

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 18648 Hillcrest Rd Dallas, TX 75252	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good personal hygiene to a resident who is unable to carry out activities of daily living for seven of seven residents (Resident #25, Resident #24, Resident #111, Resident # 12, Resident #85, Resident #67, and Resident #35) reviewed for ADL care. 1. The facility failed to provide Resident #25, who required extensive assistance, with timely incontinence care on 07/29/25 from 6:30 a.m. to 02:30 p.m. 2. The facility failed to ensure Resident #24, who required extensive assistance received consistent baths/ showers and failed to provide timely incontinence care on 07/30/25 when she called for assistance at 08:30 a.m. and was not changed until 09:55 a.m. 3. The facility failed to provide consistent showers and shaving to Resident #111, who required moderate assistance with personal hygiene. 4. The facility failed to provide consistent shaving and shampooing to Resident #12's hair, who was dependent on personal hygiene. 5. The facility failed to provide consistent showers and grooming to Resident #85, who required extensive assistance with bathing and personal hygiene. 6. The facility failed to provide consistent baths/showers and shampooing to Resident #67's hair, who was dependent on baths and personal hygiene. 7. The facility failed to ensure Resident #35 had her fingernails cleaned and trimmed on 07/29/2025. This failure could place residents at risk of skin breakdown, urinary tract infections, skin infections and loss of dignity. Findings included: 1. 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] has mixed bladder incontinence. Intervention. the resident uses disposable briefs. has a history of urinary tract infections. has potential for pressure ulcer development related to incontinence, decreased ADL's. Interventions. Follow facility policies/protocol for the prevention/treatment of skin breakdown. 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. Resident #25 had an odor of urine. In an interview with CNA R on 07/29/25 at 11:50 a.m. he stated he was not assigned to Resident #25 today. He stated Resident #25 was on hospice service and they had gotten him up shortly after the beginning of the 06:00 a.m. shift. In an interview with CNA T on 07/29/25 at 11:55 a.m. she stated Resident #25 was bathed, changed and gotten up by hospice this morning around 6:30 a.m. She stated they had to leave him up for a while after he ate to give his food time to digest. She stated they would not put him to bed, since he would have to sit up after lunch so the 2-10 p.m. shift would be putting him back to bed. She stated she had not taken him back to his room this shift. Observation of Resident #25 on 07/29/25 at 12:20 p.m. revealed he remained up in the common/dining room area. Observation of Resident #25 on 07/29/25 at 01:20 p.m. revealed he was served his lunch tray and was provided (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding assistance by ADON A. Observation of Resident #25 on 07/29/25 at 02:10 p.m. revealed he remained up in the common/dining room area. On 07/29/25 at 02:20 p.m. ADON A was notified by this surveyor, Resident #25 had been up since 06:30 a.m. and had not been checked or changed the entire shift. ADON A then instructed CNA N to take Resident #25 to his room to be checked and changed. In an observation on 07/29/25 at 2:25 p.m. CNA N was observed taking Resident #25 to his room which was under electronic monitoring. CNA N 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 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 him facing the head of the bed. CNA U and RN C transferred the resident to the bed revealing his pants were urine soaked as was the wheelchair cushion. RN C removed his gloves, performed hand hygiene and left the room to obtain sanitizer to clean the wheelchair cushion. CNA U and CNA L rolled the resident onto his back and removed his pants. CNA U unfastened the resident's brief and provided peri care. Both staff rolled the resident onto his side revealing the resident had a moderate size bowel movement. Skin was noted to be intact with some mild redness. CNA U completed the peri-care and both staff placed a clean brief and clean pants onto the resident. RN C and CNA U positioned the resident on the side of the bed and transferred the resident back to his wheelchair. In an interview with RN C on 07/29/25 at 03:00 p.m. he stated Resident #25 was saturated with urine. He stated staff were supposed to check and change residents who were incontinent of urine every 2 hours. He stated the resident's family had requested he be gotten up for all meals, but stated they had to take him to his room to check and change him between meals. He stated the resident was usually still up when he came on duty for the 02:00 p.m. to 10:00 p.m. shift. In an interview with CNA U on 07/29/25 at 03:05 p.m. she stated she worked the 02:00 p.m. to 10:00 p.m. shift. She stated when she was assigned to Resident #25, he was usually still up when they came on shift. She stated he was usually very wet when they checked and changed him on their first rounds. In an interview with Resident #25's responsible party on 07/30/2025 at 7:53 a.m. she stated she had noticed they keep him out of his room most of the day. She stated she had not looked at the camera footage from yesterday (07/29/25) but would check to see if he had been brought back to the room to be changed on the day shift and would let the Surveyor know. In a follow up interview with Resident #25's responsible party on 07/30/2025 at 9:41 a.m. she stated on 07/29/25 the hospice staff changed him around 6:30 a.m. and had gotten up. She stated he was not brought back to the room to be changed again until 2:40 p.m. 2. Record review of Resident #24's MDS assessment dated [DATE] reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), muscle weakness, and lack of coordination. Resident #24 had a BIMS score of 15 which indicated her cognition was intact. Further review revealed Resident #24 was always incontinent of bowel and bladder, and her functional status reflected she required extensive assistance for personal hygiene. Review of Resident #24's Comprehensive Care Plan, created date 06/06/25, reflected the following: Focus: [Resident #24] has an ADL Self Care Performance Deficit related to impaired mobility, weakness Goal: [Resident #24] will maintain current level of function through the review date. Intervention. TOILET USE: The resident requires. staff participation to use toilet. PERSONAL HYGIENE/ORAL CARE: the resident requires. staff participation with personal hygiene . The facility did not indicate if the resident required 1or 2-person assistance and ADL care. Review of Resident #24's orders reflected Order Summary: Torsemide Oral Tablet 100 MG (Torsemide) Give 1 tablet by mouth one time a day at 09:00 AM for Diuretic (causes the kidneys to make more urine) active MD order since 05/17/25. Record review of the facility's shower schedule with an effective date of 11/11/24, reflected Resident #24 was scheduled for showers on Tuesday, Thursday, Saturday on the 6:00 a.m. to 02:00 p.m. shift. Review of Resident #24's shower sheets for July 2025 reflected Resident#24 received a bed bath on July 4, 2025, and a documentation of refusal on July 8, 2025. There were no additional shower sheets for July 2025. Observation and interview on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/29/25 at 11:01 a.m., revealed Resident #24 was lying in bed, and she stated she did not get showers, only bed baths. She stated she had only received 2 bed baths in two months. Resident #24 did not have an odor or appear unclear. Observation and interview on 07/30/25 at 09:42 a.m., revealed Resident #24 stated she did not get a bed bath yesterday (07/29/25) on her scheduled day. Resident #24 stated she was wet and had called for someone to change her at 08:30 a.m., and no one had come. Resident #24 stated she passed urine three times this morning. Resident #24 pushed the call light, and CNA X entered Resident #24's room at 09:55 a.m. to do her incontinent care. CNA X unfastened Resident #24's brief and cleaned her front area. CNA X assisted the resident onto her right side, revealing the brief was saturated with urine which had also soaked through to the draw sheet and fitted sheet of the bed. The sheet had a yellow ring at the edges of the soaked area. No skin issue was noted. In an interview with CNA X on 07/30/25 at 09:55 a.m. she stated she was a floater and was not assigned to Resident #24, and she was just helping where needed. In an interview on 07/30/2025 at 10:01 a.m. CNA Y stated she was assigned to Resident #24 for the morning shift on 07/30/25. She stated she did not change the resident this morning. CNA Y stated she came in to work at 05:55 a.m. She stated she checked Resident #24, and she was not wet. She stated Resident #24 liked to be changed after breakfast. Breakfast was served at 07:30 a.m. She stated the last time she checked on Resident #24 was at 7:30 a.m. and Resident #24 said she did not want to be changed. CNA Y stated Resident #24 called after breakfast at 8:30 a.m. and she was ready for incontinent care, but she stated she did not change her because they were busy picking up the trays after breakfast. CNA Y stated she was supposed to make rounds on the residents at least every 2 hours to check residents and change them if they were wet. CNA Y stated the risk of incontinent care not being provided on time would be skin break down, and infection. 3. Record review of Resident #111's face sheet dated 07/31/25 reflected a [AGE] year-old male with an admission date of 05/20/24. Record Review of Resident #111's quarterly MDS assessment, dated 06/23/25 reflected he had a BIMS score of 14 which indicated he was cognitively intact. He required moderate assistance with bathing and personal hygiene. Diagnoses included diabetes and seizure disorder (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain). Record review of Resident #111's care plan revised on 07/30/25 reflected, . [Resident #111] has an ADL self-care performance deficit related to seizures disorders, repeated falls, weakness, impaired mobility.bathing.Personal hygiene.assist x 1. Record review of the facility's shower schedule with an effective date of 11/11/24, reflected Resident #111 was scheduled for showers on Tuesday, Thursday, Saturday on the 6:00 a.m. to 02:00 p.m. shift. Record review of Resident #111's shower sheets for July 2025 reflected Resident #111 received a shower and was shaved on 07/08/25 and on 07/17/25 he received a shower but no shave by CNA S. There were no other shower sheets for Resident #111 for July 2025. In an observation and interview with Resident #111 on 07/29/25 at 11:15 a.m. the Resident was observed sitting on the side of his bed. Resident #111 was observed with a full mustache that was growing over his lip and a chin beard. Resident #111 stated he had not had shower in a week and a half. He stated he used to get a shower 3 x week, then it dropped down to 2 x week and now none. He stated the staff told him it was due to some kind of change, but he did not know what. He stated he hated having a mustache and beard and stated no one had offered to shave him. He stated he preferred to be clean shaven. In an interview with CNA V on 07/30/25 at 01:00 p.m. she stated she did not recall if she showered Resident #111 last Thursday (07/24/25). She stated they had a shower aide who provided most of the showers, so she was not sure if she showered him or if the shower aide showered him. She stated she usually did not work this hall. She stated she did not recall ever shaving Resident #111. In an interview with the Staffing Coordinator on 07/30/25 at 01:05 p.m. she stated CNA S was the assigned shower aide, but stated usually the CNA who was assigned to the resident would sign out if the shower had been given in the electronic record. She stated regardless, the staff were required to turn in a shower sheet on every resident who had a shower scheduled. She stated they were to indicate what type of bath was given, bed/or shower or if the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had refused. She stated if the resident refused, then the nurse was supposed to talk with the resident to see if there were issues, or if they wanted it at another time. She stated if a resident continually refused, they were to reach out to the family for assistance and stated all of this should be documented in the record. She stated the nurse was responsible for signing off on the shower sheets and then turning them in to the Treatment Nurse. She stated obviously the CNAs were not doing their shower sheets as required. In an interview with CNA S on 07/30/25 at 01:10 p.m. she stated she was the assigned shower aide and worked Monday through Friday. She stated she had not been able to do all the showers in the last week because she had been pulled to do weights and assist with transportation. She stated when she was not available the CNA who was assigned to the resident was responsible for giving them their shower. She stated she was supposed to turn in a shower sheet for each resident she showered. She stated she did not shower Resident #111 any this week or last week. Attempted to reach CNA T on 07/30/25 at 01:30 p.m. who was the assigned CNA to Resident #111 on 07/29/25 (his assigned shower day). Message left, with no return call received. In an interview with ADON A on 07/30/25 at 01:45 p.m. she stated she had started at the facility 3 days ago. She stated she was still learning the facility's process and the residents. Informed ADON A of Resident #111's desire to be clean shaven and his lack of showers over the last week. She stated she would make sure he was showered and shaved today. In an observation and interview with Resident #111 on 07/31/25 at 09:00 a.m. the resident was observed to be clean shaven. Resident #111 stated he had gotten his shower and been shaved and he felt much better. 4. Record review of Resident #12's face sheet dated 07/31/25 reflected a [AGE] year-old-male with an admission date of 04/15/25. The resident's admission picture reflected he was clean shaven with short hair. Record Review of Resident #12's quarterly MDS assessment, dated 05/13/25 reflected he had a BIMS score of 9 which indicated he was moderately cognitively impaired. He was dependent on staff for all ADLS. Diagnoses included cerebral vascular accident (stroke), hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body), and heart failure. Record review of Resident #12's care plan revised on 05/19/25 reflected, . [Resident #12] has an ADL self-care performance deficit related to hemiparesis (partial paralysis of one side of the body) following stroke .bathing.Personal hygiene.The resident is dependent on staff for personal hygiene and oral care. Record review of the facility's shower schedule with an effective date of 11/11/24, reflected Resident #12 was scheduled for showers on Tuesday, Thursday, Saturday on the 6:00 a.m. to 02:00 p.m. shift. Record review of Resident #12's shower sheets for July 2025 reflected he had received one shower and shave on 07/08/25 by CNA S. There were no other shower sheets for Resident #12 for July 2025. In an observation and interview on 07/29/25 at 10:16 a.m. Resident #12 was observed lying in bed with a hospital gown on. Resident stated he had a stroke which had affected his left side. Resident #12 was observed to have a full, unkept beard that was approximately an inch in length, mustache and long oily hair. Resident #12 stated he was getting bed baths but had not been shaved or had his hair washed. He stated he was not able to shave himself. In an interview with CNA R on 07/31/25 at 09:00 a.m. he stated he was assigned to Resident #12 on 07/29/25. He stated he had bathed Resident #12 but had not shaved him or washed his hair. He stated he might have shaved him about 2 weeks ago but could not be certain. He stated they were supposed to shave residents on their shower days or daily if they wanted it, but stated there were only 4 CNAs covering Hall 300 and 400 and they did not always have time to get the residents shaved. In an observation of Resident #12 on 07/31/25 at 09:10 a.m. he was observed in the common/dining room area, clean shaven and hair washed and cut. In an interview with LVN J on 07/31/25 at 10:45 a.m. she stated she had been there for 3 weeks. She stated the CNAs were supposed to turn in a shower sheet for all their assigned showers. She stated if a resident refused care the staff were supposed to let her know and she was required to follow up. She stated residents who wished to be shaved needed to be shaved daily. She stated the only way she would know if a resident had received their shower was by the shower sheets and through her observation of the residents. 5. Record review of Resident #85's quarterly (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS assessment dated [DATE] reflected Resident #85 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), cerebrovascular accident, and aphasia (a language disorder that affects a person's ability to communicate). Resident #85 had a BIMS score of 15 which indicated Resident #85's cognition was intact. Further review revealed Resident #85 functional status reflected he required extensive assistance for personal hygiene. Record review of Resident #85's Comprehensive Care Plan dated 05/08/25, reflected the following: . [Resident #85] has an ADL Self Care Performance Deficit related to Activity Intolerance, weakness and debility, decline in ADL's, Goal: [Resident #85] will maintain/improve current level of function in . Personal Hygiene.Intervention. BATHING: The resident requires (2) staff participation with bathing Record review of the facility's shower schedule with an effective date of 11/11/24, reflected Resident #85 was scheduled for showers on Tuesday, Thursday, Saturday on the 6:00 a.m. to 02:00 p.m. shift. Record review of Resident #85's shower sheets for July 2025, reflected Resident #85 received a bed bath on July 12, 2025. There were no additional shower sheets for the month of July 2025 for Resident #85. Record review of the facility grievances documentations reflected, Resident #85 had filed a grievance on 07/22/25 stating he was not getting his showers, and he needed his fingernails trimmed. Review of the grievance response by the assigned department on July 23, 2025, reflected, Resident #85 received shower and nails trimmed. Observation and interview on 07/29/25 at 1:40 p.m., Resident #85 was lying in bed. Resident #85 was noted to have a long beard about two inches in length. Resident's nails on both hands were trimmed and clean. He stated he got a bed bath once a week, but sometimes it would take a couple of weeks before he got another one. Resident #85 stated the beard did not bother him, but he would like it trimmed. He stated he was supposed to get bed baths on Tuesday, Thursday and Saturdays. Observation and interview on 07/30/25 at 09:40 a.m., revealed Resident #85 stated he did not get a bed bath yesterday (07/29/25), on his scheduled day. Resident#85 could not remember the last time he had a shower/bed bath. 6. Record review of Resident #67's MDS assessment dated [DATE] reflected Resident #67 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), cerebrovascular accident, aphasia (a language disorder that affects a person's ability to communicate), and Hemiplegia or Hemiparesis (paralysis of one side of the body/weakness on one side of the body). Resident #67 had a BIMS score of 99 which indicated she was severely cognitively impaired. Further review reflected Resident #67 was dependent on the staff for all ADLS. Record review of Resident #67's Comprehensive Care Plan, created date 06/30/25, reflected the following: .[Resident #67] has an ADL Self Care Performance Deficit related to Activity Intolerance, cerebral infarction hemiplegia/hemiparesis left side. Goal: [Resident #67] will maintain current level of function in (Total assist with Bed Mobility, Transfers.and Personal Hygiene total assist.) through the review date. Intervention. BATHING: Avoid scrubbing & pat dry sensitive skin. Provide the resident with a sponge bath when a full bath or shower cannot be tolerated.the resident is totally dependent on staff to provide a bath how often 3 x weekly and as necessary . Record review of the facility's shower schedule with an effective date of 11/11/24, reflected Resident #67was scheduled for showers on Tuesday, Thursday, Saturday on the 6:00 a.m. to 02:00 p.m. shift. Review of Resident #67's shower sheets for July 2025, reflected, Resident#67 did not receive bed bath on July 4, 2025, because not here and she received a bed bath on July 16, 2025. There were no other shower sheets for the month of July 2025. Observation on 07/29/2025 at 2:19 p.m. revealed Resident #67 was lying in bed wearing a hospital gown. Resident #67's face was sweaty, and her hair looked disheveled. She had a feeding a tube. Resident #67 was unable to participate in an interview. Observation on 07/30/2025 at 8:53 a.m. of Resident #67 during a medication pass with LVN I revealed her hair remained unkempt and disheveled. LVN I uncovered Resident#67 to access her feeding tube for medication administration. Upon removing the top sheet and raising the Resident's gown, Resident #67 was noted to have a (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	strong body odor. In an interview on 07/30/2025 at 12:39 p.m. LVN I stated Resident #24 and Resident #85 refused showers most of the time. He stated it was documented on the shower sheets by the CNAs and they would let him know. He stated when the resident's refused he would talk to the residents to make sure they did not want their shower or bath. When asked when the last time he talked to Resident #24, and Resident #85 about their shower/bed bath refusals, he said he could not remember and would have to check the showers sheets. In an interview on 07/30/2025 at 12:45 p.m. LVN I stated Resident #67 LVN I got showers regularly, but did not remember if she got a shower this week. LVN I stated it was the responsibility of the assigned CNAs and the Charge Nurses to make sure residents got their showers. He stated the risk of not providing showers to the residents, they would be stinky, and he would not want that for himself. He stated it could lead to skin break down, and dignity issues. Interview on 07/31/25 at 10:09 a.m. CNA Q stated she was assigned as a shower Aide for the Residents on Hall 400 for today and had not given showers to any of the residents yet. In an interview with ADON A on 07/31/25 at 10:50 a.m. she stated they made sure everyone who needed a shower and shave received a shower and shave last night. She stated she would be educating and monitoring the CNAs on the procedure for showers, the correct documentation and turning in shower sheets. In an interview with the DON on 07/31/25 at 10:55 a.m. she stated staff were to check and change residents who were incontinent every 2 hours or more frequently if needed. She stated she expected the nurses to monitor the residents who were taken to the common area to make sure they were not left there for long periods of time without getting repositioned and checked for incontinence. She stated all resident needed to be checked before going to the dining room. She stated failing to do this placed the residents at risk of skin breakdown and a loss of dignity. The DON stated she had been working for the facility for a few weeks now, and her intervention to prevent the residents from not getting showers was to eliminate the shower aides and have the CNAs be responsible for their assigned residents according to their showers/bed bath schedule days and as needed. She stated the Charge nurses and the ADONs would be responsible for ensuring the residents were receiving their scheduled showers. 7. Record review of Resident #35's MDS dated [DATE], reflected she was a [AGE] year old female with an admission date of 05/20/2025. Diagnoses included Unspecified fracture of left femur (a fracture left thigh bone that cannot be classified into a specific category based on its appearance and location), Unspecified fracture of the lower end of right radius (a break in the lower part of the radius bone on the right forearm), Major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest in activities and a significant impact on daily life). Resident #35 had a BIMS score of 10 indicating moderate cognitive impairment. Record review of Resident #35's care plan dated 06/06/2025 reflected she had impaired cognitive function/dementia or impaired thought process related to cirrhosis of the liver (a late-stage liver disease which impairs its ability to function properly), and Resident #35 had ADL self-care performance deficit. Observation and interview with Resident #35 on 07/29/2025 at 11:02 a.m. revealed she was sitting in her wheelchair in her room. Resident #35 had approximately 1/2 inch uneven, dirty long fingernails on both hands. Resident #35 stated none of the staff offered to trim her nails and she would like for them to be short. Interview with CNA S 07/31/2025 at 10:10 a.m. revealed she expected resident's fingernails to be trimmed and cleaned, and all the staff were responsible to make sure residents' fingernails were trimmed. She stated long fingernails increased the risk of bacterial infections and skin tears among residents. She stated she received had been in serviced on fingernail care a week ago. Interview with RN D on 07/31/2025 at 10:27 a.m. revealed she expected all resident's fingernails to be trimmed and cleaned unless the resident refused it. She stated she and all the staff were responsible to make sure the fingernails were trimmed and not trimming the fingernails increased the risk for the resident to have infections, illness and skin tear. She stated she received in service on fingernail care a week ago. Interview with LVN E on 07/31/2025 at 11:01 a.m. revealed all staff were responsible to ensure the resident's fingernails were trimmed and cleaned. She stated the nurses trimmed the fingernails if a resident had a diagnosis of diabetes, if not an aide could (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	do it. She stated she provided care to Resident #35; she was not aware Resident #35 had long fingernails. She stated long fingernails increased the risk of bacterial infections and skin tear among residents. She stated she received in service on fingernails care that week. Interview with LVN G on 07/31/2025 at 11:14 AM revealed she expected all resident's fingernails to be trimmed and cleaned and all the staff were responsible to make sure residents' fingernails were trimmed. She stated long fingernails increased the risk of bacterial infections and skin tear among residents. She stated she received in service on fingernails care that week. Interview with CNA O on 07/31/2025 at 11:25 AM revealed all staff were responsible to ensure resident's fingernails were trimmed and cleaned. She stated she knew Resident #35 had long fingernails and long fingernails increased the risk for having skin tear and infections. She stated she received in service on fingernail care a month ago. Interview with the DON on 07/31/2025 at 12:19 PM revealed she expected all residents' fingernails to be trimmed and cleaned, and the entire nursing staff were responsible to make sure the fingernails were trimmed. She stated it was important to keep the fingernails trimmed and cleaned to ensure resident dignity, prevent infections and skin injury. She stated all the employees received in service on skin care every month and as needed. A record review of the facility's policy Perineal Care , revised June 2020, reflected Purpose: To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown. Policy: Perineal care is provided as part of a resident's hygienic program, a minimum of once daily and per resident need . Record review of the facility's undated policy, Showering a Resident, reflected, Purpose: A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Policy: Residents are offered a shower at a minimum of once weekly and given per resident request. Record review of undated facility policy titled, Care of the Fingernails and Toenails, Purpose: Nail care is given to clean and keep the nails trimmed. I. Fingernails are trimmed by Certified Nursing Assistants except for residents with the following conditions:A. Diabetes or circulatory impairment of the handsB. Ingrown, infected, or painful nailsC. Nails that are too hard, thick, or difficult to cut easily.		

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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. 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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 expire date, the dietary staff must determine a use by date for the food item based on the Storage Period table or 7 days. Label the original packaging, Ziplock bag, bin, or container appropriate use by date. VIII. Prepackaged individual wrapped portion control items (aka PC items) will be stored in the original box, packing, container, or bin labeled with the date received on the container, and the manufacturer's recommended shelf-life date from the original container or best by date will be used for discard. If PC items are removed from the original packing and placed in a container or bin, the product name will be on the label on the bin or container. X. Expiration or use-by dates will be checked; any product that is found to be out of date will be discarded. Perishable foods and Dairy foods that have a date on them that is best if used by, Best by, or Use by will be used by or discarded on that manufacturer's date. XI. Discard foods that have exceeded their expiration date. If the product is delivered with an out-of-date expiration date, the vendor will be called, the product will be removed from usable stock		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 19 residents (Resident #25, Resident # 12, Resident #125, Resident #16, Resident # 94, Resident #102) observed for infection control. 1. The facility failed to ensure CNA U and CNA L performed hand hygiene while providing incontinence care to Resident #25 and failed to ensure CNA L placed soiled linens and clothing in a plastic bag and not the floor on 07/29/25. 2. The facility failed to ensure RN C, CNA Q, and CNAP used the required PPE for Resident #12, who was on enhanced barrier precautions due to his foley catheter during a transfer and incontinence care observation 07/30/25, and CNA Q failed to perform glove change and hand hygiene during the incontinence care. 3. The facility failed to ensure CNA N and LVN I used the required PPE for Resident#125 who was on enhanced barrier precautions due to his feeding tube and failed to ensure CNA N performed hand hygiene during the incontinence care. 4. The facility failed to ensure LVN K disinfected the blood pressure cuff in between blood pressure checks for Residents #16, Resident #94, and Resident#102 during a medication pass on 07/31/25. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #25's Face sheet dated 07/31/25 reflected a [AGE] year-old male with an admission date of 10/27/23. In an observation on 07/29/25 at 02:30 p.m. revealed CNA U, CNA L and RN C came and pushed Resident #25 into his room. All staff performed hand hygiene and put on gloves. RN C and CNA U positioned the resident's wheelchair next to the bed with him facing the head of the bed. CNA U and RN C transferred the resident to the bed. Resident #25's pants were observed to be urine soaked as was the wheelchair cushion. RN C removed his gloves, performed hand hygiene and left the room to obtain sanitizer to clean the wheelchair cushion. CNA U and CNA L rolled the resident onto his back and removed his pants. CNA L threw the urine-soaked pants onto the floor while CNA U unfastened the resident's brief and provided peri care, wiping from front to back. Both staff rolled the resident onto his side revealing the resident had a moderate size bowel movement. CNA U completed the peri-care, removed her gloves and re-gloved without performing hand hygiene. CNA L removed the soiled linen from under the resident and threw them onto the floor, on top of the resident's wet pants. CNA L did not change gloves or perform hand hygiene. Both staff placed a clean brief and clean pants onto the resident. RN C re-entered the room and wiped the wheelchair cushion with a germicidal wipe and placed a clean towel over the cushion. CNA L grabbed a plastic bag and placed the soiled linen from the floor into the bag and the wet pants into another bag in the resident's bathroom. CNA L then removed her gloves and performed hand hygiene and left the room with the bag and both CNA U and RN C and transferred the resident back to his wheelchair. Both staff then removed their gloves and performed hand hygiene. In an interview with CNA L on 07/29/25 at 02:45 p.m., she stated they were instructed to never throw dirty linens onto the floor. She stated they did not go in the room prepared with enough plastic bags. She stated she should have changed her gloves and performed hand hygiene after handling the soiled linen, but stated she did not have any hand sanitizer with her. She stated the risk for not changing gloves and throwing the dirty linen on the floor was the spread of germs. In an interview with CNA U on 07/29/25 at 03:05 p.m., she stated she was supposed to change her gloves and perform hand hygiene when going from dirty to clean. She stated she changed her gloves but forgot to perform hand hygiene. She stated she had hand sanitizer in her pocket and just forgot to use it. She stated they were never to throw dirty linens on the floor and stated she did not realize CNA L had thrown them on the floor. She stated the risk of not performing hand hygiene was cross contamination and throwing dirty linens on the floor would spread germs. 2. Record review of Resident #12's face sheet dated 07/31/25 reflected a [AGE] year-old-male with an admission date of 04/15/25. An observation on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/30/25 at 01:55 p.m. revealed RN C, CNA P and CNA Q entered Resident #12's room to transfer him from his wheelchair to the bed. A posting outside of the resident's doorway and over the head of his bed reflected the resident was on enhanced barrier precautions. The staff had brought a mechanical lift sling (a fabric sling the resident is placed on and then hooked to a mechanical lift for transport) into the room. All three staff performed hand hygiene and put on gloves but did not put on a gown. All three staff positioned the mechanical lift sling under the resident while he was in his wheelchair. RN C unhooked the urinary drainage bag from under his wheelchair and held it below the resident's bladder while CNA P and CNA Q positioned the mechanical lift into place. After the mechanical lift was hooked to the sling, the Corporate DON who was present for the observation, prompted the staff to put on gowns. All three staff then put on a gown and transferred the resident to his bed. CNA P then removed his gown, performed hand hygiene and removed the mechanical lift from the room. RN C and CNA Q removed the resident's pants and CNA Q placed the urinary drainage bag onto the bedrail. CNA Q then opened the resident's brief and provided catheter care and then with assistance of RN C rolled the resident on his side, revealing the resident had a small soft bowel movement. CNA Q continued to provide peri-care, wiping from front to back. Once completed, CNA Q removed the soiled brief and with the same soiled gloves on, placed a clean brief under the resident. CNA P then re-entered the room and put on gloves without performing hand hygiene and did not put on a gown. He returned to the bedside and unhooked the urinary drainage bag and held it while CNA Q and RN C placed the brief under the resident. CNA Q then reached into the resident's bedside chest of drawers, still wearing the soiled gloves and retrieved a tube of barrier cream. CNA Q then applied barrier cream to Resident #12's buttocks and peri-area with the same soiled gloves. CNA Q and RN C then fastened the resident's brief, positioned him in the bed and covered him the sheets. CNA Q adjusted the head of his bed and placed his bedside table beside his bed, still wearing soiled gloves. CNA Q then gathered up the soiled linen in a bag and then all three of the staff removed their gloves and performed hand hygiene. In an interview with RN C, CNA Q and CNA P on 07/30/25 at 02:25 p.m. they all stated they had received training on enhanced barrier precautions and stated they should have had a gown on during all the care since the resident had a Foley catheter. RN C stated the risk of not following enhanced barrier precautions was the spread of MDROs. CNA Q stated she was supposed to perform glove changes and hand hygiene when she moved from one contaminated site to another. She stated she thought she had changed gloves and performed hand hygiene, but RN C stated, no you did not. He stated he was trying to signal her that she needed to change her gloves after she completed the incontinence care. Both CNA Q and RN C stated the risk to the resident was cross contamination and spread of germs and infections. 3. Record review of Resident #125's admission MDS assessment dated [DATE] reflected Resident #125 was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #125's Comprehensive Care Plan, created date 07/19/25, reflected the following, .Enhanced Barrier Precautions related to G-tube (tube inserted into the abdomen to provide nutrition) . Interventions.Staff members will wear a clean gown and gloves while performing high contact resident care activities to include Dressing, Bathing/Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance . Observation on 07/29/25 at 12:11 p.m. revealed CNA N and LVN I entered Resident #125's room to provide incontinence care. Signage was posted at the left side of the room entrance for enhanced barrier precautions, and a PPE supply cart was inside the room at the left side of the entrance. A sign was also posted over the head of the Resident bed which indicated he was on enhanced barrier precautions. Both staff performed hand hygiene and put on gloves, but no gown. CNA N opened the residents brief which was saturated with urine. CNA N cleaned from front to back and rolled the resident on his side revealing he had a large soft bowel movement. CNA N was cleaning Resident #125 buttocks front to back, using couple of wipes at a time. CNA N's gloves became soiled with feces, and she reached into the nightstand drawer, still wearing soiled gloves, and got another box of wipes she then removed her gloves and reached into her pocket to retrieve clean gloves and put them on without performing hand hygiene. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA N continued cleaning Resident #125, folded and removed the dirty brief, and put it in the plastic bag. CNA N removed her gloves and put on clean gloves from her pocket without performing hand hygiene. CNA N pushed the fitted sheet under Resident #125 and then got a clean fitted sheet put it on the bed and pushed it under Resident #125. CNA N got a clean draw sheet with the clean brief and placed them under Resident #125. CNA N with the help of LVN I turned Resident #125 to his left side. LVN, I removed the soiled sheet and put it in a plastic bag for linen. LVN I changed gloves and performed hand hygiene. CNA N finished putting the brief on Resident #125 LVN I pulled the fitted sheet over the bed. CNA N covered Resident#125 with clean sheet. Both staff put a clean gown on Resident #125. Both staff positioned the resident in the bed and CNA N lowered the bed down and put the fall mat back, close to the bed. LVN I removed his gloves and preformed hand hygiene, and CNA N removed her gloves and gathered the plastic bags and left the room without performing hands hygiene. In an interview with LVN I on 07/29/25 at 12:25 p.m. he acknowledged Resident #125 was on enhanced barrier precautions because of his feeding tube. He stated he was supposed to wear gloves and a gown when helping with incontinence care. LVN I stated adhering to proper hand hygiene, and wearing appropriate PPE was important to prevent the spread, and development of infection to residents. Interview on 07/29/25 at 12:28 PM CNA N acknowledged she was changing gloves without any form of hands hygiene during Resident #125's incontinence care. CNA N stated, she was supposed to wear gloves and a gown when providing incontinence care to Resident #125 because he had a feeding tube and was on enhanced barrier precautions. CNA N stated she was not supposed to carry gloves in her uniform pocket. CNA N stated she was supposed to follow proper hand hygiene and wash or sanitize his hands before putting on the clean gloves. CNA N stated she was supposed to follow facility policy related to EBP. She stated that adhering to proper hand hygiene, and wearing appropriate PPE was important to prevent the spread, and development of infection to residents. In an interview with ADON B on 07/31/2025 at 1:06 p.m. she stated she was the infection preventionist for the facility. She stated they did annual skills checks which included infection control, hand hygiene and glove use. She stated the staff had extensive training on EBP. She stated she thought because the previous DON had the gowns outside of the door, they would readily see it, but the new DON had requested the PPE be placed inside the room and she thought the staff were just overlooking it. She stated they posted signs outside of the door and in the resident's room that required EBP, so the staff should still be aware. She stated any direct contact with a resident with a Foley, feeding tube, etc. would require the use of gown and gloves to help prevent the spread of MDROs. In an interview with the DON on 05/20/25 at 4:35 p.m. she stated any resident who had any type of indwelling medical device was placed on enhanced barrier precautions to help reduce the spread of MDROs. She stated signage was posted outside to the door, which explained what PPE was to be worn and for what task the PPE was to be worn for. She stated any contact with a resident with a catheter or feeding tube required the use of gown and gloves. She stated the staff had received trainings on the use of enhanced barrier precautions. 4. Observations on 07/31/25 between 07:06 AM and 07:43 a.m. revealed LVN K coming out of Resident #94's room after checking the resident's blood pressure. LVN K placed the blood pressure cuff on top of the medication cart without sanitizing it. LVN K gave Resident #94 her morning medications. LVN K moved the medication cart to the front of Resident #102's room. LVN K retrieved the blood pressure cuff from the top of the medication cart and checked Resident #102's blood pressure. LVN K returned to the medication cart and placed the blood pressure cuff on top of the medication cart and again did not sanitize the cuff. LVN K gave Resident #102 her morning medications. LVN K moved the medication cart to the front of Resident #16's room. LVN K picked up the blood pressure cuff and checked Resident #16's blood pressure and again returned it to the top of the medication cart without sanitizing the cuff. LVN K gave Resident #16 her morning medications. In an interview with LVN K on 07/31/25 at 07:50 a.m. she stated she cleaned the blood pressure cuff at the start of her shift this morning. LVN K stated she forgot to clean the blood pressure cuff between resident's use. LVN K stated that she was supposed to use bleach wipes or sanitizing wipes to clean (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the equipment after each use and let it air dry between residents. LVN K stated the risk of not cleaning the cuff between each resident was cross-contamination, spread of germs, and it could harm residents who were immunocompromised [low immune system]. In an interview with the DON on 07/31/25 at 11:35 a.m. she stated all staff were expected to follow infection control policy when in the building. She stated all equipment should be cleaned between patient use according to the infection control policy. She stated there was an infection control policy specifically for equipment. The DON stated the risk to the residents was cross contamination Record review of the Facility's policy titled, Standard and Enhanced Precautions, revised January 2025, reflected, The facility will implement Standard Precautions for all residents and Enhanced Barrier Precautions (EBP) for residents at increased risk for the transmission of multidrug-resistant organisms (MDROs) or other identified pathogens. All staff must follow CDC and CMS guidelines to minimize infection risk.Enhanced Barrier Precautions.designed to reduce MDRO transmission during high-contact care activities for resident with indwelling medical devices (e.g, urinary catheters.), even when contact precautions are not otherwise indicated.Activities involving close physical contact, increasing the risk of pathogen transmission (e.g., dressing, bathing, transfers) . Record review of the facility's policy titled, Hand Hygiene, revised June 2020, reflected, .The facility considers hand hygiene the primary means to prevent the spread of infections.Facility staff.must perform hand hygiene procedures in the following circumstances.Wash hands with soap and water.when soiled with visible dirt or debris.After removing personal protective equipment PPE and before moving to another resident in the same room or exiting the room.Alcohol -based hand hygiene products can and should be used to decontaminate hands.immediately upon entering a resident occupied area .regardless of glove use.Immediately upon exiting a resident occupied area.regardless of glove use. Hand hygiene is always the final step after removing and disposing of personal protective equipment.The use of gloves does not replace hand hygiene procedures.Record review of the facility's policy titled, Cleaning and Disinfection of Environment Surfaces, revised October 2022, reflected, The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in the resident's environment.Non-critical items are those that come in contact with intact skin but no mucous membrane.Non-critical surfaces are disinfected with an EPA-registered intermediate or low-level disinfectant according to the labels safety precautions use directions.Low-level disinfection is generally appropriate for most non-critical equipment.		

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NAME OF PROVIDER OR SUPPLIER The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 18648 Hillcrest Rd Dallas, TX 75252	
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 10 of 28 residents (Resident#17, Resident#24, Resident#71, Resident#49, Resident#85, Resident#11, Resident#67 and Resident#61, Resident#125, and Resident#3,) reviewed for residents' call system.1-The facility failed on 07/29/2025 to ensure the call light system was accessible if needed by a resident who was on the floor and that call lights were not missing the pull string, in the shared residents' toilets located inside the residents' room for the following residents: Resident#17, Resident#24, Resident#71, Resident#49, Resident#85, Resident#11, Resident#67, and Resident#612-The facility failed to provide a working communication system, that was easily at reach, that would allow Resident #3, Resident#85, and Resident#125 the ability to safely call for staff for assistance.1-Observation on 07/29/25 at 11:15 AM revealed the residents' toilet call light pull string was looped at the call light outlet and was two feet from the floor, for Resident #17 and Resident#24.2-Observation on 07/29/25 at 11:30 AM revealed the residents' toilet call light pull string was missing for Resident #71 and Resident #49.3-Observation on 07/29/25 at 1:41PM revealed the resident's toilet call light pull string was looped around the grab bar and was two feet from the floor for Resident#85, Resident #11, Resident #67 and Resident #61.Interview and observation on 07/30/25 at 2:38 PM the Maintenance Supervisor who stated he looked at the call light outlets and stated the strings needed to be within the reach of a resident who was on the floor. The Maintenance Supervisor stated he just started working with the facility for the last two weeks and he would fix them right away. The Maintenance Supervisor stated the risk to a residents was the residents could fall, not get help, and could cause someone to be lying there for hours . 4- Record review of Resident #85's quarterly MDS assessment dated [DATE] reflected Resident #85 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), cerebrovascular accident, and aphasia (a language disorder that affects a person's ability to communicate). Resident #85 had a BIMS score of 15/15 which indicated Resident #85's cognition was intact. Further review revealed Resident #85 functional status reflected extensive assistance for ADL's, including bed to wheelchair transfers.Review of Resident #85's Comprehensive Care Plan date 05/08/25, reflected the following: Focus: [Resident #85] has a communication problem r/t expressive language disorder, cerebral infraction. Goal: [Resident #85] will be able to make basic needs known on a daily basis through the review date. Intervention. Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation.An observation on 07/29/25 at 1:40 PM revealed Resident #85 was sitting up in bed, and the call light button was on the floor. Resident#85 stated he was unable to call for help. Resident #85 stated the staff put the call light cord across his chest without a cord clip, and it could fall anytime on the floor. He further stated he had been asking for a cord clip for the call light and was not provided one. He stated he could not call for help for anything. The surveyor pushed the call button for the resident. CNA M answered the call light, she gave Resident#85 his pillow and put the call light across his chest. Interview on 07/29/25 at 1:43 PM CNA M stated the call light was on the floor, and not next to Resident#85. She stated the problem was he would not be able to call for help, anything could happen to him. CNA M stated if he was incontinent, he could not call if he was having an emergency he could not call.Interview and observation on 07/30/25 at 2:38 PM the Maintenance Supervisor looked at the call light cord across Resident #85's chest and stated the cord needed to be always clipped to the resident's clothes or cover and be within the reach of the resident. The Maintenance Supervisor stated he would get a call light cord clip right away for Resident #85. The Maintenance Supervisor stated the risk to a resident (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was the resident could not call for help, and his needs not met. 5- Record review of Resident #125's admission MDS assessment dated [DATE] reflected Resident #125 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (elevated blood pressure), cerebrovascular accident (a medical emergency that occurs when the blood supply to the brain is interrupted, causing brain tissue damage), and aphasia (a neurological condition that affects a person's ability to communicate). No BIMS score was documented for Resident #125. The Coding on C1000. Cognitive Skills for Daily Decision Making revealed 3. Severely impaired - never/rarely made decisions. Further review revealed Resident #125 functional status reflected extensive assistance for ADL's, including bed to wheelchair transfers. Review of Resident #125's Comprehensive Care Plan, created date 07/19/25, reflected the following: Focus: [Resident #125] is at risk for falls r/t restlessness, impaired mobility. Goal: [Resident #125] will be free of falls through the review date. Intervention. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on 07/29/2025 at 2:09 PM revealed Resident#125 was lying in bed. The call light button was next to the side rail at the right side of the bed. Resident#125 was trying to use the call light. Resident #125 was unable to use to call light, because of shaking, and uncoordinated hands movement, and the call light ended up on the floor three feet away from the Resident #125. Interview/observation on 07/29/25 at 2:11 PM revealed ADON A entered Resident#125's room, she looked at the call light button on the floor and stated the call light button had to be close to Resident#125 where he could reach it. ADON A gave the call light button to Resident #125. Resident #125 was unable to push the button. ADON A stated, she would get him a call light device that accommodated his needs. She stated the issue was the resident would not be able to get assistance. 6-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), lack of coordination, need for assistance with personal care, and Morbid Obesity Record Review of Resident #3's Quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating no cognitive impairment. Resident #3 used a wheelchair and had upper extremity impairment on one side and lower extremity impairment on both sides. Resident #3 was totally dependent for showering, toileting, dressing and transfers. Resident #3 was a fall risk. Record review of Resident #3's of care plan dated 7/12/25 reflected resident was a fall risk and should have her call light within reach and be encouraged to use it if needed. Observation and interview with Resident #3 in her room on 7/29/25 at 11:13am revealed the resident was yelling and stated she needed her call light and couldn't breathe. Staff entered the room immediately and put her oxygen on. The surveyor then entered the room and noted she had her oxygen on but Resident #3 asked for her call light. It was noted her call light was on her bed behind her and she was in her wheelchair and could not reach it. Interview and observation with the Staffing Coordinator in Resident #3's room on 7/29/25 at 11:13am revealed she was the staff that had turned on Resident #3's oxygen. She was asked where the call light was, and she found it on the resident's bed behind the resident's wheelchair. She stated Resident #3 should have her call light within arm's reach. She stated Resident #3 could not reach her call light where it was, and she placed it next to the resident in her wheelchair. She stated when the resident was asking for assistance with her oxygen, she made the oxygen a priority and overlooked the call light was not close to the resident. She stated the risk to the resident of not having her call light within reach were many things, she could have an emergency or needed something, and it would delay help. Interview with CNA Q on 7/30/25 at 2:41pm revealed Resident #3's call light should be pinned to her clothing when in her wheelchair. The risk to the resident for not having had the call light was she may have an emergency in which she couldn't breathe and the only thing that would help her notify staff would be the call light. Interview with LVN H on 7/30/25 at 3:09 pm revealed risk to residents not having had access to their call lights were infection related to delayed incontinent care, skin breakdowns, fluid loss, falls; (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was a whole list of risks to residents. Interview with the LVN on 7/31/25 at 8:45am revealed call lights should be placed next to residents. If a resident was in their wheelchair in their room the call light should be on them. Interview with RN D on 7/31/25 at 8:53am revealed Resident #3's call light should be on her lap when in her wheelchair. RN D stated Resident #3 would yell and ask for her call light if she did not have it. The risk of Resident #3 not having had her call light would be she could be in distress or may have had an accident. Interview with the DON on 7/31/25 at 10:09 am revealed the expectation for call light placement was residents should always have the call light within reach and the call light should be placed on the resident's dominant side. She stated they in-serviced staff yesterday when she was made aware of Resident #3 not having had her call light within reach. The risk to residents of not having had their call lights within reach was delayed care. The DON stated call light string in the bathrooms supposed to be within the reach of the resident lying in the floor. Interview on 07/31/25 at 10:34 AM the Administrator stated the call light string should be within the resident's reach, so they could call for help when they need it. Interview with the Administrator on 7/31/25 at 10:57am revealed the expectation was all residents should be able to always reach their call light. She stated strings for the bathroom call lights of not been being up to standard regulation of four inches from the floor could be a safety issue. She stated the risks to the residents of not having had their call light in reach were falls or delayed care. Review of the facility policy titled Communication-Call System revised June 2020 revealed Purpose: To provide a mechanism for residents to promptly communicate with nursing staff. Policy: The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Call bells located within resident bathrooms are considered emergency calls due to the potential for falls and injury and must be answered promptly.		

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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.		

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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** 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 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the Administrator. Record review of Resident #31's nurse's progress notes from 05/01/25 through 07/31/25 reflected a progress note dated 07/29/25, written by RN CC: Resident was observed with cigarettes in room. Resident's cigarettes are supposed to be in a box and given to resident during smoking scheduled times. Resident was reorientated with facility smoking policy. Resident 's cigarettes were taken from resident and to be given when it's a smoke scheduled time.Observation and interview on 07/29/25 at 11:56 AM with Resident #31 revealed she was in her room, seated in a chair with a bedside table in front of her with a pack of Lucky Strike cigarettes on the bedside table. Resident #31 stated she knew she was not supposed to have cigarettes in her room and was not going to put them in the smoking lock box because the last time she went to the hospital and returned to the facility her cigarettes were gone and believed they were stolen. In an interview on 07/29/25 at 12 PM with RN CC, she was informed Resident #31 had cigarettes in her room. She stated residents were not supposed to have smoking supplies in their rooms and was going to immediately speak with Resident #31. An interview on 07/30/25 at 1:03 PM with CNA DD revealed she was aware Resident #31 had hid cigarettes in her room in the past. She stated there had been a time that she searched the room for cigarettes, and she was not able to find them due to Resident #31 hiding the cigarettes. She stated Resident #31 told her she was not going to turn in the cigarettes because they had been stolen when they were in the lock box in the past. She stated the Administrator was aware. An interview on 07/31/25 at 10:19 AM with the Regional Social Services Consultant revealed she was not aware that Resident #31 had a behavior of hiding cigarettes and was not sure if it was care planned. She stated it would be important to care plan a behavior of hiding cigarettes, so all staff were aware of the behavior.An interview on 07/31/25 at 11:30 AM with the Administrator reflected they had spoken with Resident #31 regarding the cigarettes in her room and was provided a second smoking violation and educated her on the facility's smoking policy. She stated she expected residents to abide by the smoking rules and had educated residents in the past 3 resident council meetings of smoking rules she stated Resident #31's behavior of hiding cigarettes should be care planned so staff were aware of the behavior. She stated it was important for care plans to be specific and note any behaviors because it guided the resident's plan of care.In a follow up interview on 07/31/25 at 12:20 PM with RN CC she stated she was not aware Resident #31 had cigarettes or had hidden cigarettes before and she and the Administrator spoke with Resident #31 on 07/29/25 and obtained the cigarettes. She stated Resident #31 admitted to having the cigarettes when she spoke with her on 07/29/25. She stated Resident #31 told her that she hid them because she did not want to keep the cigarettes in the smoking supplies box because she thought they would be stolen. She stated it was important to care plan the behavior of hiding cigarettes to ensure staff were aware of the behavior. In an interview on 07/31/25 at 3:13 PM with the Regional MDS Coordinator she stated Resident #31 keeping cigarettes in her room should have been care planned because it was a behavioral issue. She stated that Resident #31's care plan had been updated to reflect hoarding cigarettes and was not updated until the surveyor brought it to staffs' attention. She stated care plans ensured staff knew what a 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 and their behaviors. She stated Resident #31's hoarding cigarettes in her room could pose a risk to her and other residents if she was hoarding cigarettes. 3. Record review (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #54's Comprehensive MDS, dated [DATE] reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of kidney failure, fracture of right leg, and traumatic brain injury, and a BIMS score of 15 (intact cognition). Record review of Resident #54's care plan, dated 07/24/25 reflected he was at risk for malnourishment and interventions included .Provide and serve diet as ordered and did not reflect his diet order for large portions dated 07/10/25. Record review of Resident #54's physician orders reflected a large portions diet order dated 07/10/25. In an interview on 07/29/25 at 2:48 PM with Resident #54 he stated the only concern was there were times he did not receive large portions and had to ask an aide for seconds. He stated it frustrated him because it seemed to keep happening despite his meal ticket showing large portions. He stated he had spoken with the Dietary Supervisor about his concern and when the Dietary Supervisor worked, his meals were the correct portions and thought it was due to having different staff in the kitchen. An interview on 07/30/25 at 1:03 PM with CNA DD revealed Resident #54 had a double portions diet. She stated there were times as recently as last week where Resident #54 did not appear to receive large portions, and she let the kitchen know and offered an alternative meal. She stated that his meal ticket always said large portions and was not sure if it was care planned. She stated she was not sure why there were times he did not seem to receive meals as ordered. An interview on 07/30/25 at 2:08 PM with the Dietary Supervisor revealed Resident #54 had an order for large portions. She stated when Resident #54 had admitted to the facility he requested large portions, and it was reflected on his meal ticket. She stated she was not aware that he had not received large portions recently and it was important to ensure residents received their diet as ordered because the facility was their home, and it might be the way he was used to eating at home. She stated if the resident had an order for large portions, it should be care planned and was not aware that the resident's order was not care planned. An interview on 7/31/25 at 11:30 AM with the Administrator revealed she was not sure if a resident's diet for large portions was something that would be care planned. In an interview on 07/31/25 at 3:13 PM with the Regional MDS Coordinator she stated Resident #54's current care plan stated, serve diet as ordered and it should be more detailed to include the order for large portions. 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 the residents for not addressing the order for large portions because the large portions were provided regardless of 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 Resident #54's diet order for large portions should be care planned because it ensured staff were aware that he was supposed to have large portions and it could negatively impact his weight. Record review of the facility's care plan policy, titled Care Planning, dated revised October 24, 2022, reflected: Purpose: To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. Procedure: 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.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 18648 Hillcrest Rd Dallas, TX 75252	
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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. **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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 acceptable to lift a resident under the arm pits due to risk of shoulder injury. She stated both hands were to be placed on the gait belt, one in the front and one in the back. She stated Resident #25 could stand at times, but due to his poor cognition it was not consistent. In an interview with the DON on 07/31/25 at 10:55 a.m. she said it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. She stated they had re-educated the staff last night (07/30/25) on correct transfers and were in the process of re-skills checks for the staff to ensure everyone was using the proper techniques. She stated at no time were staff to pull residents backwards, since it was a safety issue and a dignity issue. She stated she had been there for 3 weeks and was in the process of getting her systems in place. She stated going forward she and the ADONs would be responsible for ensuring staff were skills checked. Record review of the facility's policy, Transfer of Residents dated June 2020, reflected, .Mechanical lift procedures are used on any resident unable to independently pivot or transfer.Use a gait belt for transfers.Two-Person Assisted Transfer (resident who must be able to bear weight).May apply gait belt (unless contraindicated) around resident's waist securely enough to prevent sliding up over ribs.Each person will extend the arm closet to the resident forward between the resident's side and elbow. With fingers pointing downward, grasp the gait belt firmly. Instruct the resident to place their hand between your body and arm grasping the gait belt and holding on the back of your upper arm. There was no instruction on transporting residents in their wheelchair.		

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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. **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 O2>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 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 oxygen, then the resident would already have been on oxygen and would verify the resident was receiving the right amount of oxygen. An interview with LVN F on 7/30/25 at 3:31pm revealed he was familiar with Resident #3 and stated she was prescribed oxygen. He stated when Resident #3 requested oxygen he would check her oxygen levels to ensure she needed it and would follow the physician orders for oxygen. He reported no risk to the resident of not giving the right amount of oxygen because he always checks the physician order before administering oxygen so it would not happen. An interview with LVN J on 7/31/25 at 8:45am revealed when a resident asked for oxygen, they checked the order and turned the oxygen on based on the physician order. She did not know the risk to residents if too much oxygen was given. An interview with RN D on 7/31/25 at 8:53am revealed Resident #3 used oxygen as needed. When Resident #3 requested her oxygen she would check the orders, check the resident's oxygen saturation and pulse and administer oxygen as ordered. She stated she knew Resident #3 was ordered to receive 2 liters of oxygen via nasal cannula. The risk of not giving Resident #3 the appropriate oxygen was she would have trouble breathing. In most cases Resident #3's oxygen levels were good. An interview with the DON on 7/31/25 at 10:09am revealed the expectation was if a resident requested oxygen, the nurses should assess oxygen saturation, and if they needed oxygen they would provide the oxygen per the doctor's order on file. The risk to the resident of not getting the appropriately ordered oxygen was the resident could become confused or hypoxic (low levels of oxygen). There was no risk for Resident #3 to have oxygen between 2 liters to 4.5 liters because it could be titrated, but they should have followed the doctor's order. An interview with the Administrator on 7/31/25 at 10:57am revealed the Staffing Coordinator was a nurse and could administer oxygen. The expectation when administering oxygen was to assess the resident, check their oxygen levels and determine if oxygen was needed. If it was ordered titrated, they adjusted the oxygen by following the physician orders. The risk to Resident #3 of giving her more oxygen than what was ordered was unknown because the care plan showed her to have titrated oxygen, but the order did not. She stated the order had been corrected since the incident occurred to match the care plan, which had titrated oxygen. Record review of the facility's policy titled Oxygen Administration revised 6/2020 reflected .I. Initiation of Oxygen A. A physician's order is required to initiate oxygen therapy. Procedure I. Explain the procedure to the resident. II. Check the physician's order. III. Wash hands IV. Assist resident to semi- or high Fowler's position (a semi-sitting body position where the head of the bed is elevated between 45 and 60 degrees), if tolerated. V. Attach oxygen tubing to nozzle on flowmeter. A. If using a high oxygen flow (> 4 liters), attach humidifier to the flowmeter. B. Attach oxygen tubing to humidifier. VI. Turn on the oxygen at the prescribed rate.		

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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.		