STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455864	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for one (Resident #1) of four residents reviewed for accidents and hazards. The facility failed to ensure that Resident #1's fall mat was placed on both sides of his bed as noted in his care plan. This failure could put residents at increased risk for accidents and injury. Findings include: Review of Resident #1's face sheet dated 04/30/2024 revealed a [AGE] year-old male admitted on [DATE]. Resident #1's medical diagnoses included traumatic hemorrhage of cerebrum (brain dysfunction due to head trauma), protein-calorie malnutrition, muscle weakness, history of falling, vascular dementia. Review of Resident #1's Comprehensive MDS dated [DATE] reflected in Section C - Cognitive Patterns, the resident was rarely or never understood, had short-term and long-term memory problems, and did not make daily decision-making due to severely impaired cognitive skills. Review of Section V-Care Area Assessment Summary reflected falls were a triggered care area. Review of Resident #1's Comprehensive Care Plan initiated 03/11/2024 revealed the resident was at risk of falls. Interventions for the resident's risk of falls included: floor mat window side with an initiated date of 03/14/2024 and floor mats both sides of the bed with an initiated date of 03/18/2024. Observation on 05/01/2024 at 10:41 AM revealed Resident #1 was lying in bed and was non-interviewable with no fall mat on either side of his bed. Observation revealed two fall mats rolled up and propped up in the corner of the room next to the window and resident's bed. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/01/2024 at 10:50 AM with Nurse Aide A revealed Resident #1 had a history of falls and was supposed to have the floor mats on both sides of his bed. Nurse Aide A stated she rolled the fall mats up because she planned to get Resident #1 up in the wheelchair but needed to go find another staff member to assist her in transferring resident. Nurse Aide A stated it was her responsibility to put the fall mats back when she left the room. Nurse Aide A stated she should have put the fall mats back down while she went to find assistance and was helping other residents. Nurse Aide A stated the risk to the resident was injury if he fell out of the bed without the fall mat. Interview on 05/01/2024 at 11:30 AM with LVN B revealed Resident #1 was supposed to have floor mats on both sides of his bed because he was a fall risk and floor mats reduce injury if he fell out of bed. LVN B stated Nurse Aide A should have placed the fall mats back on the floor if she had to leave the room to get assistance. LVN B stated the resident could have been injured if he fell without a floor mat. LVN B stated it was Nurse Aide and Nurses responsibility to ensure floor mats were used for residents at risk of falls. Interview on 05/03/2024 at 2:01 PM with the DON revealed Resident #1 was at high risk for falls and should always have floor mats on both sides of his bed. The DON stated if a nurse aide needed the assistance of another staff member when caring for a resident then they should ask another staff member ahead of time, before picking up the fall mats. The DON stated if the nurse aide needed to leave the room then they should have put the fall mats back down before leaving the resident's room. The DON stated the resident could have fallen out of bed and been injured. The DON stated the nurse aide was a newer employee and would be in-serviced immediately. Interview on 05/03/2024 at 3:10 PM with the Administrator revealed if a staff member rolled fall mats up but realized they didn't have assistance with the resident then they should put the fall mats back down while they left the room to get assistance. Review of the policy titled Area of Focus: Fall Management dated reviewed 12/04/2023 reflected the facility was to promote patient safety and reduce patient falls by proactively identifying, care planning, and monitoring of patients fall indicators.

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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. 49427 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure grease trap in oven was not free of grease buildup. 2. The facility failed to ensure the sides of the stove were clean from food residue and grease build up. These failures could place residents at risk for food contamination and food-borne illness. Findings included: Observation at 04/30/2024 10:00 AM of the kitchen revealed grease trap with thick black build up that covered the outside handle of stove and a thick and sticky black build up on the inside corners and along the sides of the trap. Interview on 04/30/2024 at 10:45 AM with Cook C revealed that the stove and grease trap were supposed to be cleaned at the end of every shift, but she did not clean it or check it if she did not use the griddle top. Cook C stated it generally was cleaned by which ever cook used the griddle top, which was usually the morning shift for breakfast foods like bacon. Cook C stated she did not remember if she checked the grease trap at the beginning of her shift or before she started cooking because she did not use the griddle top for the lunch meal. Cook C observed the grease trap and stated it was not sufficiently cleaned and that the side of the oven had food residue and was unable to say if there was a risk to residents. Cook C stated it was her responsibility to clean any spills on the top of the stove that occurred on her shift during the cooking process. Observation and interview on 04/30/2024 at 3:52 PM with the Food Services Director revealed there was thick black build up that covered the outside handle of the grease trap, at the inside corners, sides, and there was food residue and grease build up on both sides of the oven and the fryer next to the oven. The Food Services Director stated the grease trap and stove were not fully cleaned and they should not have any residue or grease. The Food Services Director stated it was the cook's responsibility to clean the stove including scraping any thick areas of greasy residue and cleaning the sides of the oven. The Food Services Director stated it was his responsibility to ensure the equipment was cleaned properly. The Food Services Director stated he had taken down the cleaning checklist to review it, could not currently locate the document, and the current cleaning check list posted was for the previous week dated 04/15/2024 through 04/22/2024. The Food Services Director stated the cleaning schedule was posted in the kitchen and staff check off tasks they completed at the end of every shift, including cleaning the stove and did not currently check routinely that staff were cleaning thoroughly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/01/2024 at 9:12 AM with the Food Services Director revealed the risk to residents when stoves and grease traps were not cleaned were food contamination and it could be a hazard. The Food Services Director provided the cleaning check list and stated he added the cleaning task cleaning grease traps and in-serviced staff on cleaning kitchen equipment. The Food Services Director stated he took the stove out completely the evening of 04/30/2024 and degreased the grease trap. Observation on 05/01/2024 at 12:30 PM of the kitchen stove revealed there was food residue and grease on both sides of the stove and grease trap had same amount of thick black residue on inside corners. Interview on 05/01/2024 at 12:33 PM with Cook D revealed the stove had food residue on both sides and grease trap had thick grease build up on the inside corners. Cook D stated she does not clean certain areas of the stove, such as the flat top and grease trap, because she does not use them when she cooks lunch. Cook D stated that whichever cook uses the flat top was responsible for cleaning it after each use. Cook D was unable to say if there was a risk to resident by having food residue on sides of stove and uncleaned grease traps. Interview on 05/01/2024 at 12:45 PM with Cook E revealed he usually worked on the morning shift and used the flat top regularly for items like sausage or bacon. Cook E stated he empties the grease trap at the end of each shift, and it currently was sufficiently cleaned. Interview on 05/01/2024 at 1:25 PM with the Food Services Director revealed the grease trap had been scrapped clean and he had to use a putty knife to get the substance free and expected Cook's to check the grease trap and clean it including scrapping if needed to ensure it was free of any residue. Review of the posted cleaning schedule titled Daily Cleaning Week of 4/15-4/22 reflected cleaning stove top and grill were the cook's responsibility. Review of the facility's policy on cleaning titled Cleaning Schedule dated 10/04/19 and reviewed on 04/25/2023 reflected The Director of food and Nutrition Services develops a cleaning schedule . to ensure that the Food and Nutrition Services department remains clean and sanitary at all times. Review of the US Public Health Service, Food Code, dated 2017, retrieved on 10/25/22, reflected the following regarding Equipment, Food-Contact Surfaces and Nonfood-Contact Surfaces, equipment food-contact surfaces and utensils shall be clean to sight and touch .the nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.