STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676329	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Highland Springs	7910 Frankford Road Dallas, TX 75252

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to develop and implement a comprehensive centered care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #1) of 6 residents reviewed for care plans. The facility failed to develop a care comprehensive care plan with interventions and actions the facility could take that were specific to Resident #1's suicidal ideations when she admitted to the facility from an in-patient behavioral health facility on [DATE]. On [DATE] Resident #1 ingested approximately a bottle and a half of Benadryl (Diphenhydramine) and expired at the local hospital. An IJ was identified on [DATE] at 5:07 PM. The IJ template was provided to the facility on [DATE] at 5:25 PM. While the IJ was removed on [DATE] at 4:45 PM, the facility remained out of compliance at a scope of Isolated with a severity level potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure place residents at risk of not having their needs met, serious physical harm, injury, and/or death. Findings include: Record review of Resident #1's quarterly MDS dated [DATE] indicated the resident was a [AGE] year-old female who admitted to the facility on [DATE] and re-admitted to the facility on [DATE] from an inpatient psychiatric center with diagnoses of bipolar disorder (mental health condition that causes extreme mood swings that range from depressive lows to manic highs), major depressive disorder recurrent, severe with psychotic symptoms (mood disorder that causes a persistent feeling of sadness and loss of interest and may make a person feel like life isn't worth living as well as hallucinations and delusions), vascular dementia moderate, with psychotic disturbance (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and epilepsy (brain condition that causes reoccurring seizures. Record review reflected Resident #1 had a BIMS score of 14, which meant she had little to no cognitive impairment. The MDS also reflected Resident #1 experienced feeling down, depressed, or hopeless two to six days (several days) in the last two weeks. Record review of Resident #1's care plan, dated [DATE], reflected Resident #1 was hospitalized at a behavioral health facility from [DATE]-[DATE] and [DATE]-[DATE]. Record Review of Resident #1's care plan, dated [DATE], reflected Resident #1 would exhibit or express depression because her [family member] died, she did not have closure and did not get to say goodbye, she says she has no money; and she feels family doesn't visit much and feels stuck in her little room. Record Review of Resident #1's care plan, dated [DATE], reflected signs/symptoms of depression which included a lack of appetite, trouble sleeping at night, and would sleep in. The care plan also reflected that Resident #1 would speak with the social worker if she needed counseling and that the social worker was her mental health professional. Record Review of Resident #1's care plan, dated [DATE], reflected Resident # 1 (continued on next page)

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

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had suicidal ideations. Interventions included listening and providing comfort when Resident #1 was confused and agitated as well as communicating in a manner that promoted mental and psychological wellbeing Record review of Resident #1's Physician's Orders reflected resident had orders for:Sertraline 25 mg (3 tabs (75 mg)) Tablet oral with a start date of [DATE] to treat depressionMirtazapine 7.5 mg tablet (1) Tablet Oral with a start date of [DATE] to treat major depressive disorderRisperidone .5 mg tablet (3 tabs (1.5mg) Tablet Oral with a start date of [DATE] to treat bipolar disorder Record review of Resident #1's Progress Notes by LVN L, dated [DATE] at 5:54 AM, reflected: The aid notified this nurse that the patient wrapped a draw sheet around the neck the nurse aide helped the patient to unwrapped [sic] the draw sheet, patient states the she wants to died [sic] and join her husband but death is not coming fast. Notified MD order to keep a close eye on the patient every 15 mins[sic] and wait for further instructions. Record review of Resident #1's Progress Notes, dated [DATE] at 2:21 PM by Social Worker N reflected: .Sw met with Resident and her mood had declined in the day. Resident reported she was a disappointment and did not want to do anything. She did not want to eat and just wanted to sleep .Sw walked into her room. She stated she wanted to die yet denied any plan and stated she would not do anything to harm herself. Physician notified. Resident has a .caregiver with her from 2-4pm daily. Sw to remain available as needed. Record Review of Resident #1's Progress Notes, dated [DATE] at 6:21 AM, by LVN L reflected: Patient approached this nurse and said that she was told to notify somebody if she is feeling suicidal, she states right now am feeling suicidal am looking for a bottle of pills to take I don't care anymore. Patient sited at the nursing station with this nurse, resident continue to express that since her husband died the feeling [sic] of suicide have been in her mind, notified NP [NAME] order to send resident to .hospital.patient called 911 and after the police spoke with the patient they told this nurse that the patient states that she will use the light bulb in her room to cut herself. Patient was transported by the police car to .hospital. Record Review of Resident #1's Progress Notes, dated [DATE] at 4:15 PM, by LVN B reflected: Per administration, no special precautions necessary. Will continue to monitor frequently and provide active listening for patient to express feelings. Pt is at this time sitting in her room watching TV, no distress noted. Personal sitter here from 1400-1600 (2:00 PM - 4:00 PM), pt went outside with sitter and ate a snack. Record Review of Resident #1's Progress Notes, dated [DATE] at 5:47 PM, LVN B reflected: .Pt reports to nurse that she has had in the past sudden, severe episodes of itching all over her body. When these happened, she would take 2 Benadryl and the itching would cease. She explained, I feel like its happening again. Pt brought an unopened bottle of Benadryl from her drawer. Explained that all medications should be kept in her locked cabinet for safety, and that no medication can be given without a medical provider's knowledge and providing the nurse with an order and directions. Pt verbalized understanding and handed bottle to this nurse. Medication locked in cabinet. Provider notified, new order received for diphenhydramine 25 mg-give 2 tabs (50 mg) PO now x1dose. May repeat 50mg x 1dose in 8 hours if itching persists. MAR updated. Benadryl given. Pt reports medication effective at this time. Teaching provided to pt about not having medication in her room, it must be locked in the cabinet. Pt verbalized understanding.Record Review of Resident #1's Medical Records from local hospital dated [DATE] reflected: Summary: [AGE] year-old female presents by EMS for acute unresponsiveness. Patient was found unresponsive in her place of living by staff. EMS reports that they found an empty Benadryl bottle and partially empty Benadryl bottle and will concern for an overdose. Patient had multiple seizures witnessed by EMS. Patient did not have a witnessed cardiac arrest. Her husband committed suicide by self-inflicted gunshot wound to the head 14 months ago according to family. Patient is DNR and this was confirmed by her son.He said that he is concerned she (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	may intentionally overdosed because she has made threats of suicide recently and her husband committed suicide 14 months ago. The patient was pronounced at 10:51 AM. Record Review of Social Worker M Progress Notes, dated [DATE], reflected: .Social worker made follow-up visit for ongoing counselling. Social work has attempted numerous visits, resident previously had either been asleep or out of her room. Today, she was available, her caregiver was with her. She has a caregiver 2 hours every day to assist with activities. She is doing well. They just got back from the pharmacy. She has not seen her son.It is better when she can get out of her room. Interview on [DATE] at 12:55 PM with the DON revealed that each department is responsible for their part of a resident's care plan. The DON stated that the MDS Coordinator has been employed at the facility for about a month, but she has been in-training. The DON also stated that the Clinical Manager was responsible for the nursing portion of care plans including interventions. The DON also revealed that there was currently no clinical manager employed at the facility, and there had not been for about two weeks. The DON stated that if there was no clinical manager, he would be responsible for care plans. The DON also stated that there were interventions for Resident #1's suicidal ideations. The DON stated that he thought Resident #1 was following the interventions on the care plan because she was attending activities and speaking with the facility Social Worker per the care plan. And the DON stated that he thought the interventions on the care plan were appropriate, so no more interventions had been added. After the interview, the DON updated Resident #'1's care plan for her suicidal ideations. Interview on [DATE] at 2:12 PM with the Administrator revealed that it was reported to her that the CNA A made rounds at approximately 6:20 AM on [DATE] and Resident #1 was sleeping peacefully. The Administrator stated that about 7:15 AM the nurse and aide CNA A and LVN B went in together again to make rounds and again Resident #1 was sleeping peacefully. The Administrator said that it was again reported to her that CNA A went into Resident #1's room and found that something was wrong with Resident #1, and then went and got LVN B. The Administrator revealed that LVN B reported to her that LVN B checked Resident #1's vitals and found that Resident #1's oxygen was low. And during this process, LVN B noticed pink emesis on the resident's sheets. LVN B then reported to the Administrator that she saw two bottles of diphenhydramine sitting on Resident #1's nightstand. The Administrator stated that LVN B called emergency services. LVN B reported to the Administrator that Resident #1had two seizures while waiting for emergency services to arrive and transport her to the hospital. The Administrator stated that the resident was sent out and admitted to a behavioral health facility three times while she was a resident of their facility in [DATE], [DATE], and [DATE]. The Administrator stated Resident #1 had made a suicide pact with her husband. And when her husband committed suicide, she attempted suicide and was found by staff to have a bedsheet around her neck in her room [DATE]. The Administrator revealed that after the resident returned from her stay at the behavioral health facility and suicide attempt, the facility paid for a 24-hour sitter for a period of time (time unknown by Administrator). However, the Administrator stated that Resident #1 expressed to her that the sitter's presence made her feel like she was being punished and therefore made her feel more depressed. So, the Administrator and Resident #1 agreed the sitter would stay with the resident for two hours per day for the hours of 2:00 PM to 4:00 PM. The Administrator stated that the Medical Director made numerous psychological referrals, but the family and residents declined to pay out of pocket for the counseling appointments. The Administrator said that she thought that Resident #1 was doing better because she had attended outings recently. Administrator declined to answer when asked if LVN B notified her of Resident #1's continued depression and statements after her last in-patient mental health facility. The Administrator stated she expected the personal sitters to notify the resident's charge nurses and give the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-servicing the nursing staff regarding resident thoughts and saying they are Better off Dead. Staff were in-serviced on procedures of assessing residents and notifying the resident's provider if they say they feel they are better off dead. Record review of the staff interviews dated [DATE], of the past week about suicidal ideations of Resident #1 completed. Record review of the PHQ-9 questions, dated [DATE], by the Social Worker regarding depression and suicidal ideations with residents who are not interviewable was reviewed and included. There were seven residents identified with no findings Record review of the PHQ-9, dated [DATE], by the DON regarding depression and suicidal ideations with residents was reviewed and included. There were seven 31 residents included. One resident was found to have depression (Resident #2) and one resident (Resident #3) was found to express he would be better off dead. Record review of the Train the Trainer In-Service-Care Plans Live-dated [DATE], included the Staff Development, MDS Coordinator, and Wellness Manager in-serviced by the Education Coordinator over the topics of Resident Mental Health Deterioration-Staff Action and Reporting and Medications in Skilled Nursing. Record review of the signature sheet for the Ad Hoc QAPI committee meeting, held on [DATE], reviewed and included the DON, Director of Continuing Care, DON, Medical Director D, Medical Director E, Social Worker, and MDS, AED, and ED. On [DATE] at 4:45 PM, the Administrator was informed the IJ was removed; however, the facility remained out of compliance at a scope of isolated with a potential form more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 6 residents (Resident #1) reviewed for behavioral services. The facility failed to provide behavioral health care and services to Resident #1 who continued to express suicidal ideations and display signs and symptoms of depression after inpatient treatment for suicidal ideations at a behavioral health hospital stay from [DATE]-[DATE], resulting in Resident #1 ingesting a lethal dose of diphenhydramine (Benadryl) and expiring on [DATE]. An IJ was identified on [DATE] at 5:07 PM. The IJ template was provided to the facility on [DATE] at 5:25 PM. While the IJ was removed on [DATE] at 4:45 PM, the facility remained out of compliance at a scope of a Isolated with a severity level potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not having their behavioral health service needs met, serious physical harm, injury, and/or death. Findings include: Record review of Resident #1's quarterly MDS dated [DATE] indicated the resident was a [AGE] year-old female who admitted to the facility on [DATE] and re-admitted to the facility on [DATE] from an inpatient psychiatric center with diagnoses of bipolar disorder (mental health condition that causes extreme mood swings that range from depressive lows to manic highs), major depressive disorder recurrent, severe with psychotic symptoms (mood disorder that causes a persistent feeling of sadness and loss of interest and may make a person feel like life isn't worth living as well as hallucinations and delusions), vascular dementia moderate, with psychotic disturbance (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and epilepsy (brain condition that causes reoccurring seizures. Record review reflected Resident #1 had a BIMS score of 14, which meant she had little to no cognitive impairment. The MDS also reflected Resident #1 experienced feeling down, depressed, or hopeless two to six days (several days) in the last two weeks. The MDS reflected the resident was independent with upper body dressing, oral hygiene, and personal hygiene. The MDS reflected the resident was partial/moderate assistance with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear Record review of Resident #1's care plan, dated [DATE], reflected Resident #1 was hospitalized at a behavioral health facility from [DATE]-[DATE] and [DATE]-[DATE]. Record Review of Resident #1's care plan, dated [DATE], reflected Resident #1 would exhibit or express depression because her [family member] died, she did not have closure and did not get to say goodbye, she says she has no money; and she feels family doesn't visit much and feels stuck in her little room. Record Review of Resident #1's care plan, dated [DATE], reflected signs/symptoms of depression which included a lack of appetite, trouble sleeping at night, and would sleep in. The care plan also reflected that Resident #1 would speak with the social worker if she needed counseling and that the social worker was her mental health professional. Record Review of Resident #1's care plan, dated [DATE], reflected Resident # 1 had suicidal ideations. Interventions included listening and providing comfort when Resident #1 was confused and agitated as well as communicating in a manner that promoted mental and psychological wellbeing Record review of Resident #1's Physician's Orders reflected resident had orders for:Sertraline 25 mg (3 tabs (75 mg)) Tablet oral with a start date of [DATE] to treat depressionMirtazapine 7.5 mg tablet (1) Tablet Oral with a start date of [DATE] to treat major depressive disorderRisperidone .5 mg tablet (3 (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	tabs (1.5mg)) Tablet Oral with a start date of [DATE] to treat bipolar disorder Record review of Resident #1's Progress Notes by LVN L, dated [DATE] at 5:54 AM, reflected: The aid notified this nurse that the patient wrapped a draw sheet around the neck the nurse aide helped the patient to unwrapped [sic] the draw sheet, patient states the she wants to died [sic] and join her [family member] but death is not coming fast. Notified MD order to keep a close eye on the patient every 15 mins[sic] and wait for further instructions. Record review of Resident #1's Progress Notes, dated [DATE] at 2:21 PM by Social Worker N reflected: .Sw met with Resident and her mood had declined in the day. Resident reported she was a disappointment and did not want to do anything. She did not want to eat and just wanted to sleep .Sw walked into her room. She stated she wanted to die yet denied any plan and stated she would not do anything to harm herself. Physician notified. Resident has a .caregiver with her from 2-4pm daily. Sw to remain available as needed. Record Review of Resident #1's Progress Notes, dated [DATE] at 6:21 AM, by LVN L reflected: Patient approached this nurse and said that she was told to notify somebody if she is feeling suicidal, she states right now am feeling suicidal am looking for a bottle of pills to take I don't care anymore. Patient sited at the nursing station with this nurse, resident continue to express that since her [family member] died the feeling [sic] of suicide have been in her mind, notified NP order to send resident to .hospital.patient called 911 and after the police spoke with the patient they told this nurse that the patient states that she will use the light bulb in her room to cut herself. Patient was transported by the police car to .hospital. Record Review of Resident #1's Progress Notes, dated [DATE] at 4:15 PM, by LVN B reflected: Per administration, no special precautions necessary. Will continue to monitor frequently and provide active listening for patient to express feelings. Pt is at this time sitting in her room watching TV, no distress noted. Personal sitter here from 1400-1600(2:00 PM-4:00PM), pt went outside with sitter and ate a snack. Record Review of Resident #1's Progress Notes, dated [DATE] at 5:47 PM, LVN B reflected: .Pt reports to nurse that she has had in the past sudden, severe episodes of itching all over her body. When these happened, she would take 2 Benadryl and the itching would cease. She explained, I feel like its happening again. Pt brought an unopened bottled of Benadryl from her drawer. Explained that all medications should be kept in her locked cabinet for safety, and that no medication can be given without a medical provider's knowledge and providing the nurse with an order and directions. Pt verbalized understanding and handed bottle to this nurse. Medication locked in cabinet. Provider notified, new order received for diphenhydramine 25 mg-give 2 tabs (50 mg) PO now x1dose. May repeat 50mg x 1dose in 8 hours if itching persists. MAR updated. Benadryl given. Pt reports medication effective at this time. Teaching provided to pt about not having medication in her room, it must be locked in the cabinet. Pt verbalized understanding. Record Review of Resident #1's Medical Records from local hospital dated [DATE] reflected: Summary: [AGE] year-old female presents by EMS for acute unresponsiveness. Patient was found unresponsive in her place of living by staff. EMS reports that they found an empty Benadryl bottle and partially empty Benadryl bottle and will concern for an overdose. Patient had multiple seizures witnessed by EMS. Patient did not have a witnessed cardiac arrest. Her [family member] committed suicide by self-inflicted gunshot wound to the head 14 months ago according to family. Patient is DNR and this was confirmed by her [family member AA].He said that he is concerned she may intentionally overdosed because she has made threats of suicide recently and her [family member] committed suicide 14 months ago. The patient was pronounced at 10:51 AM. Record review of Resident #1's electronic health care record on [DATE] reflected no evidence that Resident #1 was receiving behavioral health services at the time of her suicide. Interview on [DATE] at 11:21 AM with CNA A revealed that she made rounds upon her initial arrival on [DATE] for her 6:00 AM-2:00 PM (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	shift. CNA A stated she checked on Resident #1 at approximately 6:10 AM and saw Resident #1 resting peacefully. CNA A then revealed at 8:45 AM when she went to take Resident #1 her breakfast, she saw Resident #1 lying crooked on the bed with her feet hanging off of the bed and her head perpendicular on the bed. CNA A revealed that she asked Resident #1 if she needed help getting back into bed. CNA A stated that she saw Resident #1's eyes open, but Resident #1 would not answer. CNA A revealed she could feel the resident's pulse, but Resident #1 continued to not answer her. CNA A stated that she felt she needed to notify her nurse due to the resident's unresponsiveness. CNA A stated that she did not notice any pill bottles on her nightstand when she made her rounds when she made her earlier morning round. CNA A revealed that the resident looked normal, and she did not see anything unusual like a bottle of pills on the bedside table. CNA A revealed that when making rounds and when she put away laundry, she looked for anything out of the ordinary or out of place and would report it to the nurse. CNA A stated that Resident #1 often slept all day through her shift and did not eat breakfast or lunch. CNA A stated she did not hear Resident #1 make statements about suicidal ideations. CNA A revealed that Resident #1 had a sitter two hours per day from 2:00 PM to 4:00 PM. CNA A stated that on[DATE] Resident #1 did not eat breakfast or lunch and had no abnormal behaviors that day. Interview on [DATE] at 12:06 PM with LVN B revealed that CNA A came and requested her assistance and stated that Resident #1 was breathing differently on [DATE]. LVN B stated that Resident #1 was lying perpendicular on her bed and breathing differently with her eyes open. LVN B said that Resident #1's pupils were dilated, and she was pale in color. LVN B thought she could be hypoglycemic. However, she saw pink emesis on the sheets. LVN B stated she looked over and saw two bottles on her nightstand and realized Resident #1 must have taken something. LVN B stated she stepped out into the hallway and requested assistance from LVN C. LVN B stated she dialed 911 while LVN C assisted Resident #1. LVN B revealed that while they were waiting for emergency services, Resident #1 vomited pink emesis, which had two pills in it, and two seizures that lasted between 30 and 45 seconds. LVN B said that she was unaware how many pills the resident swallowed; LVN B stated that one bottle was fuller than the other bottle. LVN B stated that emergency services took the fuller bottle with them so that the doctors would know how many pills the resident had taken. LVN B stated that Resident #1 had continued to express suicidal ideations after her third return from a behavioral health facility in [DATE] for a few months. LVN B stated she reported the continued suicidal ideations to Medical Director D and management the DON. LVN B stated Resident #1 was not sent out to a behavioral health center for her continued suicidal ideations. LVN B stated for the last six months she believed Resident #1 was depressed as evidenced by Resident #1 sleeping all day. LVN said that Resident #1 would often tell her that she was sad. LVN stated that the facility increased Resident #1's activities to aide with her depression. LVN B said that at the time she believed the added activities were benefiting Resident #1 as well as counseling by the Social Worker. LVN B was unaware of how or when Resident # 1 obtained the Diphenhydramine. LVN B stated that Resident #1 went out with her personal sitters to stores for shopping because she did have a credit card and access to funds. Interview on [DATE] at 12:55 PM with the DON revealed he received a call from LVN B on [DATE]. The DON stated that LVN B revealed Resident #1 could have ingested pink pills that were diphenhydramine. The DON said that there was only one pill left in one bottle, but there were pills on the floor and bed (each pill bottle contained 100 pills). The DON stated that LVN B and LVN C placed a rebreather on the resident which raised her oxygen from the low 70's to the low 90's. LVN B called emergency services for Resident #1. The DON explained that LVN B found pink emesis on Resident #1's bed. While waiting for emergency services, Resident #1 also vomited again, and two pills were present in the emesis. The DON revealed Resident #1 (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had suicidal ideations previously and had been sent to an in-patient facility two times for expressing suicidal ideations in [DATE] and [DATE]. The DON also stated that Resident #1 previously had attempted suicide at the facility when she was found to have a bed sheet wrapped around her neck and was sent to an in-patient treatment facility for the suicide attempt in [DATE]. The DON said that the in-patient behavioral health facility changed the resident's medications while she was there to her current medications. The DON also revealed that he thought the resident's depression and anxiety had improved the last few months. The DON stated staff tried to encourage Resident #1 to go to activities, but she wanted to stay in her room. The DON stated he went to the building after speaking with LVN B. He stated that he in-serviced nurses on securing medications and had the nurses complete room searches to ensure that residents did not have medications in their room. The DON also revealed that he asked all the alert residents the PHQ9 questions to determine if there were any other residents with depression or suicidal ideations. The DON reported there were no current residents with suicidal ideations. In-Serviced staff that if a resident said they are having suicidal ideations, the staff is to stay with them and use their cell phone to call the nurse or administration until someone comes to assess and notify the provider. The DON stated he expected the personal sitters to inform their charge nurse if the resident purchased medications at any store while they were out. The DON stated that if medications were not given to the charge nurse and locked up, the resident could be at risk of side effects or death if taken. Telephone interview on [DATE] at 1:19 PM with Family Member AA revealed that Resident #1's [family member] shot and killed himself 18 months previously in the facility's independent living apartment while Resident #1 was in the hospital. Family Member AA also stated that approximately three months after her [family member] committed suicide, Resident #1 was found with bed sheets wrapped around her neck in an attempt to end her life in the facility. Family member AA stated that he was told by staff that any medication brought to the facility was to be given to the nurse so it could be locked up. Family member AA revealed Resident #1 expressed suicidal ideations two other times, and the facility sent the resident out to a behavioral health center for treatment. Family member AA stated that he visited Resident #1 five days previous to the resident's suicide. Family member AA was not able to continue the conversation because he was on his way to the funeral home. Interview on [DATE] at 2:12 PM with the Administrator revealed that it was reported to her that the CNA A made rounds at approximately 6:20 AM on [DATE] and Resident #1 was sleeping peacefully. The Administrator stated that about 7:15 AM the nurse and aide CNA A and LVN B went in together again to make rounds and again Resident #1 was sleeping peacefully. The Administrator said that it was again reported to her that CNA A went into Resident #1's room and found that something was wrong with Resident #1, and then went and got LVN B. The Administrator revealed that LVN B reported to her that LVN B checked Resident #1's vitals and found that Resident #1's oxygen was low. And during this process, LVN B noticed pink emesis on the resident's sheets. LVN B then reported to the Administrator that she saw two bottles of diphenhydramine sitting on Resident #1's nightstand. The Administrator stated that LVN B called emergency services. LVN B reported to the Administrator that Resident #1had two seizures while waiting for emergency services to arrive and transport her to the hospital. The Administrator stated that the resident was sent out and admitted to a behavioral health facility three times while she was a resident of their facility in [DATE], [DATE], and [DATE]. The Administrator stated Resident #1 had made a suicide pact with her husband. And when her husband committed suicide, she attempted suicide and was found by staff to have a bedsheet around her neck in her room [DATE]. The Administrator revealed that after the resident returned from her stay at the behavioral health facility and suicide attempt, the facility paid for a 24-hour sitter for a period of time (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(time unknown by Administrator). However, the Administrator stated that Resident #1 expressed to her that the sitter's presence made her feel like she was being punished and therefore made her feel more depressed. So, the Administrator and Resident #1 agreed the sitter would stay with the resident for two hours per day for the hours of 2:00 PM to 4:00 PM. The Administrator stated that the Medical Director made numerous psychological referrals, but the family and residents declined to pay out of pocket for the counseling appointments. The Administrator said that she thought that Resident #1 was doing better because she had attended outings recently. Administrator declined to answer when asked if LVN B notified her of Resident #1's continued depression and statements after her last in-patient mental health facility. The Administrator stated she expected the personal sitters to notify the resident's charge nurses and give the medication to the charge nurse if any medication was obtained while they were out shopping (because the resident could have bought the Benadryl when out with a personal sitter). The Administrator stated that risks to the residents if this was not done could be death or other medical repercussions due to a medication contradiction to the resident's daily medications. Interview on [DATE] at 2:47 PM with Medical Director E revealed that she is the medical director of the independent living portion of the continuum of care retirement community. Medical Director E stated she was Resident #1's physician in the community before she became a resident at the independent living portion of the facility. Medical Director E stated that Resident #1 had been depressed her whole life and had stayed at mental health facilities before she came to the facility and additional hospital stays for self-neglect. Medical Director E stated that Resident #1 had been unhappy her whole life, and she and the facility had put hours of time into trying to get help for Resident #'1 depression. Medical Director E stated Resident #1 denied help offered by the facility's Social Workers. Medical Director E stated that you can't make someone accept help. Telephone Interview on [DATE] at 10:34 AM with Social Worker M revealed that Resident #1 told her that she would not try to kill herself though she and her [family member] had a suicide pact. Social Worker M stated that Resident #1 revealed that she did not like behavioral hospitals, and she did not want to end up back in one. Social Worker M stated that staff did not report to her Resident #1 continued to express suicidal ideations and depressions. Social Worker M said that after each time the resident was admitted to a behavioral health facility, she would have approximately four counseling sessions. Social Worker M stated Resident #1 refused help from her or to speak with her at all for the last six months. Social Worker M also revealed that Resident #1 was not seeing another therapist, and she did not think Resident #1 desired help from outside source. Social Worker M said that if Resident #1 had expressed suicidal ideations to her, she would have informed her doctor and ensured that she was sent out to a mental health facility. Telephone interview on [DATE] at 11:03 AM with personal sitter F revealed that she sat two hours per day from 2:00 PM to 4:00 PM with Resident #1 on her assigned days. Sitter F stated that she worked on [DATE], the day before Resident #1's suicide. Sitter F revealed that some days Resident #1 would sleep all day and would not be awake when or dressed when she arrived for her 2:00 PM shift. Sitter F stated on some days the resident would agree to be dressed, and she would walk the resident to the on-site pond to feed the ducks. Sitter F revealed that Saturday was a day that Resident #1 stayed in bed. Sitter F revealed that when she left her shift at 4:00 PM, Resident #1 was still sleeping and had not been out of bed all day. Sitter F stated that Resident #1 did not eat breakfast or lunch because she had not been awake at all that day. Sitter F stated that Resident #1 did not express suicidal ideations when she sat with her on previous day. Sitter F also stated she did not see any medications accessible to Resident #1 in her room. Sitter F also revealed that she did not take Resident #1 to any stores during the times she sat with her. Personal Sitter F (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 agreed to a tele visit with the last referred geriatric psychologist. However, Family Member AA did not want to pay the out-of-pocket expense for the insurance. Medical Director D stated that Resident #1 would tell staff that she did not want to live. But then tell her when she made her rounds that she was doing good and did not want to see a psychologist. Medical Director D revealed she believed that she would not tell her that she needed help or choose to see a psychologist because she did not want to be admitted to a mental health facility. Resident #1 expressed to Medical Director D that she did not like her stays at her previous mental health facilities. Medical Director D stated that Resident #1 learned what statements needed to be said to get her sent out to a mental health facility. Medical Director D revealed that she thought the resident was mentally doing better because she saw her eating in the dining room. Medical Director D also stated that after the first two mental health facility stays, the resident had personal sitters 24 hours per day. Then the resident asked not to have a sitter after the third mental health facility admission. Medical Director revealed she was unaware of how and where Resident #1 obtained two bottles of diphenhydramine. Interview on [DATE] at 2:52 PM with CNA K revealed that she was Resident #1's CNA on the 2:00-10:00PM Monday through Friday. CNA K stated that Resident #1 slept in some days until after lunch. CNA K said that she did not hear Resident #1 express suicidal ideations. CNA K also stated that she knew Resident #1 went to the pharmacy on three separate occasions with her private sitters, but she could not recall which sitter took her or when. CNA K said that it never occurred to her or the other staff to look in her bags to see if there were any harmful items. CNA K said that she reviewed Resident #1's care plan and encouraged Resident #1 to attend activities to help with her depression. Record review of the facility policy Suicide Threats, dated 07/2025, reflected: Policy.1. If a resident is threatening to commit suicide to a staff member, that staff member must reported [sic] situation immediately. 2. The licensed nurse shall immediately notify CC Leadership On call and campus dispatch. 3. A staff member must remain with the resident until the licensed nurse / medical provider arrives to examine the resident. 4. Administration, Nursing Administration, in conjunction with the Medical Provider, determine the appropriate interventions including (1) the potential of providing 1:1 supervision to promote the safety of the resident and (2) the potential need for evaluation/treatment at the emergency or acute care facility. 5. An assessment of the resident's actions and expressions will be made by the interdisciplinary care plan team as soon as possible of such incident to determine interventions that may be necessary to prevent the recurrence of such threats. Revised care/service plans will be developed to reflect such interventions. 6. Documentation of the incident must be recorded in the resident's medical record and an Incident Report completed. This was determined to be an Immediate Jeopardy (IJ) situation on [DATE] at 5:00 PM. The Administrator was notified at 5:15 PM. The Administrator was provided with the IJ template on [DATE] at 5:24 PM and a Plan of Removal (POR) was requested. The Plan of Removal (POR) was accepted on [DATE] at 12:20 PM and indicated the following: Immediate action: 1. Staff immediately initiated emergency response procedures including (nurse assessed resident. Checked blood sugar, and administered oxygen) when resident #1 was found by the nurse vomiting and convulsing with an almost empty bottle of Benadryl at bedside. The facility was notified that the resident expired at the hospital following the event.2. The nursing staff completed a 100% room sweep of all skilled nursing residents' rooms to ensure no outside or unauthorized medications were present in residents' rooms. No additional unauthorized medication was found as of [DATE].3. A communication will be sent to all family members of skilled nursing regarding our medication policy for outside medications. This will be completed by 01.20.26. We will send monthly for the next three months. Communication on facility policy for outside medications will be added to the admission (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676329	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Highland Springs	7910 Frankford Road Dallas, TX 75252

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	packet for all new residents.4. The Director of Nursing initiated interviews withal staff that have cared for resident #1 in the past week to confirm if any signs or changes in resident mood or suicidal ideations were observed. No manifestations of suicidal ideations or mood change were observed in past week.5. Suicide threats are to be taken seriously and immediately reported to the licensed nurse, clinical leaders, campus dispatch and/or administration. *If a resident threatening to commit suicide to a staff member, that staff member must report situation immediately to licensed nurse. *The licensed nurse shall immediately notify CC Leadership on Call and campus dispatch. *Administration, Nursing Administration, in conjunction with the Medical Provider, will determine the appropriate interventions including: The potential of providing 1:1 supervision to promote the safety of the resident and The potential need for evaluation/treatment at an emergency or acute care facility *An assessment of the resident's actions and expression (mood and behaviors) will be made by the interdisciplinary care plan team as soon as possible of such incident to determine interventions that may be necessary to prevent the recurrence of such threats. Revised care/service plans will be developed to reflect such interventions. *Documentation of the incident must be recorded in the resident's medical record and an Incident Report completed.6. The Director of Nursing or designees will conduct wellness interviews of all 38 interviewable residents utilizing PHQ9 questions #1,2, and 9 to assess for any immediate signs of depression, depression symptoms and/or thoughts of self-harm. Any resident identified with concerning responses will have appropriate interventions implemented immediately including provider notification, psychiatric refe