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	05/31/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observations, interviews, and record review, the facility failed to ensure residents who were incontinent of bladder or had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 Residents (Resident #2) reviewed for incontinent care. The facility failed to ensure Resident #2 had the foley catheter inserted with a physician orders. This failure could affect residents by placing them at increased risk of discomfort, skin ulcerations, and improper medical treatment. Findings included: Record review of Resident #2's face sheet, dated 05/31/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include hypertension, Alzheimer's, chronic pain, anxiety, bipolar disorder, and delusional disorder. Record review of the comprehensive quarterly MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 13, indicating no cognitive impairment. Resident #2 was always incontinent of bowel and bladder. No indication of Resident #2 having a foley catheter nor a diagnosis of urinary retention. Record review of the order summary report for Resident #2's active as of 05/29/24, revealed no order for a foley catheter. Record review of Resident #2's Comprehensive Care Plan, revised on 12/29/24 revealed, Focus, (Resident #2) has FUNCTIONAL bladder incontinence r/t Alzheimer's, Impaired Mobility, incontinence. Intervention, Monitor/document for s/sx UTI: pain, burning, blood- tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Monitor/document/report to MD PRN possible medical causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decreased bladder capacity, diabetes, Stroke, medication side effects. Review of Resident #2's progress notes dated 05/28/2024 at 22:04 a note documented by RN E, revealed Resident #2 was complaining having difficult urinating and per the aide who was taking are of the resident reported Resident #2 had not voided. RN E called Resident #2's primary care provider and she was unable to reach the primary care provider. RN E inserted the foley catheter and informed the oncoming nurse to follow up with the resident's primary care provider. Interview on 05/29/24 at 02:48 PM with RN E revealed she was the charge nurse for Resident #2. RN E stated she inserted a foley catheter on Resident #2 because the resident had not voided, and the resident stated he wanted a foley catheter. RN E stated she called the resident's primary care provider, and she was not able to reach the primary care provider, so she went ahead, and inserted the foley catheter. RN E stated she informed the oncoming nurse to follow up with the primary care provider, regarding the resident's use of the foley catheter. RN E stated that at the time she inserted the foley catheter she did not have the orders from the primary care provider. RN E stated she was supposed to obtain the order from the primary care provider before inserting the Foley catheter, because any invasive procedures required a doctor's orders. The foley catheter could be a contraindication for the resident which could result to negative side effects to the resident. In an interview on 05/30/24 at 01:45 PM ADON F stated he was the nurse in charge of the Resident #2, and he was not aware of the resident having a foley catheter until yesterday (05/30/24). ADON F stated if the resident had a change of condition, the charge nurse was to assess the resident, inform the resident's primary care provider, and then follow the orders. ADON F stated RN E was not supposed to insert the foley catheter without the physician orders, and because it was an invasive procedure which could be contraindicated for the resident, which could harm the resident. ADON E stated he was in the process of educating the nurse on obtaining physician orders prior to any procedures. In an interview on 05/31/24 at 10:48 AM with the DON he stated he was made aware of the nurse completing an invasive procedure without the physician orders. The DON stated the nurse was to wait for the orders, and not complete the procedure because it was not under the staff's scope of practice. The DON stated he expected the staff to follow the physician orders to complete any procedures. He stated the staff was to wait for the physician to give an order because the resident could have a contraindication for the foley catheter and may be the change of condition could be caused by something else. The DON stated it was an issue that was being addressed by the facility. Review of the facility policy, titled Catheter Indwelling, revised 06/2020 reflected, I. Catheterization is provided under the direction of a physician's order, which will include the medical necessity for use, the size of the catheter, and balloon. II. The Attending Physician's decision to use an indwelling catheter will be based on valid clinical indicators including: A. Urinary retention that cannot be treated or corrected medically or surgically and for which alternative therapy is not feasible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 24 residents (Resident #25) reviewed for medication storage. The facility failed to appropriately store Resident #25's medication; Unisom and Ketoconazole that were left at the resident's bedside table. These deficient practices placed residents at risk for harm by misappropriation of property and not receiving the therapeutic effects of their medications. The findings included: Record review of Resident #25's face sheet dated 05/31/24 reflected the resident was a [AGE] year-old female. Resident #25 was admitted to the facility on [DATE] with diagnoses including, hypertension, vascular dementia, anxiety, major depressive disorder, insomnia, and lack of coordination. Record review of Resident's #25's Quarterly MDS assessment, dated 05/10/2024, reflected Resident #25 had a BIMS score of 15, indicating no cognitive impairment. Review of the care plan did not indicate that Resident #25 was able to self-administer medications. Observation and interview on 05/29/24 at 09:50 AM revealed Resident #25 was in the room, resting in bed. At the bedside, the resident had medications in a bottle and in a tube. The resident stated she was taking the medications due to her headaches and the cream for itching. She stated the bottled medication was brought to her by her sister about 1 month ago, and the cream was from a prescription about a week ago from the dermatologist. Resident #25 stated the staff knew about the medication and the medications were stored on the bedside table. Resident #25 stated she was not aware she was not supposed to have medications in the room. On 05/29/24 at 10:00 AM the state surveyor went into Resident #25's room with LVN C, and took the medications from the bedside table. LVN C informed the resident she was not supposed to have medications in her room and self-medicate without the physician orders. The medications LVN C picked up from the bedside table were, Unisom 25mg (sleep tablet) the bottle had one tablet remaining, on the bottle it indicated it came with 32 tablets. Another medication was Ketoconazole cream and had been used. In an interview with Resident #25 she stated her sister had brought her the sleeping tablets about a month ago and she used the medication because she had difficulty sleeping. She stated she had seen her dermatologist about 1 week ago and she was prescribed Ketoconazole which she used under her breasts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/29/24 at 10:03 AM with LVN C she stated Resident #25 was alert and oriented and she was not aware of the resident having the medications. LVN C stated Resident #25 was not supposed to have medications in the room and self-administer medications without an order. She stated the resident could overdose and/or could cause medication interactions. LVN C stated she would call the primary care provider and obtain the orders for the medications. In an interview on 05/30/24 at 1:45 pm with ADON F he stated he was not aware Resident #25 had medications in the room, until he was informed by the charge nurse. ADON F stated Resident #25 had been educated previously not to have medications in her rooms that the facility was not aware of, and for the family not to bring the medications to the resident without the facilities knowledge. Resident #25 was not supposed to have medications in the room because she could over medicate herself which could lead to negative side effects. In an interview on 05/31/24 at 10:48 am with the DON he stated he completed rounds daily in all of the residents' rooms and he had not seen the medications in Resident #25's room. The DON stated previously Resident #25 had history of having medications in her room and the DON suspected the resident was hiding the medications. The DON stated the resident was not to self-administer any medications and he expected the staff to pull out any medications noted in any of the resident's rooms. The DON stated the resident was not supposed to have medications in the room because they did not have orders for the medications and some of the medications could cause medication interactions from the ones she was taking. Review of the facility policy revised 08/2020, titled Self Administration of Medication reflected, Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or rooms with, residents who self-administer.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observations, interviews, and record review, the facility failed to update and notify residents that menu changes were made prior to serving the meal. For the lunch meal on 5/30/2024 residents were served ground beef with sauce, baked rice with peas and carrots, steamed vegetables, a deep-fried egg roll, strawberry cake with shredded pineapple on top instead of the posted lunch menu of Mongolian Beef, Fried Rice, Stir Fry Vegetables, Egg roll, and Pineapple Upside cake. The Dietary Manager did not document or make any changes to the listed menu. These deficient practices could affect 92 residents who receive meals from the facility kitchen in that they would not receive the meal that was on the menu listing. The findings were: Record review of Resident #42's Admission Record dated 5/31/24 revealed he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #42's Quarterly MDS assessment dated [DATE] revealed he had severe cognitive impairment, his diagnoses included hypertension (high blood pressure), diabetes, high cholesterol, history of stroke, and vitamin deficiency. Record review of Resident #42's Care Plan revealed, an entry dated 2/19/23 that reflected: Focus: [Resident #42] has nutritional problem or potential nutritional problem r/t cognitive communication deficit. Goal: [Resident #42] will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition, and consuming at least (50)% of at least (3) meals daily . Interventions/Tasks: Monitor/document/report to MD PRN for s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals .Provide, serve diet as ordered. Monitor intake and record q meal Record review of Resident #42's Order Summary Report dated 5/31/24 reflected an order for a Regular diet, regular texture, and thin consistency. The order was dated 12/26/24. During a confidential resident interview on 5/29/24 at 10:20 AM, the resident stated their main complaint was, The food is awful, worse since that second outfit took over, hamburger, hamburger, hamburger, cheap crap. They put hamburger meat in everything. During a confidential resident interview on 5/29/24 at 11:50 AM, the resident stated they were generally happy with their care but did not always like the food. They stated they never requested an alternate meal and were unaware they could do that. They stated, a salad would be great! They stated breakfast was good, but lunch and dinner were always hit or miss. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and confidential resident interview on 5/29/24 at 12:15 PM, the resident was sitting in a chair preparing to eat their lunch that they identified as being provided from outside the facility. They stated the food there tasted like dog food and complained the facility used too much hamburger meat. The resident stated they mainly ate meals from outside the facility. They stated they did not complain to management about it because they did not feel it would do any good. During an observation and interview on 5/29/24 at 1:55 PM, Resident #42 was observed visiting with another resident in their room. He described the food as just okay. An observation on 5/29/24 at 9:15 AM revealed LVN B was checking hall trays near the 100 hall. During an observation and interview on 5/31/24 at 10:00 AM, Resident #42 was observed sitting on the side of his bed, eating breakfast. He pointed to a sausage patty on his plate and stated, I don't want that ever. He could not recall if he had ever told anyone he did not like sausage but stated he never ate it. When asked if he ever asked for an alternative choice, Resident #42 stated, I don't get any choice, I just take what they give me. He stated he did not recall seeing a menu and did not know he could ask for something else if he was unhappy with what he was served. Review of the meal ticket located on resident #42's tray reflected: Menu: Choice of Juice, Choice of Hot or Cold Cereal, Egg of Choice, Bacon, Toast . Notes: 2 fried eggs, raisin bran. During an interview on 5/31/24 at 10:05 AM, RN A, Resident #42's Charge Nurse, stated he did not recall ever seeing menus passed out to residents. He stated he knew he was supposed to check their trays and, if a resident told him they did not like what they were served, he contacted the kitchen to request something else . During an interview on 5/31/24 at 10:20 AM, LVN B stated she had checked the trays for accuracy during breakfast. She stated the nurses checked the trays and assisted the CNAs with passing them to the residents. When shown Resident #42's meal ticket from his tray and asked why he received sausage when the ticket showed bacon. LVN B stated the menu depended upon what was available in the kitchen and there were sometimes alternates on the tray. She stated, if an item was circled or listed as a preference, she would not have given it to the resident. She stated, if a resident complained, she typically contacted the kitchen and requested something else for the resident. She stated she had not seen any menus passed to the residents recently. She stated she had recently switched to the day shift from previously working 2 PM to 10 PM shift. She stated the residents used to get a sheet of paper with the menu so they could circle their preferences and she could not recall when she last saw one. She stated the risk to the residents was they may not get enough to eat . (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/31/24 at 10:27 AM, the Dietary Supervisor was observed talking to residents on the 100 Hall. When asked about Resident #42, he proceeded to enter the resident's room. Resident #42 repeated his objection to receiving sausage on his tray and stated he never knew he was allowed to ask for something else to eat. The Dietary Supervisor asked him if he was receiving the weekly menu with the list of alternates and Resident #42 told him he did not know what he was talking about. The Dietary Supervisor noted Resident #42's preferences and stated he would add them to his order. After exiting Resident #42's room , the Dietary Supervisor was approached by Resident #82 in the hallway who wanted to request some alternates to her meals due to recent dental work. Resident #82 was asked by the Dietary Supervisor if she had seen the menus that were passed every week along with the list of alternates. Resident #82 stated she had not seen the menu or list since the previous Dietary Supervisor was working there. She stated she only knew what the menu was for the day by wheeling herself to the area near the dining room where the menu was posted. She stated she already knew what the alternates were, but they had stopped providing lists to the residents. Interview on 05/30/24 11:15 AM with the [NAME] he described the lunch meal posted on the menu was Mongolian Beef, Fried Rice, Stir Fry Vegetables, Egg roll, and Pineapple Upside cake. As the cook prepared lunch, he explained he had made a personal sauce recipe for the ground beef he was cooking. The [NAME] said rice was cooked in the oven that makes it less sticky and to cut out some of the sodium he omitted the soy sauce and the egg. The [NAME] cooked carrots and peas then later combined them with the rice. The [NAME] also prepared steamed mixed vegetables. The cook did not indicate why he was not following the posted menu . Interview on 05/30/24 at 01:38 PM with Dietary Supervisor and the test tray for posted lunch revealed the test tray was not what was posted but instead was ground beef, beef sauce, rice cooked in the oven, carrots and peas, mixed vegetables, and egg rolls that were deep fried with strawberry cake with shredded pineapple on top. The rice, carrots, and peas were mixed. The Dietary Supervisor revealed the reason for the change in what was served was due to the vendor not sending the beef cubes he ordered for the Mongolia Beef meal. The Dietary Supervisor said he normally orders for 1 week but to make a switch in the forgoing delivery dates and had to order for 10 days . Re-ordering it would be too late for the lunch meal on 5/30/2024. The Dietary Supervisor said he could have changed the menu, but he could not have renamed it. The Dietary Supervisor did not say why he did not change the menu. The Dietary Supervisor revealed the aids were unable to find white cake mix for the pineapple upside down cake and used what cake mix they could find. He stated that they had strawberry cake mix and topped it with shredded pineapple. The Dietary Manager revealed the dietary vender provides beef, turkey, and chicken. The Dietary Supervisor revealed if residents do not like the menu and he was not able to change the menu. The Dietary Manager revealed he will talk to the residents one-on-one or as a group whichever was best to discuss the menus and food. Ninety-two residents receive meals from the facility kitchen .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observations, interviews, and record review, the facility failed to maintain medical records on each resident that were accurately documented, for 2 (Resident #35 and Resident #82) of 6 residents reviewed for clinical records. Resident #35's prescription medication of Pimozide Tablet 2MG was written as being indicated for psychosis; however, Resident #35 did not have a history of psychosis. Resident #82 had active physician's orders for weekly laboratory work including CBC, BMP, and ammonia levels. Resident #82's physician indicated these orders should have been previously discontinued. These failures could place residents at risk of receiving inaccurate services based on their comprehensive assessments. Findings included: 1.) Review of Resident #35's Face Sheet, dated 05/31/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #35's annual MDS Assessment, dated 03/15/24, reflected she was cognitively intact. She had diagnoses including depression (a common and serious medical illness that negatively affects how you feel, the way you think and how you act) and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Resident #35 was not identified as having any potential indicators of psychosis. Review of Resident #35's Care Plan, undated, reflected no evidence that she had diagnoses including psychosis. Resident #35 was identified as having diagnoses including depression and schizophrenia. Review of Resident #35's Physician's Orders, dated 05/31/24, reflected she had orders including: *Pimozide Tablet 2MG (Give 1 tablet by mouth in the morning for psychosis) - Start date 12/21/22 An observation of Resident #35 on 05/30/24 at 12:05PM revealed she was clean, well-groomed, and appropriately dressed. She was free from any odors. There were no concerning marks or bruises noted on her person. She was free from any signs or symptoms of distress. She did not appear to be overly medicated and/or sedated. During an interview with Resident #35 on 05/30/24 at 12:05PM revealed she reported no concerns regarding her mental health status or medication regimen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing on 05/31/24 at 11:03AM, he stated the indication of psychosis for Resident #35's prescribed medication of Pimozide Tablet 2MG was not an appropriate diagnosis or indication for that medication. He stated there must have been an error when the medication was being input in the electronic medical record. The Director of Nursing stated the potential risk of having an improper and/or incorrect diagnosis/indication for prescribed medications was that the resident could be treated for the wrong medical condition. Review of the facility's Psychotherapeutic Drug Management policy, dated 06/2020, reflected the purpose was .to ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s) . The policy did not outline which diagnoses were appropriate indications for psychotherapeutic drug management. 2.) Review of Resident #82's Face Sheet, dated 05/31/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Review of Resident #82's MDS Assessment, dated 05/16/24, reflected she was cognitively intact. Resident #82 had diagnoses including cirrhosis of the liver (a chronic liver disease that occurs when healthy liver tissue is replaced by scar tissue and prevents the liver from functioning normally). Review of Resident #82's Care Plan, dated 05/21/24, reflected she was at-risk for being hospitalized due to her diagnosis of cirrhosis of the liver, as well as her non-compliance with her treatment plan. Interventions included continued education of medication compliance to Resident #82, continued medication administration, and continued monitoring of her bowel movements. Review of Resident #82's Physician's Orders, dated 05/31/24, reflected orders including: *Xifaxan Oral Tablet 550 MG (Give 1 tablet by mouth two times a day for impaired brain function due to liver disease) - Start Date 02/22/24 *Orders to complete labs including CBC, BMP, and ammonia levels weekly on Thursdays - Start Date 02/23/24 *Lactulose Oral Solution 10 GM/15 ML (45 ML by mouth three times a day for Hepatic Encephalopathy/impaired brain function due to liver - give to have BM 3-4 times in 24hrs hold if diarrhea occur and notify charge/NP/MD) - Start Date 03/04/24 Review of Resident #82's electronic medical record, on 05/31/24, reflected since the time she was ordered to have labs including CBC, BMP, and ammonia levels weekly on Thursdays was written on 02/23/24, she had only had labs completed on the following dates: 02/23/24, 02/24/24, 02/26/24, 03/06/24, 05/24/24. An observation of Resident #82 on 05/29/24 at 11:33AM revealed she was clean, well-groomed, and appropriately dressed. She was free from any odors. There were no concerning marks or bruises noted on her person. She was free from any signs or symptoms of distress. During an interview with Resident #82 on 05/29/24 at 11:33AM, revealed she did not report having any knowledge regarding missed laboratory work, such as CBCs, BMPs, and/or ammonia levels. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing on 05/31/24 at 12:45PM, he stated although an order was written for Resident #82 to have weekly laboratory work completed beginning on 02/23/24, Resident #82's physician determined, after further evaluation, that Resident #82 did not actually require weekly laboratory work as of 03/06/24. The Director of Nursing stated he intended on clarifying with Resident #82's physician as to how to proceed with Resident #82's care. The Director of Nursing stated the risk of an individual with diagnoses including cirrhosis of the liver not receiving regular laboratory work included possible changes in condition that were associated with their medical condition. He stated he would have expected Resident #82 to have more frequent laboratory work completed, as per her current written orders. During an interview with Resident #82's Nurse Practitioner on 05/31/24 at 1:40PM, she stated she conducted in-person evaluations for Resident #82 at least once or twice per week due to her diagnosis of cirrhosis of the liver. She said the order for weekly laboratory work including CBC, BMP, and ammonia levels, which was written on 02/23/24, should have been discontinued after further evaluation on or around 03/06/24. She stated Resident #82 did not need weekly laboratory work completed, as the facility monitored her for changes in condition. When the facility determined she had increased ammonia levels, they contacted her (the Nurse Practitioner) or the physician for further direction. She stated the facility had been following this protocol for Resident #82. During an interview with Resident #82's physician, who was also the facility's Medical Director, on 05/31/24 at 3:00PM, he stated Resident #82 was non-compliant with her treatment plan and frequently refused her prescribed medications that aided in maintaining appropriate levels of liver functioning. Resident #82's physician stated he was not aware that an order had been previously put in the system by the Nurse Practitioner for weekly laboratory work including CBC, BMP, and ammonia levels. He stated he did not feel as though Resident #82 needed weekly laboratory work. He stated the facility monitored Resident #82 for changes in condition and when possible changes were identified, he was notified and laboratory work was completed at that time as warranted. He stated due to Resident #82's complex medical history, abnormally high ammonia levels did not affect her nearly as much as they would other individuals. Review of the facility's Laboratory, Diagnostic, and Radiology Services policy, dated 06/2020, reflected, . Laboratory, diagnostic, and radiology services will be coordinated pursuant to an order by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with the scope of practice under state law . and .The Facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic, or radiology provider .