| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455861 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Landmark of Plano Rehabilitation and Nursing Cente | 1621 Coit Rd<br>Plano, TX 75075 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747<br><br>Based on observation, interview, and record review, the facility failed to ensure residents' environment remained as free of accident hazards as was possible for 1 (Resident #17) of 11 residents reviewed accident hazards.<br><br>The facility failed to ensure Resident #17's walker was repaired or replaced after it had been damaged during transport in February 2024. Resident #17 attempted to fix the walker himself utilizing zip ties, but the walker still malfunctioned and was described by Resident #17 as being scary to use.<br><br>This failure could place residents at an increased risk of accidents, such as falls.<br><br>Findings included:<br><br>Review of Resident #17's Face Sheet, dated 07/11/24, reflected he was a [AGE] year-old male who admitted to the facility on [DATE].<br><br>Review of Resident #17's MDS Assessment, dated 04/09/24, reflected he was cognitively intact. He had diagnoses including cellulitis (a common and potentially serious bacterial skin infection), lymphedema (a chronic condition that causes swelling in the body due to a buildup of lymph fluid in the tissues), and morbid (severe) obesity due to excess calories (a BMI of 40 or greater). Resident #17 was identified as utilizing a walker for mobility purposes.<br><br>Review of Resident #17's Care Plan, dated 07/09/24, reflected there was no mention of him utilizing a walker for mobility purposes.<br><br>Observation of Resident #17 on 07/09/24 at 10:00AM revealed he was sitting up in his bed. He was clean, well-groomed, and appropriately dressed. He was free from any odors. He displayed no obvious signs or symptoms of distress. There were no concerning marks or bruises noted on his person. There were no noted concerns regarding his appearance. Resident #17 had a walker by his bedside. It was noted that the walker had two zip-ties that were placed on each side of padded backrest. The padded backrest would not stay in an upright position.<br><br>(continued on next page) |



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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with Resident #17 on 07/09/24 at 10:00AM, he stated the padded backrest of his walker was broken during a transport in February 2024. He said although he advised the Social Worker and someone in the therapy department that the walker had been broken, the facility had not yet repaired the walker. He said he had been asking consistently for months for his walker to be repaired. He stated he utilized zip ties to try to fix the walker himself, but the padded backrest still would not stay in an upright position. Resident #17 stated this made the walker scary to utilize, as he used the padded backrest as support on a regular basis.<br><br>During an interview with the Social Worker on 07/10/24 at 10:32AM, he stated in February 2024, Resident #17 advised that the padded backrest of his walker had been broken during transport with an independent transport company. The Social Worker stated he advised the therapy department that the walker had been broken and needed either repair or replacement. The Social Worker stated he did not believe there was a risk of the padded backrest of Resident #17's walker being broken, as Resident #17 did not get up and out of bed on a regular basis.<br><br>During an interview with the Director of Rehabilitation on 07/10/24 at 10:41AM, he stated he had not been made aware that the padded backrest of Resident #17's walker was previously broken during transport. He stated the facility was in the process of getting Resident #17 approved for a motorized wheelchair. The Director of Rehabilitation stated the risk of the padded backrest of Resident #17's walker was low, as there were other mechanisms of support included on the walker.<br><br>During an interview with the Director of Nursing on 07/11/24 at 1:20PM, she stated she had not been advised that the padded backrest of Resident #17's walker was broken until 07/10/24. The Director of Nursing stated the facility would be replacing Resident #17's walker. The Director of Nursing stated an improperly functioning and/or broken walker included an increased risk of falls.<br><br>A policy regarding the repair of assistive devices was requested on 07/11/24, but the Administrator advised during the exit conference on 07/11/24 that such a policy was unable to be located. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193<br><br>Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #25) reviewed for gastrostomy tube management.<br><br>The facility failed to ensure Resident #25 was provided with the correct water flushes before and after medication administration through a gastrostomy tube (g-tube, feeding tube).<br><br>This failure could place residents who received medications by gastrostomy tube at risk for injury, aspiration into the lungs (fluid or food enter the lungs accidently), decreased quality of life, hospitalization and decline in health.<br><br>The findings included:<br><br>Record review of Resident #25's face sheet dated 7/11/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), dysphagia oropharyngeal phase (difficulty swallowing occurring in the mouth and/or the throat), major depressive disorders.<br><br>Record review of Resident #25's most recent quarterly MDS assessment, dated 5/20/24 revealed the resident did not have cognitively impaired for daily decision-making skills and required a feeding tube.<br><br>Record review of Resident #25's Order Summary Report, dated 7/11/24 revealed the following:<br><br>- NPO (Nothing by mouth), with order date 5/19/24 and no end date<br><br>-Enteral Feed Order every shift Flush tube with 30 ml water before and after medication and feedings with an order date 4/2/24.<br><br>-Enteral Feed Order every shift Flush with at least 5mls of water between each medication with an order date 4/2/24.<br><br>Record review of Resident #25's comprehensive care plan, revision date 4/12/24 revealed the resident had a g-tube in place related to swallowing problem.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 7/10/24 at 9:35 AM revealed LVN C administrating medications via feeding tube to Resident #25. LVN C crushed the following medications in different medication cups and mixed with about 5 cc - 10 cc of water: Zoloft 25 mg 1 tablet, Allegra 180 mg 1 tablet, Folic acid 1 mg 1 tablet, multi-vitamin 1 tablet, Vitamin B-12 1 tablet, Eliquis 5 mg 1 tablet, Digoxin 0.125 mg 1 tablet. LVN C then checked for placement (nurses are responsible for ensuring that g-tubes are placed correctly before using them for medication administration) and then flushed with 30 cc of water (flushing prevents blocking of the tube). LVN C then proceeded to administer medications and did not flush in between each medication administration. LVN C then flushed with 30 cc of water after medication administration.<br><br>In an interview on 7/10/24 at 9:52 AM with LVN C regarding flushing after each medication administration, she stated she did not need to flush after each medication and the orders did not indicate to flush, and she stated she would review the orders again.<br><br>Follow up interview on 7/11/24 at 10:37 AM LVN C stated she was supposed to flush with 5cc of water after each medication administration. LVN C stated she assumed the 5cc was the water she used to mix with the medications, but she realized after physician order review, she was supposed to flush after each medication administration. LVN C stated she had not received any recent in-service on medication administration via the feeding tube.<br><br>In an interview on 7/11/24 at 01:20 PM with the DON stated the nurse was expected to follow the physician orders and the DON expected the nurse to flush after each medication to make sure that the medications were going in and to prevent medication interactions. The DON stated LVN C was supposed to follow the physician orders. Not following the doctor's orders could result in infection, medication residue, drug interactions, or patient discomfort. The DON provided proficiency audit for different skills completed by the LVN C on 5/11/24 and indicated the nurse completed a skill on g-tube medication administration.<br><br>In an interview on 7/11/24 at 2:00 The Director of Nursing stated they did not have a policy specifically for medication administration via the feeding tube. |