

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Continuing Care at Highland Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for three (Residents #5, #7, and #33) of six residents reviewed for care plans. The facility failed to ensure Residents #5, #7, and #33's comprehensive care plans addressed their use of psychotropic medications (drugs that affect the mind, emotions, and behavior) and related behavioral concerns as identified in their comprehensive assessments. This failure could place residents at risk of receiving inadequate interventions not individualized to their mental health care needs. 1. Record review of Resident #5's annual MDS dated [DATE], reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had severely impaired cognitive function. Diagnoses included: Alzheimer's Disease (a brain disease that slowly destroys memory, thinking, and the ability to carry out daily tasks), and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms (severe, persistent sadness and loss of interest that interferes with daily life accompanied by hallucinations or delusions), Dementia in other disease classified elsewhere, severe, with psych disturbances (a condition where dementia symptoms arise from a different underlying illness and are characterized by a severe decline in cognitive function along with psychotic disturbance). Staff assessment of Resident #5's mood reflected over the past 2 weeks showed she experienced poor appetite or overeating at a frequency of 2-6 days and self-isolating at a frequency of rarely. Record review of Resident #5's Active Physician's Orders for September 2025 reflected she was prescribed Sertraline (Zoloft, used to treat a variety of mental health conditions by increasing the level of the neurotransmitter serotonin in the brain) 100 mg tablet one time a day for depression with a start date of 06/30/2025. Record review of Resident #5's Comprehensive Care Plan dated 06/07/2025 revealed there were no goals or interventions related to her depression or Alzheimer's Disease diagnoses, behaviors associated with these diagnoses, or the use of the psychotropic medication (Zoloft) used to treat depression. 2. Review of Resident #7's admission MDS assessment dated [DATE] reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had intact cognitive function. Diagnoses included: Major Depressive Disorder, recurrent, severe with psych symptoms, (severe, persistent sadness and loss of interest that interferes with daily life accompanied by hallucinations or delusions) and anxiety disorder (ongoing uncontrollable, and excessive worry, fear, or dread that significantly interferes with daily life). Resident self-assessment of her mood reflected over the past 2 weeks showed she experienced feeling down, depressed, or hopeless at a frequency of 2-6 days. Record review of Resident #7's Active Physician's Orders for September 2025 reflected she was prescribed the following medications: Zoloft (used to treat a variety of mental health conditions by increasing the level of the neurotransmitter serotonin in the brain) 25 mg tablet one time a day for depression with a start date of 07/11/2024. Abilify (an atypical antipsychotic medication that treats certain mental and neurological conditions, it works by balancing levels of dopamine and serotonin in the brain to help regulate mood, thoughts, and behavior) 2 mg tablet one time a day to (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 - Minimal harm or potential for actual harm Residents Affected - Some	treat depressive psychosis with delusion with a start date of 05/29/2025. Record review of Resident #7's Comprehensive Care Plan dated 07/22/2025 did not reflect any goals or interventions related to her depression, anxiety or the use of psychotropic medications (Zoloft and Abilify). 3. Review of Resident #33's Quarterly MDS assessment dated [DATE] revealed she was an [AGE] year-old female admitted to the facility on [DATE] and had mild cognitive impairment. Diagnoses included: Major Depressive Disorder, Single Episode, Unspecified (a single severe bout of depression where a person experiences prolonged low mood, loss of interest, and other symptoms for at least two weeks, but there is not enough information to specify the severity of the depression). Resident self-assessment of her mood reflected over the past 2 weeks showed she experienced feeling down, depressed, or hopeless at a frequency of 2-6 days and self-isolating at a frequency of rarely. Record review of Resident #33's Active Physician's Orders for September 2025 reflected she was prescribed Lexapro (antidepressant medication used to treat certain mental health conditions by balancing serotonin levels in the brain) 5 mg tablet one time a day with a start date of 02/19/2025. Review of Resident #33's Care Plan dated 05/22/2025 revealed the care plan did not reflect any goals or interventions related to her depression diagnosis or the use of the psychotropic medications, Lexapro. In an interview with the Clinical Manager on 09/10/2024 at 12:00 PM, she explained the difference between a Comprehensive Assessment and a Comprehensive Care Plan. When a patient is admitted, staff open a holistic admission assessment, which serves as the baseline care plan. Once all disciplines complete their sections, the holistic was closed and a Comprehensive Care Plan was opened, carrying over the information. However, she noted that at times the incorrect button was clicked, preventing old information from transferring into the new care plan. The Clinical Manager stated that everything included on the interim care plan should be reflected in the Comprehensive Care Plan, including medications such as antipsychotics, antidepressants, insulin, anticoagulants, and psychotropics. She emphasized the importance of including mental health medications, as this guides staff in understanding residents' conditions, how to approach them, and how to respond if issues arose. During an interview on 09/11/2025, at 12:45 p.m., ADON explained she was responsible overall for care plans for the facility. She stated medications such as antidepressants and antipsychotics must be reflected in residents' care plans, as that would allow the team to monitor effectiveness and determine whether adjustments in dosage may be needed. She stated that she, along with the clinical manager, ensured interventions related to psychotropic use were implemented and updated when changes occurred. The ADON emphasized that the interdisciplinary team (including the ADON, DON, social worker, therapy manager, dietician, clinical manager, and activities staff) reviewed care plans weekly to ensure accuracy, with audits also occurring once a week. While she was not aware of concerns regarding three specific residents care plans, she stated that updates are typically made as care progresses. She noted she had not spoken to the Clinical Manager directly but oversaw her work and was responsible for ensuring she understood and followed the care plan process. Record review of Care/Service Plans Policy dated 05/2021 reflected the following: Each guest/resident will have an individualized Care/Service plan developed. Care/Service Plans will include guest/resident preferences, strengths, routines, personal and cultural preferences and choices as well as clinical needs. A comprehensive person centered care plan will be developed by the Interdisciplinary Team and be completed within 72 hours of admission and will include measurable objectives, preferences, goals, any specialized services as a result of the PASARR evaluation, resident's discharge plan and will address the resident's medical, nursing, mental and psychosocial needs as identified from the resident's comprehensive assessment.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure residents were free of any significant medication errors for one (Residents #27) of two residents reviewed for medications. The facility failed to ensure LNV A administered a medication as ordered to Resident #27 by crushing Aspirin ER (used to prevent cardiovascular events like heart attack and stroke in high-risk patients) and Potassium ER Chloride (mineral supplement prescribed by a doctor to treat or prevent hypokalemia (low potassium levels); medications that should not be crushed. This deficient practice placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. Record review of Resident #27's admission record dated 09/10/25 revealed an admission date of 04/05/24 with diagnoses which included, hypertensive heart disease with heart failure, presence of cardiac pace maker, reduced mobility, peripheral vascular disease, and lymphedema (a condition characterized by swelling in the body's tissues due to a buildup of lymph fluid). Record review of Resident #27's quarterly assessment MDS dated [DATE] revealed she had a BIMS score of 15, indicating no cognitive impairment. Record review of Resident #27's care plan dated on 09/10/25 revealed, for the nurse/aide to administer medications per the orders and monitor for side effects from the medications, and the resident will not have any complications from the medications. Record review of Resident #27's physicians orders dated September 2025 revealed the physician prescribed for Resident #27 to receive the following medications: Carvedilol 25 mg 1 tablet Potassium Chloride 20 milliequivalent ER (Extended Release) , 1 tablet Aspirin 81 mg ER 1 tablet Chlortalidone 25 mg 1 tablet Thera M-plus 9 mg, Iron 400 mcg 1 tablet Systane eye drops Amlodipine 5 mg 1 tablet Observation on 09/10/25 at 09:42 AM, revealed LVN A crushed together and administered the following medications to Resident #52: Carvedilol 25 mg 1 tablet Potassium Chloride 20 milliequivalent ER (Extended Release) , 1 tablet - indicated not to crush Aspirin 81 mg ER 1 tablet - indicated not to crush Chlortalidone 25 mg 1 tablet Thera M-plus 9 mg, Iron 400 mcg 1 tablet Amlodipine 5 mg 1 tablet In an interview with LVN A on 09/10/2025 at 3:08 PM revealed she worked in the morning shift and administered medications. LVN A stated she had been in-serviced and had medications audit administering medications per the physician orders and following the five rights of medication administration. LVN A stated she was not supposed to crush medication if it indicated not to crush or if it was an ER medication. She stated she did not realize the medications were extended release. LVN A stated she was not supposed to crush the medications because the medications were supposed to be released slowly and not at once with could lead to side effects like stomach irritation. In an interview on 09/11/2025 at 12:19 PM with the DON he stated LVN A had reported to the DON that she had crushed medications that were not supposed to be crushed because they were extended releasing medications. The DON stated the staff had been in-serviced on medication administration. The DON stated the staff was not supposed to crush the extended-release medications because they were supposed to dissolve in the stomach, and they could have side effectives like stomach irritation and the medications not being effective. Review of the facility policy dated 04/2005 and titled Medication Administration, Receipt, Storage & Disposal, reflected, . Medications are administered in accordance with Nursing Standards of practice and state law. 4. Trained staff designated to administer medications will verify that he/she is administering medications using the 5 Rights of Medication Administration/Assistance and are documented immediately following completion of task for each resident. i) Right resident ii) Right medication iii) Right dose iv) Right time v) Right route .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's freezer. These failures could place residents at risk for food-borne illnesses. Observation of the facility's freezer on 09/09/24 at 9:23 AM revealed: - 1 tub of ice cream with lid open and exposed to air; - 1 box of pie crust shells open and exposed to air; - 1 box of biscuits open and exposed to air; In an interview on 09/09/2025 at 9:45 AM, the Chef stated she had been unaware that some boxes were open and exposing food to air. She admitted she did not know how to address the issue and had not realized it was a problem. The Chef explained that she was new to the position, still in training, and unsure about the facility's procedures. She added that she reported directly to the Dietary Manager, who was responsible for training her in proper food safety practices. In an interview with the Dietary Manager on 9/10/2025, at 2:00 p.m., she explained she oversaw all kitchen operations. She stated that all frozen foods were expected to be wrapped, covered, or sealed once their original boxes were opened. She stated the managers closing each night were responsible for walking through the kitchen to check labels, cleanliness, and any opened items, though no record was kept of these checks. She stated that the freezers were reviewed nightly at closing. She identified the risks of leaving frozen foods unwrapped as foodborne illness, freezer burn, contamination from exposure to bacteria or cross-contamination between raw and ready-to-eat foods, and overall loss of product quality. She emphasized that uncovered foods were discarded to prevent these risks, as improper handling could affect both safety and resident satisfaction. Review of the facility policy titled Standard Operating Procedure for Food and non-food storage, dated 04/2024 reflected the policy did not have guidelines for opened foods stored in the freezer.		