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	04/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for comprehensive care plans.The facility failed to ensure Resident #1's preferences related to television channels and volume; room temperature and bed position were included in his care plan. This failure could place residents at risk of their preferences not being honored and feeling uncomfortable in the facility. Record review of Resident #1's comprehensive care plan, revised on 12/19/25, reflected . [Resident #1] has an ADL self-care performance deficit r/t Activity Intolerance, Dementia (a decline in mental ability) Date Initiated: 07/15/2024 Revision on: 12/19/2025 [Resident #1] will maintain current level of function in (ADLs) through the review date. Date Initiated: 07/15/2024 Revision on: 03/03/2026 Target Date: 01/12/2026 Assist resident to bed Daily after lunch (between 1-2pm) Date Initiated: 07/15/2024 LVN to provide nail care as indicated Date Initiated: 03/10/2026 Provide meal trays for all three meals. (even when family brings outside food for the resident) Date Initiated: 07/15/2024 Turn off lights and television at bedtime. Date Initiated: 08/09/2024.[Resident #1] is dependent on staff formeeting his cognitive stimulation needs, social needs. Date Initiated: 06/02/2021.The resident's preferred activities are: watching television, having visits by his family/sitter and ice cream snacks. Date Initiated: 07/09/2024 Revision on: 01/13/2025.[Resident #1] has an ADL self-care performance deficit r/t Activity Intolerance, Dementia Date Initiated: 07/15/2024 Revision on: 12/19/202 Resident #1 will maintain current level of function in (ADLS) through the review date.Date Initiated: 07/15/2024 Revision on: 03/03/2026 Target Date: 01/12/2026.Bed Mobility: Ensure feet are not touching foot board when in bed Date Initiated: 07/15/2024 Revision on: 07/15/2024 Bed Mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed (2-4 hours) and as necessary Date Initiated: 07/15/2024. Resident #1's care plan had not included his preferences for his television to be on channel 54 or 55 and the volume at 30, the air conditioner to be set at 71 or 72 and his head to always be raised. Record review of Resident #1's Quarterly MDS assessment, dated 3/16/26, reflected the resident was rarely understood and therefore his cognition was not assessed. The resident was totally dependent on others for all self-care needs.Record review of Resident #1's face sheet, dated 4/9/26, reflected an [AGE] year-old male with an admission date of 10/2/22. The resident had the following active diagnoses: muscle weakness, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients), peripheral vascular disease (a progressive circulation disorder involving damage to blood vessels), gastroparesis (a chronic disorder where stomach muscles work poorly slowing or stopping the movement of food), generalized anxiety disorder (a condition characterized by excessive, uncontrollable and persistent worry) and dysphagia (difficulty swallowing). An observation of Resident #1 room on 4/9/26 at 11:20 AM revealed several posters in the room with statements of Resident #1's preferences. Poster #1 reflected Always elevate head. Poster #2 reflected Turn on TV if (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 - Few	awake on channel 54 or 55 and volume level at 30. Poster #3 reflected Please keep temperature at 71/72, heat when cold outside and cool when hot outside. Surveyor attempted to interview Resident #1 but he was unable to respond to questions. An interview with CNA A on 4/9/26 at 1:18 PM revealed she assisted the CNA with but was not his regular CNA. CNA A stated Resident #1's family had a lot of preferences and there were a lot of notes in the room that told them Resident #1's preferences.An interview with CNA B on 4/9/26 at 1:27 PM revealed she worked with Resident #1 daily and was familiar with his preferences. CNA B stated Resident #1 wanted his TV on, all the time, but should be muted when asleep, which included at night. CNA B stated Resident #1's head should have been up all the time except when they cleaned him up or took care of him. CNA B stated Resident #1 had to always have his head up because he would throw up. The CNA stated Resident #1's air conditioner should not be up but could not explain the right temperature. CNA B stated she had no access to Resident #1's care plan. An interview with LVN C on 4/9/26 at 1:41 PM revealed she would determine a non-verbal resident's preferences based on the family's request. LVN C stated there was no specific plan in the residents' medical record that list resident's preferences and did not look at Resident #1's care plan. LVN C was unable to state the importance of listing the residence preferences in the care plan because she stated she had not completed any portion of the care plan and had not looked at the care plan. An interview with Agency LVN D on 4/9/26 at 2:02 PM revealed it was her fist time working with Resident #1 and she stated she learned about his preferences when the previous nurse gave her report at the end of her shift. Agency LVN D stated she was told Resident #1 did not like to be woken before 8 and was assisted feed. Agency LVN D stated those were the only two things provided during report from the previous nurse, however Resident #1 had a bunch of signs on his walls in his room that would tell her what he liked. Agency LVN D stated if the signs were not there she would not have known about his preferences and would have expected the previous nurse to provide that information during report. Agency LVN D stated she had never looked at a resident's care plan. An interview with Resident #1's relative on 4/9/26 at 2:30pm revealed she had put the posters up with Resident #1's preferences for his bed, the air conditioner and the TV. The relative stated she was tired of reminding the staff what Resident #1 liked. The relative stated she had expressed these preferences to staff several times and had finally decided to put posters up so all staff would be on the same page with Resident #1's care. The relative was unable to state when she had put the posters up but stated it was in the last couple of weeks. An interview with MDS Nurse Coordinator E on 4/9/26 at 3:55 PM revealed she was familiar with Resident #1 but had not completed his care plan. MDS Nurse Coordinator E stated she had seen all the posters in Resident #1's room with his preferences and believed those should have been on his care plan. MDS Nurse Coordinator E stated she was unsure of how long the signs had been up, but as soon as a nurse or staff had seen them they should have notified the MDS Nurse Coordinators. MDS Nurse Coordinator E reviewed Resident #1's care plan and stated he did not have anything listed for the temperature of his room, his head needing to be elevated or anything about his preference for TV channels and volume level. MDS Nurse Coordinator E stated these preferences should have been added to the Care Plan immediately, as soon as staff were made aware of them. MDS Nurse Coordinator stated it was the responsibility of MDS Nurse Coordinator F to update Resident #1's preferences in his care plan. MDS Nurse Coordinator E stated the purpose of care plans was to inform the resident plan of care while at the facility. MDS Nurse Coordinator E stated nurses had access to the care plans in the event they were unsure of the residents' care. MDS Nurse Coordinator E stated the risk to the residents of their preferences not listed on the care plan would have been an effect on their comfort and safety at the facility. An interview with the DON on 4/9/26 at 4:13 PM revealed the expectation was all preferences stated by residents or their representatives should have been listed on the care plan. The DON stated all of Resident #1's preferences on the posters on his walls should have been listed on his care plan. The DON stated it was the responsibility of everyone (nurses, DON, and ADON) to update residents' preferences in their care plans. The DON stated if a resident's preferences were not listed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the Care Plan, then the care plan was considered incomplete and the resident could miss out on special care he required. An interview with the Administrator on 4/9/26 at 4:34 PM revealed preferences the resident or representative had should have been listed in the resident's care plan. The Administrator stated if the preferences were not in the care plan it could affect the comfort of the resident and the facility providing a home-like environment for them. The Administrator stated it was the responsibility of the MDS coordinators to update resident preferences in the care plan.An interview with MDS Nurse Coordinator F on 4/9/26 at 4:59 PM revealed she completed Resident #1's care plan. MDS Nurse Coordinator F stated she was aware of all the posters in Resident #1's room but had not paid attention to what they stated. MDS Nurse Coordinator F stated any preferences Resident #1 had should have been included in his care plan, however she stated no one told her to add the preferences he had on the wall to the care plan. MDS Coordinator F stated care plans should have been individualized and therefore if preferences were not included in the care plan, then the plan was not individualized and could affect the wellbeing of the resident. MDS Nurse Coordinator F stated preferences should have been updated as soon as the staff were made aware of them. A record review of the facility's policy Person Centered Care Planning, revised 8/29/25, reflected .Each resident will have a person-centered comprehensive care plan developed and implementedto meet his or her preferences and goals, and address the resident's medical, physical, mental andpsychosocial needs.