to dentist In an interview and observation on 07/29/25 at 2:09 PM with Resident #8, he stated he needed to see a dentist since March 2025 because he had broken teeth and an infection that needed to be addressed. Observation revealed broken and missing teeth on the top and bottom of his mouth. He stated he thought he had been seen by the dentist twice and they looked at his teeth and - he had not heard any information about a follow up exam or treatment. He stated he was not sure who was scheduling the follow up visits and the facility was aware because he mentioned it to the Physician and the Social Worker. He stated he was able to eat and experienced some discomfort at times, but it did not cause him pain.In an interview on 07/31/25 at 10:19 AM with the Regional Social Services Consultant revealed she was one of the social workers who covered the facility while a full-time social worker was being onboarded and they were responsible for coordinating dental follow up visits and referrals. She reviewed Resident #8's dental assessment dated [DATE] and stated she would have expected Resident #8 to be seen by dental services since March 2025 and would have to contact the company to determine if he was seen. She stated it was important to ensure residents had timely dental referrals and follow ups because dental issues could impact their day-to-day life. She stated residents who had broken teeth or abscesses could experience pain and difficulty eating. In an interview on 7/31/25 at 11:30 AM with the Administrator revealed she would have expected Resident #8 to have been seen by dental services since March 2025 for his root tips and dental concerns. She stated that the social worker was responsible for making referrals and follow up visits for residents. She stated the Regional Social Services Consultant and other social workers were responsible for resident social services referrals and the facility had recently hired a full-time social worker. She stated she expected dental follow ups and referrals to be timely because residents could experience pain or difficulty eating. In an interview on 07/31/25 at 3:53 PM with the DON she stated she was not familiar with Resident #8 because she recently began working at the facility. She stated dental follow ups and referrals were the responsibility of the social worker. She stated it was important to ensure residents had timely dental care follow ups to ensure they received the care they needed and did not experience discomfort, pain, or problems eating.Record review of the facility's referral policy, titled Referrals to Outside Services, dated August reflected: .Purpose: To provide residents with outside services as required by physician orders or the Care Plan.The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility. To facilitate this process, the Facility maintains service provider contracts with a variety of providers.

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	676315	A. Building B. Wing	07/31/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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	676315	A. Building B. Wing	07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen.1. The facility failed to ensure food item in the facility walk-in refrigerator was dated, labelled and not expired.2. The facility failed to ensure food item in the facility refrigerator was dated and labelled.These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included:Observation of the facility walk in refrigerator on 07/29/2-25 at 09:14 AM revealed cabbages in a tray were not labelled or dated, butter in an open box was not dated or labelled, salad mix in two plastic bags were not labelled, an open box of dessert was not dated, shredded cabbage in a plastic bag had an expiration date of 07/23/2025. Garlic bread in a plastic bag in the refrigerator was not dated or labelled. An interview on 07/30/2025 at 02:46 PM with [NAME] Z revealed all the kitchen employees were responsible to ensure the food items were dated, labelled and not expired. She stated she expected all the food items to be dated the day she received it, put the date when the box was open, and throw any expired food item into trash. She stated dating, labelling was important to ensure the food was fresh and not expired. She stated not dating, labeling and expired food increased the risk for food poisoning and food borne illness among the residents. She stated she received training and in services on food handling every month and the most recent she received was that day. An interview with the Dietitian on 07/30/2025 at 03:06 PM revealed she expected all the food items to be dated, labelled and not expired. She stated the dietary manager was responsible to ensure all the food items were dated, labelled and not expired. She stated the staff did not have to put a date on the food item if it had the delivery date sticker by the food vendor. She stated not having a date, label, or use of expired food may cause food borne illness among the residents. She stated all the kitchen employees received in service training on dating labelling and handling food every month. She stated they did not use the expired food item and it was discarded. An interview with Dietary Aide AA on 07/30/2025 at 03:13 revealed all the kitchen employees were responsible to ensure the food items were dated, labelled and not used beyond the expiry date. He stated the cooks were responsible to ensure the food items in the refrigerator and freezer were dated, labelled and not expired. He stated dating, labeling and discarding expired food were important to ensure residents were not affected by food poisoning and illness. He stated he received in service that week on food handling, dating, labelling, discarding food items beyond the expiration date. An interview with Dietary Aide BB on 07/30/2025 at 03:20 PM revealed all the kitchen staff were responsible to ensure the food items were dated, labelled and not expired. He stated the staff were responsible to put the date the day they received the item, the date they opened a box. He stated not dating, labelling and using food beyond expiration date increased the risk of residents getting sick due to food borne illnesses. He stated he received in service training on food labeling and dating that week. An interview with the Dietary Manager on 07/30/2025 at 03:28 PM revealed all the kitchen staff were responsible to make sure the food items were dated, labelled and not expired. She stated she expected the staff to date when they received the food item, date it when they opened the box and to throw away the expired items. She stated not dating, labelling and discarding expired food could lead to food borne illness and death among the residents. Record review of the facility policy titled food labeling and dating, dated 1/25/25 reflected To establish guidelines for storing, thawing, and preparing food. Policy: Food items will be labelled, dated, stored, thawed in accordance with good sanitary practice. Procedure: I. Dietary employees will be trained regarding proper food storage procedures, labeling, and dating. II. The product name will be labelled on food items, including the original packaging, zip-lock bag, and storage bin. III. Label each package, box, can, etc., with the date of receipt. Items stored should be dated upon receipt, unless they contain a manufacture's use-by, or a date delivered. If the vendor pick stickers have the receive date or delivery date printed on the pick sticker, this can serve as a receiving date labelling. IV. The practice of First In, First Out (FIFO) will be utilized. Products that do not have an imprinted use-by or expiration date on the product will be dated when they are received and rotated as new inventory is purchased. V. Frozen bread products will be labelled with the product name, the storage box, rack or bin will be dated with the received date, the date item was pulled to thaw, and the date with the manufacture's recommended shelf-life. VI. Opening a food item can change the storage life of a product. Once a package or container is opened, the item must be labeled with an open by date and use-by date or dated with the use-by or expired on the manufacturer's recommended shelf-life. A. If the manufacturer does not include a recommended use by or