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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Care at Highland Springs	7910 Frankford Road 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on interview and record review, the facility failed to ensure that the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences of 1 (Resident #1) of 4 residents reviewed for activities of daily living. 1. The facility failed to ensure that Resident #1 had a mobility device that was accessible and comfortable to her that promoted independence, activity involvement and psychosocial need. This failure could place residents at risk of increased isolation and depression. Findings Include: Record Review of Resident #1's Quarterly MDS with an ARD (Assessment Reference Date) of 06/26/2024, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's diagnoses included: Chronic Diastolic Heart Failure (Cardiac condition where the left ventricle of the heart is stiff and does not fill with blood properly), Scoliosis (Sideways curvature of the spine), Major Depressive Disorder (Clinical Depression), and Anxiety Disorder (group of mental disorders characterized by significant and uncontrolled feelings of anxiety and fear). Resident #1 had a BIMS score of 10, indicating a moderately impaired cognition. Record Review of Resident #1's comprehensive care plan titled, [Facility Name] Holistic Care Plan dated 06/26/2024 revealed that Resident #1's daily routine was to attend activities and events that involve socialization on campus. The care plan revealed that Resident #1's health decline upset her and she did not want to lose her independence. Care Plan revealed that Resident #1 required total (Hoyer) lift transfer. Care Plan revealed that Resident #1 enjoyed going outside to sit for a while, go outside and walk, and to be around animals. Care Plan revealed that the facility would provide Resident #1 with an environment that was conducive to mental and psychosocial wellbeing. Record Review of Resident #1' physician progress note dated 07/08/2024 revealed that Resident #1 was seen by MD A on 07/08/2024 for a follow-up visit at the facility. The progress note revealed that Resident #1 was oriented to person, place and time and Resident #1's judgement and insight were fair. The progress note revealed that Resident #1 had the capacity to make health care decisions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of document titled, Physical Therapy Evaluation and Plan of Care dated for 07/30/24 revealed that Resident #1 started physical therapy services on 03/21/24. Physical Therapy evaluation revealed that Resident #1 had a fall out of bed and sliding out of wheelchair. Physical Therapy evaluation revealed that Resident #1 would benefit from skilled physical therapy services to reduce noted functional deficits including w/c (wheelchair) mobility and safety. Physical Therapy Evaluation revealed that therapy interventions would include wheelchair skills transfer training. Physical Therapy Evaluation revealed that Resident #1's Long Term Goals would be to demonstrate improved wheelchair mobility to min A (Minimal Assistance) level to be able to propel WC (Wheelchair) > 100 feet and make turns without assist for increase function and mobility. Record Review of document titled, PT (Physical Therapy) Discharge Summary dated for 07/30/24 revealed that Resident #1 was discharged from physical therapy services on 04/12/2024. Review of the Physical Therapy Discharge Summary revealed that Resident #1 did not meet her long-term goals. Physical Therapy Discharge Summary revealed that Resident #1 required dependent assistance when sitting in [her] wheelchair, but was usually not in her wheelchair due to pain. Physical Therapy Discharge Summary revealed that resident #1 had a power wheelchair, but did not like to utilize it due to back pain. Review of document titled Occupational Therapy Evaluation and Plan of Care dated for 07/30/24 revealed that Resident #1 started occupational therapy services on 03/22/24. Occupational therapy evaluation revealed that Resident #1 stated to Occupational Therapist that she would like to get out of bed and she did not like being in bed for prolonged periods of time. Occupational Therapy Evaluation revealed that Resident #1's Short Term Goals was that Resident #1 will tolerate sitting in her wheelchair for >3 hours for increased access to community social activities. Review of document titled, OT (Occupational Therapy) Discharge Summary dated for 07/30/2024 revealed that Resident #1 was discharged from Occupational Therapy services on 04/20/2024. Occupational Therapy Discharge summary revealed that Resident #1's short term goal of tolerating sitting in a wheelchair for >3 hours for increased access to community social activities was not met. Resident #1 did not sit in w/c (wheelchair), Resident #1 tolerated sitting in recliner for about 3 hours. Record Review of document titled, Social Work/RSC Charting dated for 06/24/24 revealed that Resident #1 remained in her room; either in bed or her recliner. Resident #1 stated she felt down at times due to not getting out of her room. Staff had attempted to put Resident #1 in the WC (Wheelchair) and get her to activities, yet she asked to be transferred back to bed due to discomfort being in the WC (Wheelchair). Record Review of document titled, Nursing Charting dated for 07/29/24 revealed that Resident #1 was asked if she wanted to sit in her W/C (Wheelchair) and Resident #1 refused and stated not today. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 07/30/2024 at 10:30AM revealed that she had been a resident at the facility for a few months at that time. Resident #1 revealed that she transferred to the healthcare center from the campuses Independent Living Community. Resident #1 revealed that she had been unable to utilize her power wheelchair due to the size, as it was too narrow. Resident #1 stated it was uncomfortable for her for prolonged periods of time. Resident #1 revealed that the facility had brought her two manual wheelchairs, but they were too short and narrow. Resident #1 revealed that the facility had not attempted to provide another mobility device for her. Resident #1 revealed that she had felt confined and isolated to her room as she is unable to move in and out of her room without a mobility device. Resident #1 revealed that she had been unable to attend social activities or go outside, which were things that she enjoyed. Resident #1 revealed that at that time, she gave up on trying to get out of her room and asked the staff to just put her in her recliner. Resident #1 revealed that if she had a comfortable wheelchair, she would be able to get out of her room. Observation on 07/30/24 at 10:40am of Resident 1's room revealed three mobility devices in Resident #1's bathroom, which was located in Resident #1's room. Observation revealed a black power wheelchair located in the back with Resident #1's name. The power wheelchair appeared to be dusty with several incontinence supplies stacked on the power wheelchair seat itself. Observation revealed two other mobility devices in front of the power wheelchair which included two manual wheelchairs. Resident #1 revealed that the two manual wheelchairs are too short and two small in width to be able and sit for more than thirty minutes at a time. Resident #1 revealed the power wheelchair is too narrow to be able and sit for more than thirty minutes at a time. Interview with Therapy Manager on 07/30/24 at 11:55AM revealed that Resident #1 was assessed for power wheelchair usage on admission and approved, but due to resident's statements that it was too uncomfortable, staff had not been placing her in the power wheelchair. The Therapy Manager revealed that Resident #1's wheelchair tolerance was low, and her current power wheelchair was too narrow. Therapy Manager revealed that they attempted last week with two manual wheelchairs, but this was unsuccessful. Therapy Manager revealed that they had not attempted other alternatives for mobility devices or started the process to assess the resident for a new power wheelchair. The Therapy Manager did not reveal why the facility did not provide other mobility device alternatives or risks for not providing proper mobility equipment for residents. Interview with the Social Worker on 07/31/24 at 12:51PM revealed that Resident #1 expressed on admission her desire to use a power wheelchair. The Social Worker revealed that Resident #1 was assessed by therapy per Resident #1's request for power wheelchair usage. The Social Worker revealed that on 07/30/24, after the situation was [NAME] to her attention by the surveyors, the Social Worker met with Resident #1 and removed the manual wheelchairs from her room. The Social Worker confirmed that both the manual wheelchairs and power wheelchair were uncomfortable for Resident #1. The Social Worker was unsure of other mobility device alternatives that the facility provides. Interview with CNA D on 08/01/24 at 3:57PM revealed that she had been working at the facility for almost a year on the 2pm-10pm shift and she was typically assigned to Resident #1. CNA D revealed that Resident #1 could vocalize her needs and preferences. CNA D revealed that she was typically in the recliner when she got to her shifts and was unsure why Resident #1 did not utilize a wheelchair or other mobility device. CNA D revealed that Resident #1 had not expressed to her feelings of isolation or depression. CNA D revealed that if a resident needed a mobility device and does not have one that accommodates their needs, she would tell her charge nurse. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 07/31/24 at 2:50PM revealed that residents needs and preferences are assessed on the baseline care plan. The DON stated the admitting nurse is the one who completed the baseline care plan. The DON revealed that Resident #1's power wheelchair was not fitting and the facility provided a manual wheelchair at that time. The DON revealed he was unaware the manual wheelchair did not fit as well. The DON revealed they had other mobility devices available if needed and that the facility can provide alternative devices, but the DON could not state what other mobility devices the facility had on hand to provide. The DON revealed that a risk for not providing proper mobility equipment for residents would be increased feelings of isolation. Record Review of the Facility's policy titled, Holistic Assessment Post- Acute and Long-Term Care revealed that, Guests/residents who will be residing in either Post Acute or Continuing Care neighborhood will be assessed by an interdisciplinary team at time of admission, re-admission, quarterly and/or significant change of condition per state and federal guidelines to establish preferences, routines, and care/clinical needs. The assessment will focus on the guests'/residents' preferences, daily routines and care/clinical needs.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 1 of 1 facility's reviewed for grievances. The facility failed to make information known to Resident's and their Representatives either individually or through postings in prominent locations throughout the facility on who the facility grievance official was, their contact information, how to file an anonymous grievance and their right to obtain a written decision related to their grievance. The facility failed to ensure Resident's #1,# 2, and# 3 had information known to them on how to file a grievance or concern, who the grievance official was, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. These failures could affect the Resident's and their representatives' abilities to file a grievance in a timely manner and inhibit their right to request a written decision regarding the resolution of their grievance. These failures could affect Resident's #1, #2, and #3 by not having the necessary information available to file a grievance or concern either orally or anonymously, in a timely manner. Findings Include: 1. Record Review of Resident #1's Quarterly MDS with an ARD (Assessment Reference Date) of 06/26/2024, revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's diagnoses included: Chronic Diastolic Heart Failure (Cardiac condition where the left ventricle of the heart is stiff and does not fill with blood properly), Scoliosis (Sideways curvature of the spine), Major Depressive Disorder (Clinical Depression), and Anxiety Disorder (group of mental disorders characterized by significant and uncontrolled feelings of anxiety and fear). Resident #1 had a BIMS (Brief Interview of Mental Status) score of 10, indicating a moderately impaired cognition. Record Review of Resident #1' physician progress note dated 07/08/2024 revealed that Resident #1 was seen by MD A on 07/08/2024 for a follow-up visit at the facility. The progress note revealed that Resident #1 was oriented to person, place and time and Resident #1's judgement and insight were fair. The progress note revealed that Resident #1 had capacity to make health care decisions. Interview with Resident #1 on 07/30/2024 at 10:30am revealed that she had been a resident at the facility for a few months at that time. Resident #1 revealed that she transferred to the healthcare center from the campuses Independent Living Community. Resident #1 revealed that she has had concerns in the past, but was unsure of who to report the concerns to. Resident #1 revealed that, in the past, she would go to her family member. Resident #1 revealed that she did not know who the facility grievance official is, how to file a grievance in an anonymous way or that she was entitled to a written decision regarding the resolution to her grievance or concern from the facility. Resident #1 revealed that she had not been educated on the facilities policies or procedures related to grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Record Review of Resident #2's Quarterly MDS with an ARD (Assessment Reference Date) of 06/28/2024, revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's diagnoses included: Aphasia (Comprehension and Communication Disorder), Major Depressive Disorder (Clinical Depression) and Chronic Kidney Disease Stage 3 (Moderate Kidney Damage). Resident #2 had a BIMS score of 15 indicating no cognitive impairment. Record Review of Resident #2's physician progress note dated 07/05/2024 revealed that Resident #2 was seen by MD A on 07/05/2024 for a follow-up visit at the facility. The progress note revealed that Resident #2 was awake and alert in bed, but had some word finding difficulties while talking. The progress note revealed that Resident #2 had capacity to make health care decisions. Interview with Resident #2 on 07/31/2024 at 9:20AM revealed that she had been a resident at the facility for 8 or 9 months. Resident #2 revealed that she did not know who the facility grievance official was, how to file a grievance in an anonymous way, or that she was entitled to a written decision regarding the resolution to her grievance or concern from the facility. Resident #2 revealed she would go to the facility Operations Director or Social Worker if she had a grievance. Resident #2 revealed that she had not seen any postings on how to file a grievance or her rights as a resident related to grievances. Resident #2 revealed that nobody at the facility had educated her on the facility's policies or procedures related to grievances. 3. Record Review of Resident #3's Quarterly MDS with an ARD (Assessment Reference Date) 01/29/2024, revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #3's diagnoses included: Major Depressive Disorder (Clinical Depression), Aphasia following unspecified cerebrovascular disease (Comprehension and Communication Disorder following conditions like a stroke, brain bleed, brain aneurysm), and Personal History of Transient Ischemic Attack (Temporary period of symptoms similar to stroke). Resident #3 had a BIMS score of 15 indicating no cognitive impairment. Record Review of Resident #3's physician progress note dated 07/30/2024 revealed that Resident #3 was seen by MD A on 07/30/2024. The progress note revealed that Resident #3 got frustrated at times due to her expressive aphasia, but was redirectable by staff. The progress note revealed that Resident #3 was alert and oriented to person, place, and time. An observation and interview with Resident #3 on 07/31/24 at 9:05AM revealed Resident #3 was sitting in her lounge chair. Surveyor greeted resident, Resident #3 became frustrated when trying to answer surveyor questions, interview continued via written communication per Resident #3's request. Resident #3 revealed that she had been at the facility for a few months. Resident #3 revealed that she felt frustrated because staff was unable to recognize what she wanted Resident #3 revealed that she had not filed a concern or grievance because she was not sure who to go to. Resident #3 revealed that she does not know how to file a grievance or concern in an anonymous way or that she was entitled to a written decision regarding her grievance or concern from the facility. Resident #3 revealed that she had not seen any postings on how to file a grievance or concern or her rights related to grievances. Resident #3 revealed that nobody at the facility had educated her on the facility's policies or procedures related to grievances. Observation of the facility on 07/30/24 at 1:30PM revealed no postings related to the facilities policy on grievances, who the grievance official was, their contact information, how to file a grievance in an anonymous way, or their right to a written decision related to their grievance from the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the facility on 07/31/24 at 11:05AM revealed no postings related to the facilities policy on grievances, who the grievance official, their contact information, how to file a grievance in an anonymous way or their right to a written decision related to their grievance from the facility. Observation of the facility on 08/01/2024 at 10:00AM revealed no postings related to the facilities policy on grievances, who the grievance official was, their contact information, how to file a grievance in an anonymous way, or their right to a written decision related to their grievance from the facility. Interview with CNA B on 08/01/24 at 9:00AM revealed that she had been working at the facility for about three years. CNA B revealed the facility procedure on grievances was if a resident were to come to her or any staff member with a concern or grievance, she would tell the Unit Manager. CNA B stated that the facility grievance official was the Administrator. CNA B revealed that she was aware that residents had the right to file a grievance in an anonymous way, but could not state how the resident's in the facility could. CNA B could not reveal where the facility provided specific information related to grievances processes and procedures and information for the facility Grievance Official. Interview with LVN A on 08/01/24 at 9:30AM revealed that the facility policy on grievances was if a resident were to come to her or any staff member with a concern or grievance, she would tell the Unit Manager or the Administrator. LVN A revealed that the facility grievance official was the Administrator. LVN A revealed that she was aware that residents had the right to file a grievance in an anonymous manner, but could not state how the resident's in the facility could file a grievance anonymously. CNA B could not reveal where the facility provided specific information related to grievances processes, procedures and information for the facility Grievance Official. Interview with the Unit Manager for Post-Acute Care on 08/01/24 at 3:00PM revealed that the facility policy on grievances was that if a resident came to her or any staff member with a grievance, it should be filed immediately with the Social Worker. The Social Worker would then give the filed grievance to herself and Administrator for investigation and follow-up. The Unit Manager revealed that the Social Worker was the facility Grievance Official. The Unit Manager revealed that residents were informed of the facility's procedures related to grievances in their town hall meetings. The Unit Manager revealed that she was unsure who informed residents on the grievance procedures on admission. The Unit Manager could not reveal where the facility provided specific information related to grievances processes, procedures, and information for the facility grievance official. Interview with the DON on 08/01/2024 at 3:20PM revealed that the facility policy on grievances was that the facility Social Worker was tasked with filing and handling all facility grievances. The DON revealed that if a resident went to a staff member with a concern or grievance the staff member should tell the Social Worker immediately. The DON revealed that the Social Worker was the facility grievance official. The DON revealed that he was aware that residents had the right to file a grievance in an anonymous manner, but could not state how the resident's in the facility could file a grievance in an anonymous manner. The DON could not reveal where the facility provided specific information related to grievances processes, procedures, and information for the facility grievance official. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Social Worker on 08/01/24 at 3:45PM revealed that the facility's grievance policy and procedure was if a resident had a grievance or concern, they could reach out to the Ombudsman. The Social Worker revealed that if the grievance was facility related, then the resident could tell any staff member and that staff member would alert the social worker. The Social Worker revealed that she was the facility grievance official since she kept the grievance binder. The Social Worker revealed that once a grievance was then an investigation would occur and the assigned department head would follow-up for resolution. The Social Worker could not reveal where the facility provided specific information related to grievances processes, procedures and information for the facility grievance official. Interview with the Administrator on 08/01/24 at 4:26PM revealed that the facility grievance policy and procedure was if residents have a concern or grievance, that staff member would get the Social Worker. The Administrator revealed that the Social Worker would begin the grievance process and then it would be spoken about the following day in the stand-up morning meeting which included all the department heads. The Administrator revealed that residents were informed of the facility's grievance policies and procedures in the admission agreement. The Administrator did not reveal how residents could file an anonymous grievance. Review of the facility's admission agreement titled, Acknowledgement and Receipt of Admission Documents, dated 09/2021, revealed a section titled, Facility Practice Disclosures. Facility Practice Disclosures revealed a subsection titled, Concerns. The subsection revealed that it is the policy of the facility that all resident and family concerns will be addressed thoroughly, without fear of reprisal and followed to resolution in a timely fashion. Concerns may be presented to any staff member orally, in writing or in person and may be reported anonymously. Review of the facility's admission agreement did not reveal or identify the facility Grievance Official for whom is responsible for overseeing the grievance process, receiving, and tracking grievances to their conclusions or the residents right to obtain a written decision regarding his or her grievance. Review of the facility's admission agreement did not reveal how the residents, or their representatives could file a grievance in an anonymous manner if they chose to do so. Review of the facility's policy on grievances titled, Grievance/Concerns Investigations and Resolutions, dated 07/2023, revealed that grievances may be filed orally or in writing and can be filed anonymously . The Grievance Officer for Skilled Nursing [is the] Social Worker. Review of the facility's policy on grievances revealed that residents will be notified of their right to file a grievance via the Residents Rights document provided upon admission to the community. Review of the facility's admission agreement titled, Acknowledgement and Receipt of Admission Documents, dated 09/2021, revealed a section titled, Resident's [NAME] of Rights. This section revealed that that resident's had the right to complain about the resident's care or treatment. The complaint may be made anonymously or communicated by a person designated by the resident. Record Review of this document did not reveal any additional information regarding grievances or concerns.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on interview, and record review, the facility failed to coordinate assessments with the Pre-Admission Screening and Resident Review (PASARR) program for 4 (Resident #3, Resident #5, Resident #7, Resident #8) out of 4 residents reviewed for PASARR assessments. The facility failed to transcribe PL1s' (PASARR Level 1 Screenings) to the LTC Online Portal for 4 (Resident #3, Resident #5, Resident #7, Resident #8) out of 4 residents reviewed for PASARR assessments. This failure could place residents who are eligible for PASARR services at risk of not receiving needed services. Findings Include: Record Review of Resident #5's Admission MDS with an ARD (Assessment Reference Date) of 03/16/2024 revealed she was an [AGE] year-old-female who admitted to the facility on [DATE]. Resident #5's active diagnoses included: Major Depressive Disorder (Clinical Depression), Legal Blindness, Chronic Obstructive Pulmonary Disease (Progressive Lung Disease). Resident #5 had a BIMS score of 11 indicating a moderately impaired cognition. Record Review of document titled, PASRR Level 1 Screening dated 03/11/2024 revealed that Resident #5' PL1 screening indicated that Resident #5 did not have evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled PASRR Level 1 Screening dated 03/11/2024 for Resident #5 revealed that the facility did not transcribe or submit the PL1 for Resident #5 to the LTC Online Portal. Record Review of Resident #3's Quarterly MDS with an ARD (Assessment Reference Date) 01/29/2024, revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #3's diagnosis included: Major Depressive Disorder (Clinical Depression), Aphasia following unspecified cerebrovascular disease (Comprehension and Communication Disorder following conditions like a stroke, brain bleed, brain aneurysm), and Personal History of Transient Ischemic Attack (Temporary period of symptoms similar to stroke). Resident #3 had a BIMS score of 15 indicating no cognitive impairment. Record Review of document titled, PASRR Level 1 Screening dated 10/23/23 revealed that Resident #3's PL1 screening indicated that Resident #3 did not have evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled PASRR Level 1 Screening dated 10/23/23 for Resident #3, revealed that the facility did not transcribe or submit the PL1 for Resident #3 to the LTC Online Portal. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #7's Admission MDS with an ARD (Assessment Reference Date) of 07/18/2024 revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #7's active diagnosis included: Major Depressive Disorder (Clinical Depression), Unspecified Dementia (Major Neurocognitive Disorder), and Spinal Stenosis (Narrowing of the Spine). Resident #7 had a BIMS score of 12 indicating moderately impaired cognition. Record Review of document titled, PASRR Level 1 Screening dated 07/12/2024 revealed that Resident #7's PL1 screening indicated Resident #7 did not have evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled, PASRR Level 1 Screening dated 07/12/2024 for Resident #7 revealed that the facility did not transcribe or submit the PL1 for Resident #7 to the LTC Online Portal. Record Review of Resident #8's Admission MDS with an ARD (Assessment Reference Date) of 07/08/2024 revealed she was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #8's diagnosis included: Major Depressive Disorder (Clinical Depression), Alzheimer's Disease (Brain disorder that causes memory loss and behavior changes), and Delirium due to know physiological condition(Serious change in mental abilities due to a disorder or condition). Record Review of document titled, PASRR Level 1 Screening, dated for 07/03/2024 revealed that Resident #8's PL1 screening indicated Resident #8 did not have an evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled PASRR Level 1 Screening dated 07/03/2024 for Resident #8 revealed that the facility did not transcribe or submit the PL1 for Resident #8 to the LTC Online Portal. Interview with the DON on 07/30/2024 at 2:55PM revealed the facility ensured every new admission entered the facility with a completed Level 1 screening. The Level 1 screenings were then placed in the resident's hard charts. The DON revealed that the MDS nurse should have been uploading the PL1's to the LTC Online Portal and ensuring they accurately reflected the resident's clinical condition or diagnoses. The DON revealed that when a resident admits to their facility with a positive PL1 this will trigger a Level II screening from the local mental health authority. The DON revealed that he was unsure how the local mental health authority was being notified of the positive PL1 admissions if none of the PL1's were being submitted to the LTC Online Portal. The DON revealed that if the PL1's were not being submitted to the LTC Online Portal, then this could have placed residents at risk of missed services. Interview with the MDS Nurse on 07/31/24 at 3:37PM revealed that the facility ensured that all new admissions admit to the facility with a completed PL1 screening. The Level 1 screenings were then placed in the resident's hard charts. The MDS nurse revealed that the facility was not uploading any PL1's to the LTC Online Portal as they were unaware, they had to . The MDS nurse revealed the facility did not have an identified person who was responsible for ensuring the PL1's were accurate on admission. The MDS nurse revealed that if the PL1's were not submitted to the LTC Online Portal then this could have placed residents at risk of missed services. (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	08/01/2024

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 07/31/24 at 3:58PM revealed that she was unsure of the PASARR requirements or processes. The Administrator revealed that the current procedure was to ensure all new admissions had a PL1 screening then the PL1 would be placed into the resident's hard chart. The Administrator revealed that the facility was not transcribing or uploading any resident's PL1's to the LTC Online Portal . The Administrator revealed that the facility did not have a designated person at the facility to oversee PASARR procedures. Review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASRR), dated 06/2021 revealed that if the Level 1 Screen is positive, the individual should be referred to the local mental health screening agency for a Level 2 evaluation prior to admission, unless they qualify for an exemption. Review of the document titled, Detailed Item by Item Guide for Local Authorities and Nursing Facilities to Complete the PASRR Level 1 Screening Form by Texas Health and Human Services dated for June 2023 revealed that example of MI diagnoses are . Mood Disorder (Bipolar Disorder, Major Depressive Disorder, or other Mood Disorder).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observation, interview and record review, the facility failed to accurately submit a PL1 (PASARR Level 1 Screening) screening when residents admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for 3 (Resident #5, Resident #7, Resident #8) out of 4 residents reviewed for PASARR screenings. The facility failed to submit a new PL1 screening when residents were diagnosed with a new diagnosis of Mental Illness, Intellectual Disability or Developmental Disability during their stay for 1 (Resident #3) out of 4 residents reviewed for PASARR screenings. The facility failed to ensure that Resident #5, Resident #7, and Resident #8 had accurate PL1's on admission. 1. The facility failed to submit a correct PL1 screening for Resident #5 when she admitted to the facility on [DATE] with an active diagnosis of Major Depressive Disorder. 2. The facility failed to submit a new PL1 screening when Resident #3 was diagnosed on [DATE] with Major Depressive Disorder during her stay. 3. The facility failed to submit a correct PL1 screening for Resident #7 when she admitted to the facility on [DATE] with an active diagnosis of Major Depressive Disorder. 4. The facility failed to submit a correct PL1 screening for Resident #8 when he admitted to the facility on [DATE] with an active diagnosis of Major Depressive Disorder. These failures could affect residents by not receiving a Level II PASARR Evaluation to assess for needed services. Findings Include: 1. Record Review of Resident #5's Admission MDS with an ARD (Assessment Reference Date) of 03/16/2024 revealed she was an [AGE] year-old-female who admitted to the facility on [DATE]. Resident #5's active diagnosis included: Major Depressive Disorder (Clinical Depression). Resident #5 had a BIMS score of 11 indicating a moderately impaired cognition. Record Review of Resident #5's History of Present Illness (HPI) revealed a date of service of 03/11/2024 from MD A. The HPI revealed the resident had a history of MDD (Major Depressive Disorder) with chronic anxiety. Review of HPI document revealed that Resident #5 was being treated for MDD (Major Depressive Disorder). Record Review of document titled, PASRR Level 1 Screening dated 03/11/2024 revealed that Resident #5' PL1 screening indicated that Resident #5 did not have evidence or indicator of mental illness, intellectual disability, or developmental disability. (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	08/01/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the document titled, PASRR Level 1 Screening dated 03/11/2024 for Resident #5 revealed that the Facility did not transcribe or submit Resident #5's PL1 to the LTC Online Portal. Record Review of the document titled, PASRR Level 1 Screening dated 03/11/2024 for Resident #5 revealed that the Facility did not correct the PL1 to indicate Resident #5 did in fact have a diagnosis of Mental Illness. The facility failed to submit a correct PL1 to the LTC Online Portal. 2. Record Review of Resident #3's HPI revealed a date of service of 10/25/24 from MD A. HPI revealed that Resident #3 was not currently being treated or had an active diagnosis of MDD (Major Depressive Disorder). Record Review of Resident #3's Quarterly MDS with an ARD of 01/29/2024, revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #3's diagnoses included: Major Depressive Disorder (Clinical Depression . Resident #3 had a BIMS score of 15 indicating no cognitive impairment. Record Review of Resident #3's Quarterly MDS revealed Resident #3 had a current diagnosis of MI (Mental Illness) of MDD (Major Depressive Disorder). Record Review of document titled, PASRR Level 1 Screening dated 10/23/23 revealed that Resident #3's PL1 screening indicated that Resident #3 did not have an evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled, PASRR Level 1 Screening dated 10/23/23 for Resident #3, revealed that the Facility did not transcribe or submit Resident #3's PL1 to the LTC Online Portal. Record Review revealed that the Facility did not submit a new PL1 when Resident #3 was diagnosed with a MI (Mental Illness) during her stay at the facility. 3. Record Review of Resident #7's Admission MDS with an ARD of 07/18/2024 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #7's active diagnosis included: Major Depressive Disorder (Clinical Depression), Unspecified Dementia (Major Neurocognitive Disorder), and Spinal Stenosis (Narrowing of the Spine). Resident #7 had a BIMS score of 12 indicating a moderately impaired cognition. Record Review of Resident #7's HPI revealed a date of service of 07/15/2024 from MD A. HPI revealed that resident had a history of MDD (Major Depressive Disorder) with psychosis. Review of HPI document revealed that Resident #5 was being treated for MDD (Major Depressive Disorder). Record Review of document titled, PASRR Level 1 Screening dated 07/12/2024 revealed that Resident #7's PL1 screening indicated Resident #7 did not have an evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled PASRR Level 1 Screening dated 07/12/2024 for Resident #7 revealed that the Facility did not transcribe or submit Resident #7's PL1 to the LTC Online Portal. Record Review revealed that the Facility did not correct the PL1 to indicate Resident #7 did in fact have a diagnosis of Mental Illness. The facility failed to submit a correct PL1 to the LTC Online Portal. (continued on next page)

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	676329	A. Building B. Wing	08/01/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record Review of Resident #8's Admission MDS with an ARD (Assessment Reference Date) of 07/08/2024 revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #8's diagnosis included: Major Depressive Disorder (Clinical Depression), Alzheimer's Disease (Brain disorder that causes memory loss and behavior changes), and Delirium due to know physiological condition (Serious change in mental abilities due to a disorder or condition). Record Review of Resident #8's HPI (History of Present Illness) revealed a date of service of 07/05/2024 from MD A. HPI revealed that resident had a history of MDD (Major Depressive Disorder) with psychotic features. Review of HPI document revealed that Resident #8 was being treated for MDD (Major Depressive Disorder). Record Review of document titled, PASRR Level 1 Screening, dated for 07/03/2024 revealed that Resident #8's PL1 screening indicated Resident #8 did not have an evidence or indicator of mental illness, intellectual disability, or developmental disability. Record Review of the document titled, PASRR Level 1 Screening dated for 07/03/2024 for Resident #8 revealed that the Facility did not transcribe or submit Resident #8's PL1 to the LTC Online Portal. Record Review revealed that the Facility did not correct the PL1 to indicate Resident #8 did in fact have a diagnosis of Mental Illness. The facility failed to submit a correct PL1 to the LTC Online Portal. Interview with the DON on 07/30/2024 at 2:55PM revealed that the MDS nurse was responsible for ensuring that all residents PL1's were correct, reflect their current and active diagnoses and were submitted to the LTC Online Portal. The DON revealed that if a resident had a positive PL1 then the local mental health authority would come to the facility and complete the Level II screening. The DON revealed that if PL1's were incorrect and did not accurately reflect the resident's current diagnoses this could have placed the residents at risk for missed services. Interview with the MDS nurse on 07/31/24 at 3:37PM the facility was not uploading any PL1's to the LTC Online Portal as they were unaware they had to. The MDS nurse revealed that the facility was not auditing PL1's to ensure they accurately reflected the residents' diagnoses. The MDS nurse revealed she was not aware the facility had to submit a new PL1 if a resident is diagnosed with Mental Illness, Intellectual disability or Developmental Disability during their stay at the facility. The MDS nurse revealed that if the PL1's were not being submitted to the LTC Online Portal accurately this could place the residents at risk for missed services. Interview with the Administrator on 07/31/24 at 3:58PM revealed that she was unsure of the PASARR requirements or processes. The Administrator revealed that the current procedure was to ensure all new admissions had a PL1 screening then the PL1 would be placed into the resident's hard chart. The Administrator revealed that the facility was not transcribing or uploading any PL1's to the LTC Online Portal. The Administrator revealed that the facility did not have a designated person at the facility to oversee PASARR procedures or to ensure that the PL1's reflected the residents' current diagnoses. Review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASRR), dated 06/2021 revealed that if the Level 1 Screen is positive, the individual should be referred to the local mental health screening agency for a Level 2 evaluation prior to admission, unless they qualify for an exemption.

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	676329	A. Building B. Wing	08/01/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37028 Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #12) of 8 residents reviewed for quality of life. The facility failed to ensure Resident #12 was taken to the bathroom when he requested and did not have to soil himself. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for falls, and a decreased quality of life. Findings include: 1. Record review of Resident #12's Admission MDS assessment dated [DATE], reflected Resident #12 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart failure, fracture of the left, 4th finger, primary osteoarthritis, and chronic kidney disease. Resident #12 had a BIMS score of 12 which indicated Resident #12's cognition was moderately impaired. Resident #12 required maximum assistance with toileting. He was occasionally incontinent of urine and was never incontinent of bowel. He was not on a toileting a schedule. Review of Resident #12's Comprehensive Care Plan, dated 07/05/24, reflected the resident required the extensive assistance of one staff for toileting. An observation and interview on 07/30/24 at 10:51 AM with Resident #12 revealed the resident was seated in his wheelchair in his room. Both of his wrists were swollen and misshapen. He said he had arthritis and was not able to use them very well and required staff to cut his food for him. He said that the staff were too busy to take care of him and on 07/30/24 he had to wait over an hour to get help. He said that sometimes it would happen 3-4 times a day. He said on 07/30/24 in the morning before breakfast he soiled himself because no one came to help him to the bathroom. An interview on 07/30/24 at 1:29 PM with CNA A revealed she had worked at the facility for five years. She said the morning of 07/30/24 she arrived at the facility at 7:00 AM, but instead of going to Resident #12's room she gave 2 residents a shower first. She said she did not get to the resident until 7:45 AM. She said she did not know if he pressed the call light for help to the bathroom before she got to his room. She said someone else could have answered his call light and she did not know he had called for help. She said she would usually do check and change with him when he got up, after breakfast, and he would notify her after that. She said staff did not check residents at shift change when giving report. She said she did not know who covered the 6:00 AM - 7:00 AM part of her shift on 07/30/24. She said residents could get bedsores if they were not taken to the bathroom when they needed to go. An observation and interview on 08/01/24 at 10:15 AM with Resident #12 and his family member revealed when he had to soil himself, he felt like staff did not really care about him and just rushed in and rushed out of his room. (continued on next page)

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	676329	A. Building B. Wing	08/01/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/01/24 at 1:13 PM with RN B revealed she provided care to Resident #12 and had worked at the facility for 5 years. She said the resident was continent during the day and staff would take him to the bathroom when asked to go. She said she did not work on 07/30/24 and it was the responsibility of all staff to answer the call lights. An interview on 08/01/24 at 2:00 PM with the Clinical Manager for Post-Acute Care revealed she had worked at the facility for five and half months. She said she did not know if Resident #12 was incontinent during the day. She said he was not on a toileting schedule, and he was alert and oriented and could call for help. She said call lights were supposed to be answered in less than 5 minutes. She said she checked Resident #12's call light record for 07/29/24 - 07/30/24 for the hours between 10:00 PM - 8:00 AM and the resident pressed the call light 10 times. She said the longest wait time was 16 minutes. She said it was unusual for him to press his call light so many times and she did not know why he did. She said she wanted staff to do end of shift rounds for the residents, but she said it did not always happen. The Clinical Manager for Post-Acute Care said she did not know who or if a staff covered for CNA A the morning of 07/30/24 between the hours of 6:00 AM - 7:00 AM. She said a resident was at risk for falls and dignity issues if they had to soil themselves. She said the facility was well staffed. An interview on 08/01/24 at 3:10 PM with the DON revealed he had worked at the facility for 4 weeks. He said residents were supposed to be checked on every 2 hours. He said call lights were supposed to be answered as soon as possible. He said it was his expectation that staff check on residents at the start of their shift. He said Resident #12 was at risk for dignity issues if he was left to soil himself. Record Review of the facility policy titled Resident Rights - Continuing Care revised 06/06/23 reflected, The facility will promote and protect the rights of each resident and places a strong emphasis on individual dignity and self-determination .

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	676329	A. Building B. Wing	08/01/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47030 Based on observation and interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 2 (Pod 1 and Pod 2) out of 2 units reviewed for environment. 1. The facility failed to ensure that the mechanical lift on Pod 1 was locked and secured when not in use. 2. The facility failed to ensure that the mechanical lift on Pod 2 was locked and secured when not in use. 3. The facility failed to ensure a parked wheelchair in the common area on Pod 1 was locked and secured when not in use. 4. The facility failed to ensure that razors intended for shaving use were locked and secured. These failures could place residents at risk for falls and/or injury. Findings Include: Observation of the facility's Pod 1 Unit on 07/30/24 at 9:45 am revealed an unlocked and unsecured mechanical lift parked in front of a resident's room. Observation of the facility's Pod 1 Unit on 07/30/24 at 9:50am revealed an unlocked and unsecured wheelchair in the unit's common area. Observation of the facility's Pod 2 Unit on 07/30/24 at 9:58am revealed an unlocked and unsecured mechanical lift parked in front of a resident's room. Observation of the facility's Pod 2 Unit on 07/30/24 at 10:10am revealed a wheeled supply cart, unlocked, which contained several blue razor blades. Interview with LVN B on 07/30/24 at 10:30am revealed that they had several resident's on the unit's on Pod 1 and Pod 2 that required mechanical lift assistance. LVN B revealed that once the staff was finished with the mechanical lift they should be stored in the facility's Spa Room and locked. LVN B revealed that wheelchairs, when not in use, were kept in the resident's bathrooms or at their bedside locked if the resident could independently transfer without assistance. LVN B revealed wheelchairs for public use were kept in a separate room and should not have been kept in the common area unlocked. LVN B revealed a risk for leaving facility equipment unlocked when not in use was injury to the resident or staff. (continued on next page)

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	676329	A. Building B. Wing	08/01/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN A on 08/01/24 at 9:30 AM revealed that wheelchairs, for common use, were kept in the facility's spa room. LVN A revealed that Hoyer lifts, when not in use, were supposed to be locked and kept at the end of the hallways. LVN A revealed that every staff member was responsible for ensuring equipment was locked and safely stored. LVN A revealed that used razors should be immediately placed in the sharps container, unused razors should be kept locked in the facility's storage room. LVN B revealed a risk to improperly storing equipment could be injury to the resident or staff. Interview with CNA C on 08/01/24 at 12:36PM revealed that mechanical lifts, when not in use, were kept in the hallways and they should be kept locked. CNA C revealed that unused wheelchairs should not be kept unlocked in common areas and should be stored in the bathrooms. CNA C revealed that razor blades were kept locked in the facility's supply room, but CNA C stated razor blades as well could be kept unlocked in resident's rooms. CNA C revealed risks of improperly storing equipment could be resident's injuring or cutting themselves. Interview with the Unit Manager for Post-Acute Care on 08/01/24 at 3:00PM revealed that mechanical lifts were to be kept off the hallway and away from exit doors. Unit Manager revealed that mechanical lifts and wheelchairs should be stored and locked when they were not in use. The Unit Manager revealed that razors were kept locked in the storage closet and should never be kept in an unlocked compartment. The Unit Manager revealed that risks of improperly storing equipment could be residents potentially cutting or injuring themselves. Interview with the DON on 08/01/24 at 3:20PM revealed that all equipment including mechanical lifts and wheelchairs were to be kept in the storage room. The DON revealed that everyone was responsible for ensuring safe storage and maintenance of all facility equipment. The DON revealed that razors were to be be kept in the facility's supply room, which was locked and never to be kept in an unlocked compartment. The DON revealed that risks of improperly storing equipment could be residents potentially cutting or injuring themselves. Interview with the Administrator on 08/01/24 at 4:26PM revealed that mechanical lifts were kept at the end of the hallways, not blocking the exits or in the facility spa room when not in use. The Administrator revealed that the mechanical lifts were to be locked when not in use. The Administrator revealed that it was the facility Unit Manager's responsibility for overseeing and rounding to ensure all equipment on the unit's was stored safely and properly. The Administrator revealed that razors were kept locked in the facility's supply room, if resident's were able to safely shave themselves independently, they could keep razors in their room. The Administrator revealed that risks of improperly storing equipment could be residents potentially cutting or injuring themselves. The facility did not provide a policy related to mechanical lifts , wheelchairs or razor blade storage.

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	676329	A. Building B. Wing	08/01/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observation, interview and record review, the facility failed to provide food that was palatable for two (lunch meal 08/01/24) of four meals reviewed for palatability. [NAME] L added water to the puree recipe on 07/31/2024 . The facility failed to serve pureed mashed potatoes, root vegetable soup, purred roast beef that was palatable. The facility failed to serve mechanical chopped roast beef or root vegetable soup that was palatable. These failures could affect residents by placing them at risk of weight loss, altered nutritional status and a diminished quality of life. Findings Included: Observation on 08/01/24 at 1:05pm of lunch test tray revealed the pureed lunch was served on a tray with a cover. The purred lunch tray revealed a white ceramic container with pureed mashed potatoes, pureed roast beef, both items were in the same container in round formations. The pureed lunch was also served with a white ceramic bowl, covered by plastic which contained pureed root vegetable soup and a white ceramic bowl containing a brown sauce, which was meant for the pureed roast beef. Pureed lunch test tray revealed the mashed potatoes to be bland, texture was thick. The Pureed lunch tray revealed the root vegetable soup to be overly salty. The Pureed lunch tray revealed the pureed roast to be bland, textured was thick. Observation on 08/01/24 at 1:05pm of lunch test tray revealed the mechanical lunch was served on a tray with a cover. The mechanical lunch tray revealed mechanically chopped roast, served with a salad which contained: lettuce, tomatoes, and chopped carrots which was served with buttermilk ranch. The mechanical lunch tray was also served with carrots that were chopped into large pieces. The Mechanical lunch tray revealed the roast beef to be dry, thin consistency that resembled breadcrumbs and the flavor resembled ground beef. The Mechanical lunch tray revealed the mechanical chopped carrots to remain in whole form. In an Interview with [NAME] L on 08/01/2024 at 12:24 PM, she stated t she added water to the puree meal. She stated that she has added water to puree previously to add a softer texture to the food. She stated she was not trained or informed not to add water to the puree meals. She stated the risk/harm that could be caused in adding water to a resident's pureed meal was that it could change the taste of the meal. She stated that adding the water to a pureed recipe could also cause a resident to become ill or sick. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview with the Dietary Manager on 08/01/2024 at 12:30 PM, she stated that staff have been trained and educated not to add water when preparing the puree meals. She stated that the harm that could be caused by adding water to a puree recipe could decrease the nutritional value for the meal. She stated that added water to the puree meal could also change the taste and flavor of the meal. She stated that she would speak with the Sous Chef, and they would reeducate and train the staff on how to properly prepare puree meals. Interview with the Dietician on 08/01/24 at 1:25pm revealed she expected all meals to be served warm and flavorful. The dietician tasted the pureed mashed potatoes and stated the mashed potatoes lacked flavor that was appetizing. The Dietician revealed it was the responsibility of the kitchen staff to taste the food for palatability and flavor before the food was served to the residents. The Dietician revealed they do not follow a recipe for puree diets. The Dietician reported that the facility did not have a puree recipe. Interview with Dietary Manager on 08/01/24 at 1:30pm revealed she expected all meals to be served warm and flavorful. The Dietary Manager tasted the pureed mashed potatoes and confirmed the mashed potatoes lacked flavor. The Dietary Manager tasted the pureed root vegetable soup and stated it was too thick and too salty. The Dietary Manager tasted the mechanical roast beef and stated it resembled ground beef and the flavor did not match roast beef. The Dietary Manager revealed it was the responsibility of the kitchen staff to taste the food for palatability and flavor before the food was served to the residents. Interview with Sous Chef on 08/01/24 at 1:43pm revealed that they are limited on the flavors they can use as the company does not allow sodium enhanced seasonings. Interview with the Administrator on 08/01/24 at 4:00pm revealed it was her expectation that the food was served to the residents warm and per the diet orders. The Administrator revealed she did not try the food served for lunch on 08/01/24. Record Review of the facility policy titled, SOP Texture Modified Diets dated 01/2024, revealed that the Mechanical Soft with Ground Meat diet should be fork tender or easily mashed tableside with fork into finely chopped pieces. Pureed Diet should be pureed to a smooth consistency thick enough to mound on the plate, and [NAME] or formed to give an attractive plate presentation. Record review of the job duties of the Sous Chef for Dining Services revealed, Responsible for ensuring the efficiency quality and production of all food items, to include receiving, storage and sanitation. 3. Directs the preparation and service accuracy for all forecasted menu items to include recipes, proper food handling, food safety, temperature control, taste, consistency, diet restrictions (therapeutic and consistency when applicable) and portion control, utilizing production forecast Record review of the facility's list of residents who receive Modified Diets/Liquids included 4 Residents.

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	08/01/2024

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Continuing Care at Highland Springs	7910 Frankford Road Dallas, TX 75252

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: The facility fialed to ensure that food in the kitchen was labeled, dated and/or sealed. These deficient practices could affect 42 residents who received meals and/or snacks from the main kitchen and place them at risk for food borne illness. Findings Included: Observation of the kitchen on during the Initial Brief Tour on 07/30/2024 at 9:25 AM, revealed that inside the large freezer there was rack in the entry of the freezer that contained a silver pan of pink shrimp on a sheet pan. There was a piece of parchment paper covering the shrimp with a florescent green label dated 07/30. There was 1 open box of celery and green bell peppers that were on the bottom of the shelf. The refrigerator contained an open container of fruit cups that were unsealed. There were 3 large white containers on the floor underneath the counter that stored loose sugar, brown rice and flour. All 3 large white containers were ajar and were not sealed. The 3 large white containers were not labeled and there were white measuring scoops observed in all 3 large white containers. The ice machine had dust on the side vents. There was a white towel with red stain observed on top of the grate for the beverage dispenser for apple juice, orange juice and cranberry juices. The 4 slice Bread Toaster had crumbs on the top and bottom. The 16 ounce open containers of Seasonings of Black Pepper, Ground All Spice were not labeled and dated. On a rack in the kitchen there was 1 paper cup of coffee on a shelf in the kitchen that was unsealed. In an Interview with the Dietary Manager on 07/30/2024 at 2 PM, she stated herself and the Sous Chef are the Supervisors in the Kitchen. She stated any food that was not sealed, labeled and dated correctly can cause the potential for food-born illness to the residents and the kitchen staff. She stated her expectation was for the staff to be reeducated and trained so that the mistake was not made again. In an Interview with the Sous Chef on 07/30/2024 at 2:15 PM, he stated he was the Supervisor of the staff in the kitchen alongside the Dietician. He stated he was unaware that the vegetables, such as the green bell peppers and celery could not be stored in an open box and that was his first time hearing about that. He was directed to throw the shrimp away in the trashcan due to the Menu having seafood salad with shrimp on 08/01/2024 for the Lunch Meal. He stated that the harm to the residents ingesting freeze dried food due to incorrect food storage could be sickness and air-borne illnesses. Record review of the document, Record Learning Content for In-Service Training revealed, Infection Control: Basic Concepts, Infection Control: Enhanced Barrier Precautions, Infection Control and Food Safety Fundamentals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy for Dining Services, SOP (Standard Operating Procedure) Food | Non-Food Storage revised 02/2024, revealed Purpose/Scope: To ensure that all food and merchandise received will be properly handled and stored to maintain food safety. SOP: Food is stored in compliance with applicable federal, state and local regulations regarding sanitary storage conditions. Perishable Storage: 6. In the refrigerator, covered cooked food is to be stored on shelves above raw food to prevent cross-contamination from dripping . 8. All produce is removed from original box and stored in plastic food storage containers. Non-Perishable Storage: 6. Dry bulk foods, such as flour, sugar, and rice will be labeled and stored in metal or plastic containers with tight fitting lids. Scoops for dispensing these items will be stored separately in a holder. 7. All foods are removed from boxes and stored in proper location in the storeroom according to the order sheets. Training / Education: Education regarding this policy and procedure will be completed with appropriate personnel as needed. Ongoing training and education will be provided on an as needed basis, as determined by the employee's direct supervisor / manager. Record review of the facility's policy for Dining Services, General Services and Housekeeping, Restaurant and Cafe Cleaning dated 06/17/2024, revealed Purpose/Scope: The purpose of this policy is to establish guidelines and procedures for the cleaning of the restaurants and cafes in both Independent Living and Continuing Care. This policy aims to provide a clean, safe and sanitary environment for residents, employees, and visitors by outlining the responsibilities, schedules, and standards for restaurant and cafe cleaning. This policy applies to [NAME] Senior Living, LLC, its managed communities, and its affiliates. Definitions: High-Touch Surfaces: those that people frequently touch with their hands, which could therefore become easily contaminated with microorganisms and picked up by others on their hands. For example, door handles, light switches, and shared equipment. Policy: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is the policy of the company that restaurants and cafes shall be cleaned and disinfected in a manner which promotes a clean, safe and sanitary environment. Housekeeping is responsible for regularly cleaning all restaurants and cafes according to the procedures and schedule outlined in this policy. These areas must be kept free of litter, dust, dirt, and any visible marks or stains using approved products and techniques and should only be cleaned by Housekeeping during non-operating hours. Record review of the job duties of the Clinical Dietitian for Dining Services revealed, The Dietitian plans, develops, implements and maintains programs and systems of nutritional care.Assists in the supervision of organization, sanitation and safety of dining rooms, kitchen, storage areas, and loading dock. Record review of the job duties of the Sous Chef for Dining Services revealed, Responsible for ensuring the efficiency quality and production of all food items, to include receiving, storage and sanitation. 2. Manages daily kitchen production and food Preparation for on-time service of resident meals . 4. Supervises proper presentation of all food items and to provide maximum appeal and freshness. 7. Supervises organization and sanitation of dining rooms, kitchen, storage areas and loading dock. Record review of the job duties of the General Manager for Dining Services revealed, Manages all aspects of mealtime preparation, service and the overall efficiency of the Kitchen, Dining Room, In-Room dining program and Resident meal service in Family dining areas. a. Directly manages the overall dining program including meal service/Front of House and culinary/Back of House program (menu development, preparation, service, delivery and financial) and supports the hospitality program. b. Responsible for the overall supervision and efficiency of culinary, utility staff and service associates (including training, evaluating and disciplining). Supports supervision, direction and efficiency of meal service and hospitality with all Continuing Care staff (Care Associates, Program staff, Nursing, CC managers, etc.) c. Assures the dining program (meal service and nutrition clinical care) is in compliance with all Federal, State and Local regulations and is provided with a hospitality focus. d. Provides dining service training for functions . Essential Duties and Responsibilities: include the following. 17. Ensures that food and supplies are inventoried, ordered, received and stored according to facility standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18. Monitors preparation and service accuracy for all menu items to include recipes, proper food handling, food safety, proper temperature, taste, consistency, diet restrictions (therapeutic and consistency when applicable) and portion control using the production sheets. 19. Ensures proper presentation of all food items and to provide maximum appeal and freshness . Maintains effective communication with all managers, fell ow supervisors, subordinates and all other coworkers. 22. Ensures that food service programs are in operated in compliance with federal, state and/or local laws and statutes. Supervisory Responsibilities: Supervises the Culinary staff, Utility staff and Service Associates. Works with Care Associates, Nurses, and Program Staff. Works closely with the Clinical Dietitian. 1. Record review of facility's policy for Infection Prevention: Infection Prevention and Control Safe & Sanitary Environment revised 07/2021, revealed .5. Dining Venues: All food contact surfaces will be cleaned and sanitized after each use, between tasks and the beginning of the shift. 2. All Food Service cooking and preparation equipment will be cleaned and sanitized after each use and maintained in a clean and sanitized condition. 3. Equipment that supports cooking equipment is also included in partnership with General Services, the cleaning of these items will be scheduled accordingly and cleaned in accordance with the SOP for each item. (I.e. Hood/Baffle cleaning). 4. All food service equipment will be cleaned and sanitized following scientific cleaning procedures for each specific piece of equipment. Follow the detailed cleaning instructions per equipment .Daily, weekly, and monthly cleaning schedules will be written and followed for all food service equipment. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.