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	11/08/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092 Based on interview and record review, the facility failed to ensure 1 of 1 members of the facility staff were able to demonstrate competency in the provision of skills and techniques necessary to provide quality care as outlined by the comprehensive care plan for 1 of 1 residents reviewed for plans of care. (Resident #1). The facility failed to ensure the staff providing activities of daily living (ADL) care were knowledgeable and competent on the facility's transfer and repositioning policy; Certified Nurse Aide (CNA) A grabbed Resident #1's neck to reposition him in bed, which resulted in the facial grimacing. The noncompliance was identified as past noncompliance (PNC). The facility identified the noncompliance on 9/5/2024 and corrected the noncompliance on 9/9/2024 before the investigation began on 11/7/2024. This deficient practice placed 1 resident with an ADL self-care performance deficit at risk of injury by not receiving care and services in accordance with resident care plans, facility policy, and state professional standards. Findings include: (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's Care Plan, dated 9/16/24, revealed Resident #1 was a [AGE] year old male admitted to the facility on [DATE] with diagnoses of being cognitively impaired (difficulty with thinking, learning, remembering, and making decisions), dementia unspecified severity without behavioral disturbance (a medical condition that causes a person to lose cognitive functioning without behavioral disturbances), psychotic disturbance (severe mental disorders that cause abnormal thinking and perceptions), mood disturbance and anxiety (mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), cognition deficit (a person's impaired ability to think, learn, remember, and make decisions), schizoaffective disorder bipolar type (experiences both schizophrenia and a mood disorder, specifically bipolar disorder), major depressive disorder single episode unspecified (a mental condition that's diagnosed when someone has experienced a single depressive episode and no other previous episodes), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), unspecified dementia with behavioral disturbance (a diagnosis for dementia that doesn't have a specific diagnosis and has behavioral disturbances), generalized anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), delusional disorders (type of mental health condition in which a person can't tell what's real from what's imagined), adjustment disorder with mixed disturbance of emotions and conduct (adjustment disorder where a person experiences both significant emotional symptoms like anxiety or depression alongside behavioral issues like acting out, aggression, or rule-breaking, all in response to a stressful life event), pain disorder with related psychological factors (a somatoform disorder in which pain is a somatization independent from depression, anxiety or delusion), vascular dementia with behavioral disturbance (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), psychotic disorder with delusions due to known physiological condition (hallucinations or delusions that are caused by another medical disorder), and other speech disturbances (problems creating or forming the speech sounds needed to communicate with others). Record Review of Resident #1's Minimum Data Sheet (MDS), dated [DATE] revealed Resident #1 received a Brief Interview of Mental Status (BIMS) of 99. This indicates that Resident #1 was not able to complete the interview. Record Review of Resident #1's Care Plan, dated 9/16/24, revealed Resident #1 has an ADL self-care performance deficit related to Activity Intolerance, Dementia. Resident #1 Requires assistance with Activities of Daily Living (ADL's) as needed. ADL's Include: - Bed Mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed (2-4 hours) and as necessary, - BED MOBILITY: Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; and frequent repositioning. Further review revealed the care plan the family made an allegation of abuse on 9/05/2024. Resident #1 was transferred to a new hall at the family's request and CNA A was suspended. CNA A completed inservice's on transfers and repositioning. The facility took the following actions to correct the non-compliance: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility reported incident dated 9/5/2024 revealed the facility self-reported the allegation of abuse. The report stated the resident had no injuries or marks, and there was no reported emotional distress. The report alleged on 9/5/2024 at 8:45 AM, CNA A forcibly grabbed Resident #1's neck to pull him up in the bed before feeding him. The facility notified the physician and family, suspended the alleged perpetrator, assessed resident, conducted staff interviews, resident safe surveys, and conducted abuse prevention Inservice's. Record review of Progress Note dated 9/5/24 revealed a head-to-toe skin assessment was completed on 9/5/24. The wound care nurse performed the daily treatment, no new skin problems were noted, the back and neck area of the skin were normal. Record Review of the Witness Interview / Statement Form dated 9/5/24 written by CNA A, revealed that CNA A stated she entered Resident #1's room around 8:45 AM to assist with breakfast. CNA stated Resident #1 was leaning over to the left side of his bed. CNA A stated she held his shoulders to try to reposition him, but he resisted so CNA A left him leaning to his side. CNA A then went on to start feeding Resident #1 juice and coffee. CNA A also fed Resident #1 eggs, bacon, sausages, and toast. At 9 AM Resident #1's sitter arrived and took over the feeding. Record review of Abuse & Neglect In-service Form dated 9/9/24 revealed that the Director of Nursing performed in-service training to CNA A on 9/5/24. Record review of Safe Survey Forms dated 9/5/24 revealed that Safe Survey interviews with residents at the facility were completed by the Director of Nursing on 9/5/24. The interviews revealed that the residents have not been a victim of abuse and neglect at the facility, the residents were treated with dignity and respect at the facility, and the residents felt that the staff did care about them. Record Review of the Video Recording reviewed on 11/7/24 at 2:12 PM revealed that CNA A grabbed Resident #1 on the left side of his neck while he was leaned over on his left side. This was an attempt to reposition Resident #1 so that he would be sitting up straight in his bed. When CNA A pulled on Resident #1, he grimaced and appeared to be in pain for a moment. Interview on 11/7/24 at 2:01 PM with Familiar Party D revealed that CNA A grabbed Resident #1 by the neck to reposition him. She stated CNA A went into the room and saw Resident #1 leaning to the side. CNA A then immediately grabbed Resident #1 by the neck to move him so that he was sitting up straight. She stated she has a video recording of the incident and t Resident #1 grimaced on the video at the time that he was pulled by the neck. She stated the incident did not cause injury. She thought it was out of laziness and inappropriateness. Attempted Interview on 11/7/24 at 2:45 PM with Resident #1 revealed that Resident #1 was cognitively impaired and not able to verbally communicate effectively. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/8/24 at 10:30 AM with the Director of Nursing C revealed that he was aware of the incident involving CNA A and Resident #1. He stated that he understood why the repositioning of Resident #1 by CNA A during his was inappropriate. He stated that Resident #1's family member has complained multiple times about him leaning so the staff felt like it was necessary to reposition him so that he could be sitting up straight. He stated that the family member often made comments such as he is leaning; how could you leave him like that. The staff have been trained to reposition him so that it meets his needs. He stated that after the incident occurred the facility immediately removed CNA A. He also stated that although CNA A has returned to the facility, she does work on Resident #1's hall any longer. He stated the facility performed an in-service on turning and repositioning after this incident occurred. He also stated Resident #1 now required a second person go in to help with positioning and transfers. He stated that CNA A understood why she was being suspended and separated from Resident #1. He stated the staff were also trained to contact somebody else for help if they had questions about repositioning. Director of Nursing C stated If I was by myself, I would use either the sheets or use the hand on his shoulder. Don't go to his neck or head area to reposition. He stated that CNA A should not have grabbed Resident #1 by his neck. The facility did perform an assessment to check for injury. There was no redness. There were no signs or symptoms of pain. Interview on 11/8/24 at 11:00 AM with Administrator B revealed that he was aware of the incident involving CNA A and Resident #1. He stated that the facility performed a self-report and suspended CNA A while the facility performed an investigation. He stated that CNA A performed Inservice training on how to properly perform transfers and repositioning when she returned. He believed that the incident occurred because CNA A was trying to reposition Resident #1 so that he was more comfortable. He stated that the family will complain if they see Resident #1 leaning over in bed. He stated that the family will make comments like why do you leave him leaning. He stated that normally if the resident was at an angle the staff should have laid the resident down to pick him up another way. He claimed that CNA A only pulled on Resident #1's neck one time. The staff stopped after they attempted to reposition him and realized that he was resisting and would not sit up straight. Interview on 11/8/24 at 11:52 AM with CNA A revealed she went into Resident #1's room to perform his breakfast feeding. Resident #1 was leaning sideways in the bed. CNA A stated that she wanted to reposition his head so that he could straighten up. CNA A stated the family always complained about him leaning. CNA A stated Resident #1 can control his head. CNA A stated when she tried to reposition him, she grabbed him by his neck and pulled to straighten him up, it did not work so he went back to his starting position again. CNA A left the resident in that position because she thought that he was comfortable that way. She stated that he was fine. He had no injury. CNA A stated that on the same day the DON called to ask her about the repositioning. Resident #1 has video monitoring in his room. CNA A explained what happened and the facility separated her from Resident #1. The staff performed an Inservice for repositioning. She stated that the DON also said that if the resident was total assistance, the staff need to get two people for repositioning. Get another CNA or nurse. She stated that she was told not to grab anyone by the neck again. Record Review of the Facility Transfer and Reposition Policy revised on 9/19/24, states that while repositioning in bed staff should not pull from head of bed and that manual patient repositioning was dangerous.