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	04/24/2025

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 - 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** 34399 49427 Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to attain or maintain the resident's highest practicable mental and psychosocial well-being for 3 of 10 residents (Resident #73, #4, and #14) reviewed for Care Plans. 1. The facility failed to ensure Resident #73's comprehensive care plan reflected her psychotropic medications and ADL dependence. 2. The facility failed to ensure Resident #4's comprehensive care plan included her preference for bed baths and her specific ADL assistance needs. 3. The facility failed to ensure Resident # 14 care plan reflected she preferred her family member, Resident #33, to assist her with eating and assistance with activities of daily living. These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. Review of Resident #73's Admission MDS dated [DATE] reflected Resident #73 was admitted to the facility on [DATE] with diagnoses of hypertension, dementia, malnutrition, depression and cognitive communication deficit. Resident #73 had a BIMS of 3 indicating he was severely cognitively impaired. Resident #73 was dependent with ADLs of hygiene, showering and dressing. Review of Resident #73's telephone physician order dated 04/03/25 reflected Resident #73 was taking Depakote 125 po BID for diagnosis of Impulse Disorder. Review of April 2025 MAR reflected Resident #73 was administered Depakote as ordered by physician. Observation on 04/08/25 at 12:11 PM revealed Resident #73 sleeping in the recliner. (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	Interview on 04/08/25 at 12:14 PM with CNA Y revealed Resident #73 was dependent on staff for assistance in transfers and other ADLs. Interview on 04/10/25 at 2:02 PM with DON revealed Resident #73 was dependent with ADLs and it should be care planned so the staff were aware of his assistance needs. DON stated he could not find the Depakote medication care planned for Resident #73. Interview on 04/10/25 at 02:20 PM with MDS Coordinator A revealed Resident #73 should be care planned for total assistance for ADL care and recently had a decline. She stated Resident #73 should be care planned for his psychotropic medication of Depakote with interventions. 2. Review of Resident #4's face sheet undated reflected Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with included diagnoses of heart disease, type 2 diabetes and hypertension. Review of Resident #4's Quarterly MDS dated [DATE] reflected Resident #13 had a primary diagnosis of type 2 diabetes. She had a BIMS of 13 indicating she was cognitively intact. Resident #4 required substantial/maximal assistance with personal hygiene and dependent with ADLs of toileting, showering and dressing. Review of Resident #4's comprehensive care plan last revised on 11/25/24 reflected Resident #4 is at risk for falls. Intervention included to assist with ADLs as needed. It did not reflect specifically what type of assistance needed for ADLs. It did not specify Resident #4 preferred bed baths. Observation and interview on 04/08/25 at 11:49 AM revealed Resident #4 lying in her bed. She stated she was provided bed baths on Monday, Wednesday and Fridays per her preference. Interview on 04/09/25 at 03:01 PM with CNA P revealed she did give resident bed baths on Mondays, Wednesdays and Fridays on her shift per resident preference. Interview on 04/09/25 at 03:04 PM LVN B revealed Resident # 4 required assistance with ADLs and preferred bed baths. Interview on 04/09/25 at 3:06 PM with LVN C revealed Resident #4 was dependent on staff for her ADL assistance needs. Interview on 04/10/25 at 2:02 PM with DON revealed Resident #4's ADL assistance needs should be care planned. DON stated it was important for resident care plans to be person-centered and specific about ADL assistance needs and psychotropic medications so staff would be aware of resident needs and to include interventions specific to these areas. Interview on 04/10/25 at 02:20 PM with MDS Coordinator A revealed Resident #4's ADL care should be care planned she needed assistance with ADLs. She stated the care plan should be person-centered to reflect Resident #4's needs. 3. Record review of Resident #14's Comprehensive MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of quadriplegia (paralysis of all limbs) and hypotension (low blood pressure) and a BIMS score of 12 (moderately impaired cognition). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #14's care plan revealed she had little to no activity involvement due to physical limitations, dated 12/10/24, interventions included prefers to socialize with: [Resident #33] who lives in the room with her . There were no focus areas that addressed Resident #14's preference to be fed and provided assistance with other activities of daily living by Resident #33. Record review of Resident #33's Quarterly MDS, dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of type 2 diabetes (varying blood sugar level), dementia (loss of cognition), hypertension (high blood pressure) and a BIMS score of 10 (moderately impaired cognition). Record review of Resident #33 care plan revealed he had anxiety and interfered with Resident #14's care, dated 02/06/25. Interventions included educate resident/family caregivers of the possible outcome(s) of not complying with treatment of care .give clear explanation of all care activities prior to assisting spouse and as they occur during each contact . provide resident with opportunities for choice during care provision. Observation and interview on 04/08/25 at 10:15 AM revealed Resident #14 was lying in bed and Resident #33 was seated in a wheelchair next to her bed. Resident #14 stated there were times that it seemed like staff knew he wanted to be involved in Resident #14's care and sometimes other staff did not know. Resident #33 stated that she agreed and preferred for Resident #33 to assist with her care as much as possible, including when she ate. In an interview on 04/10/25 at 11 AM with Restorative Aide I revealed Resident #14 and Resident #33 ate in their room and Resident #14 preferred for Resident #33 to feed her. In an interview on 04/10/25 at 11:36 AM with the Activity Director revealed Resident #14 preferred to be fed by Resident #33. She stated it was important for Resident #14's preferences to be care planned so that all staff were aware of her preferences and that the MDS Coordinator was responsible for the care plans. In an interview on 04/10/25 at 11:45 AM with RN G revealed Resident #14 preference to be cared for by Resident #33 should be care planned because care plans should be person centered. In an interview on 04/10/25 at 2:24 PM with the MDS Coordinator revealed it was not care planned that Resident #14 preferred Resident #33 to feed her or provide support in activities of daily living. She stated Resident #14's preferences should have been care planned because care plans are supposed to be person centered to ensure resident preferences were honored. She stated that care plans are updated during quarterly reviews and as changes occurred. In an interview on 04/10/25 at 2:50 PM with the Administrator revealed Resident #14's preference for Resident #33 to be involved in her care as much as possible should have been care planned because care plans were supposed to be person centered to ensure resident preferences were honored. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of comprehensive care plan policy titled, Resident Assessment Instrument & Care Plan Development, dated reviewed 09/05/2024, reflected .Procedure . 8. The information identified using the MDS and Care Area Assessment process is used to develop an individualize person-centered Care Plan that includes the patient's voice, the patient's goals while residing in the facility and for discharge that assist the patient to attain and/or maintain their highest practicable level of well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #4 and Resident #289) of 8 residents reviewed for ADLs. 1. The facility failed to ensure Resident #4 had her fingernails cleaned and trimmed on 04/08/25 and 04/09/25. 2. The facility failed to ensure Resident #289's nails were cleaned and trimmed on 04/10/25. The facility failed to ensure Resident #289's facial hair was shaved on 04/10/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1. Review of Resident #4's face sheet undated reflected Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with included diagnoses of Heart disease, type 2 diabetes and hypertension. Review of Resident #4's Quarterly MDS dated [DATE] reflected Resident #13 had a primary diagnosis of type 2 diabetes. She had a BIMS of 13 indicating she was cognitively intact. Resident #4 required substantial/maximal assistance with personal hygiene. Review of Resident #4's comprehensive care plan last revised on 11/25/24 reflected Resident #4 has Diabetes. Resident #4 is at risk for falls. Intervention included to assist with ADLs as needed. Review of Resident #4's podiatrist visit documentation dated 02/17/25 reflected Resident #4 had diabetes and podiatrist debrided corn/callous and toe nails on this visit. It did not reflect fingernails were trimmed. It reflected visit as medically necessary but no sooner than 60 days. Observation and interview on 04/08/25 at 11:49 AM revealed Resident #4 lying in her bed with her fingernails in both hands were approximately 0.5 inch in length extending from the tip of her fingers, and dark brown substance underneath the nails. Resident #4 stated she needed her fingernails trimmed and could not recall the last time they were trimmed. She stated no one had asked her to trim her finger nails. She stated she was given bed baths on Monday, Wednesday and Fridays. She stated the CNA had not trimmed her fingernails. Observation on 04/09/25 at 2:57 PM revealed Resident #4's fingernails were approximately 0.5 inch in length extending from the tip of her fingers with a dark brown substance underneath the fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/09/25 at 03:01 PM with CNA P revealed she did not trim the fingernails since Resident #4 was a diabetic. She stated she did give resident bed baths on Mondays, Wednesdays and Fridays on her shift. She stated she had not noticed the fingernails being long. She stated she had not communicated to the nurse about the fingernails being long. She stated nurses were responsible for trimming fingernails for diabetic residents. Interview on 04/09/25 at 03:04 PM LVN B revealed Resident # 4 was a diabetic and the podiatrist was responsible to ensure fingernails were trimmed for Resident #4. She stated Resident #4 did get bed baths on her shift on Mondays, Wednesdays and Fridays. LVN B stated she did not know when the last time Resident #4's fingernails were trimmed. She stated she would have to ask the SW to find out the last time podiatrist came to facility for Resident #4. She stated CNAs should be cleaning Resident #4's fingernails as needed. Interview on 04/09/25 at 3:06 PM with LVN C revealed nurses were responsible to ensure fingernails trimming was completed for diabetic residents including Resident #4. She stated she was not sure the last time Resident #4's fingernails were trimmed. Observation and Interview on 04/09/25 at 3:12 PM with DON revealed Resident #4 had fingernails which needed to be trimmed and cleaned. The DON asked Resident #4 if it was okay for him to trim her fingernails. Resident #4 stated she was a diabetic to the DON and she was okay with him trimming them. The DON stated charge nurses were responsible to ensure Resident #4's fingernails were trimmed. He stated podiatrist did trim fingernails for Resident #4 on visits but they only came out monthly to the facility. He stated he will get the documentation of the last podiatrist visit. He stated the risk to the resident for not getting fingernails cleaned was infection and residents not getting finger nails trimmed could place residents at risk of scratching or cut themselves. The DON stated he will start an in-service with nursing about ensuring fingernails are trimmed. He stated Resident #4's finger nails did seem dirty and needed to be trimmed. He stated he had trimmed Resident #4's fingernails before but it had been a long time. He stated Resident #4 needed to have her fingernails trimmed they were longer. Interview on 04/10/25 at 9:38 AM with SW revealed Resident #4 had seen podiatrist in February 2025. She stated podiatrist only came to facility every 2 months. Follow-up interview on 04/10/25 at 10:47 AM with DON revealed nurses were ultimately responsible for ensuring fingernails trimmed and cleaned for residents. He stated CNAs should be cleaning resident fingernails. He stated he had today started an in-service for CNAs and nurses to ensure resident fingernails trimmed and cleaned. 2. Record review of Resident #289's Face Sheet dated, 04/10/25, reflected a [AGE] year-old woman admitted on [DATE] with diagnoses of enterocolitis due clostridium difficile (inflammatory condition that affects both the small and large intestines), morbid obesity, and muscle weakness. Record review of Resident #289's MDS assessment dated [DATE], reflected Resident #289 had a BIMS 13 indicated Resident #289's cognition was intact. Further review revealed Resident #289 was dependent for showering/bathing and toileting hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #289's Comprehensive Care Plan, dated 04/03/25, reflected the following: Focus: [Resident #289] ADL assistance and therapy services needed to maintain or attain highest level of function . Interventions/Tasks: Assist with mobility and ADLs as needed. Observation and interview on 04/10/25 at 09:49 AM revealed Resident #289 had facial hair on her chin about an inch long. Resident #289's fingernails on both hands were .05-.07 cm in length extending from the tip of her fingers with dark substance underneath the nails. Resident #289 stated she would like the hair on her chin removed and her fingernails cut. She stated she never wore her fingernails long. She stated no one has asked her if she wanted the facial hair on her chin removed or her fingernails cut. She stated it does not make her feel good with hair on her chin. In an interview on 04/10/25 at 10:12 AM, CNA K stated she did not notice Resident 289's fingernails were long and dirty or that she had facial hair on her chin. CNA K stated Resident #289's fingernails needed to be trimmed and clean as well as the facial hair on her chin shaved. CNA K stated the risk to Resident #289 would be infection and Resident #289 not feeling good about herself. In an interview on 04/10/25 at 10:30 AM, LVN L stated that both nurses and CNAs were responsible for grooming and doing nail care for the residents. She stated that residents should be groomed, and fingernails should be trimmed and cleaned on shower days and as needed. She stated that long and dirty nails could lead to risk of infections. Review of facility's policy Activities of Daily Living dated 12/11/18 and last revised on 02/12/24 reflected The resident will receive assistance as needed to complete activities of daily living (ADLs). Under procedure, .For Fingernail Care, the following procedure will be followed: 1. Ensure fingernails are clean and trimmed to avoid injury and infection .4. Provide privacy and perform nail care, taking care not to trim the skin below the skin line and not to cut the skin. 49837

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 34399 49427 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #329) of 5 residents reviewed for accidents and hazards. The facility failed to ensure Resident #329 was missing from the facility for approximately 1.5 hours without any staff being aware until notified by the apartment complex staff. Resident crossed a parking lot and service road to get to the apartment complex. Review of [NAME] maps ([NAME] Maps to Apartment Complex, [NAME], TX 75075) revealed the apartment complex was about 500 feet from the facility. The noncompliance was identified as Past Noncompliance (PNC) Immediate Jeopardy on 04/24/25. The noncompliance began on 03/18/25 and ended on 03/31/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of elopements, falls, injuries, hospitalization and/or death. Findings included: Record Review of Resident #329's Discharge MDS, dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE] to another facility. He had the diagnoses of metabolic encephalopathy (brain dysfunction caused by a metabolic disorder), chronic kidney disease, and he had a memory problem with inattention behaviors that came and went. Record review of Resident #329's Admission assessment dated [DATE] reflected he was able to make himself understood and was orientated to person, place, and time. Record review of Resident #329's Elopement Risk Evaluation, dated 03/07/25 reflected resident was not at risk of elopement. He did not have a history of elopement, did not wander, and did not verbally express that he wanted to leave the facility. Record review of Resident #329's care plan reflected he was at risk for elopement and had an actual elopement, dated 03/18/25. Interventions included add resident to elopement book, frequent one on one monitoring until discharge to a secure unit, provide for safe wandering and activities to divert from exit seeking. He was at risk for falls and required assistance with activities of daily living and interventions included to assist with mobility and activity of daily living care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #329's nurse progress note, dated 03/18/25 at 6 PM by LVN M revealed Resident #329 had eloped and was brought back to the facility by staff and was assessed with no injuries or signs of discomfort. Resident #329 was moved rooms, placed on one-on-one supervision, 15-minute checks, and the Administrator, unit manager, physician, and family were notified. Further review revealed a progress note dated 03/19/25 at 10 PM by LVN M revealed Resident #329 had remained on one-on-one supervision until he was discharged to another facility. Record review of the Provider Investigation Report (PIR), dated 03/25/25, reflected an incident report, dated 03/18/25 by LVN G. Resident #329 had left the facility around 2:30 PM and was returned by the Maintenance Director at 4 PM. Staff were in-serviced on resident elopements and abuse and neglect dated 03/18/25 and included the Receptionist and LVN M. Resident #329 was assessed and showed no distress and had no injuries. He was moved to a room within eyesight of nurses' station, placed on one-on-one monitoring until discharged on [DATE] at 6:20 PM. The facility notified the physician and resident representative. Further review of PIR reflected an employee education form, dated 03/26/25, for the Receptionist with training that included the elopement policy, patient identification binder, reviewing the updated daily census, online training on elopements and reviewing and putting pictures of new residents who are at risk in the patient binder. Record review of Resident #329's elopement assessment, dated 03/18/25, completed by LVN M, reflected Resident #329 had left the building around 3 pm and was brought back to the facility by staff. Resident #329 had no injuries, distress, or discomfort noted with stable vital signs, and he was unable to describe what had happened. Notifications were made the physician, responsible party, and Administrator on 03/18/25. Record review of in-service, dated 03/18/25, by RN G, titled Missing Residents/Actual Development Event, reflected that all staff on all shifts had been in-serviced including LVN M and the Receptionist. Record review of the police incident report dated, 03/18/25 at 3:40 PM, reflected Law Enforcement Officer responded to a welfare concern regarding an elderly man who had entered an apartment complex for low-income seniors and was asking for assistance. The Law Enforcement Officer arrived and spoke to Resident #329, whose clothes appeared well maintained and clean and Resident #329 did not make sense when talking and stated that he had taken a bus from another city and was trying to get to another city. The apartment complex had reached out to the facility and was able to determine that he was a resident at the facility and when the Maintenance Director came to pick up Resident #329 he told the Law Enforcement Officer that he was not sure how the resident left the facility and all doors were locked and had passcodes to open the door. The Law Enforcement Officer reported the incident to Adult Protective Services. Record review of the facility's Logbook Report, dated generated on 04/09/25, of elopement drills for the past 12 months reflected the task name of: Emergency Preparedness Drills: Conduct Elopement drill (Missing Resident Drill) reflected the following due dates: 06/30/24, 09/30/24, 12/31/24, 03/31/25. Record review of the facility's Logbook Documentation for task: Conduct Elopement drill (Missing Resident Drill) for the past 6 months reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start dated 06/26/24 at 1 PM, ended at 1:15 PM (6 AM- 2 PM Shift) and marked done on time by the Maintenance Director on 06/26/25. Start dated 09/17/24 at 9:30 AM, ended at 10:30 AM (6 AM- 2 PM Shift) and marked done on time by the Maintenance Director on 10/07/24. Start dated 12/31/24 at 11 AM, ended at 12 PM (6 AM-2 PM Shift) and marked done on time by the Maintenance Director on 12/31/24. Start dated 03/18/25 at 3:55 PM, ended at 4:10 PM (2 PM-10 PM Shift) and marked done on time by the Maintenance Director on 03/31/25. Interview on 04/07/25 at 12:34 PM with Law Enforcement Officer revealed on 03/18/25 in the afternoon he was called to an apartment complex around the corner from the facility because Resident #329 had wandered from the facility to a nearby apartment complex. He stated that the apartment complex called the facility to ask if Resident #329 was their resident after about 30 minutes and it was uncertain what time the resident had eloped from the facility. He stated that the resident did not seem to have any psychosocial harm or physical injuries, he was confused, and a staff member came and took Resident #329 back to the facility. Interview on 04/09/25 at 9:26 AM with the Receptionist revealed she did not realize Resident #329 was a resident at the facility when she unlocked the front door when another visitor was leaving the facility. She stated he exited behind the visitor around 2:30 PM. She stated she realized Resident #329 was a resident when he returned with the Maintenance Director. She stated she had been in-serviced on elopements, participated in elopement drills, and now updated the elopement book each day. Observation of elopement book with the Receptionist revealed it was updated to include face sheets with pictures of residents at risk of elopement. In an interview on 04/09/25 at 2:59 PM CNA N said she used to work with Resident #329 and was not working the day he eloped. She stated that Resident #329 walked around the facility but did not exit seek or show any signs of wandering before the elopement. She stated if she had seen any signs of exit seeking, she would have notified the nurse. She stated that she kept a list of residents at risk of elopement in her pocket and the facility conducted elopement drills. She stated that she had been in-serviced on elopements after the incident. In an interview on 04/10/25 at 8:59 AM LVN M said he noticed during his shift rounds around 3 PM that Resident #329 was not in his room and thought Resident #329 was in therapy and did not check. He stated he learned the resident had left the facility when he was brought back by the Maintenance Director. He stated that he assessed Resident #329 when he returned, and he had no injuries and did not appear upset. He stated that he had participated in past elopement drills and had been in-serviced on elopements after the incident. He stated that staff were updated on any residents who were elopement risks during morning meetings and shift change, and there was an elopement book at the nurses' station with residents who were at risk of elopement. He stated in the future he would find where the resident was and ensure they were in therapy rather than assume. He stated it was important to prevent elopements because a resident could be harmed if they left the facility without supervision. (continued on next page)

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	455864	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd Plano, TX 75075

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/10/25 at 10:07 AM RN G said elopement drills were conducted by her and the Maintenance Director every 3 months. She stated that she was working when the resident came back to the facility, and he did not seem upset and had no injuries. She stated she conducted the elopement and abuse and neglect in-services with staff and notified the physician and the family. She stated Resident #329's room was moved in between both nurses' stations and he was on one-on-one supervision until he discharged to another facility. In an interview on 04/10/25 at 2:50 PM the Administrator said Resident #329 did not display any exit seeking or wandering behavior before the incident and was placed on one to one supervision until he was discharged to a facility with a secure unit. He stated that the Receptionist did not realize Resident #329 was a resident at the facility when he had exited along with a visitor of the facility. He stated that staff were immediately in-serviced on elopements and included the Receptionist who was also provided additional education. He stated that Resident #329 had no injuries and did not seem upset. He stated it was important to ensure residents did not elope from the facility to ensure residents are kept safe. In an interview on 04/10/25 at 3:27 PM the Maintenance Director said he was the employee that picked up Resident #329 from the apartment complex next-door to the facility that was separated from the facility with a grass median. He stated that the resident did not appear upset or injured. He stated that he and RN G conducted the elopement drills every 3 months and that there are elopement books at the receptionist and nurse's stations that identify the residents at risk of elopement. He stated that they conducted an elopement drill after the resident had eloped and staff were in-serviced on elopements and abuse and neglect. He stated that it was important to ensure residents did not elope because they could get lost, get hit by a car, or be seriously injured or die. In interviews covering all three shifts (6 AM- 2PM, 2 PM-10 PM, and 10 PM- 6 AM), the following staff said they had been in-serviced (03/18/25 -03/19/25) after the elopement on 03/18/25 on preventing and responding to elopements, participated in past elopement drills, knew the alert code for an eloped resident, were aware of where to find the elopement book at the nurses' station and carried a list of residents who were at risk of elopement: 04/08/25 from 1:20 PM to 1:46 PM with LVN C, CNA Q, and MA R 04/09/25 from 1 PM- 5 PM with 2 LVNs (LVN E & T), 7 CNAs (CNA S, D, Q, N, V, W, X), 2 Unit Managers (Unit Manager U & AA) 04/10/25 from 9:55 AM- 11:10 AM with the Restorative Aide I, the Treatment Nurse, and RN G Review of inservices sign in sheets dated 03/18/25 and 03/19/25 revealed staff were inserviced on elopement on 03/18/25 and 03/19/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's elopement policy, titled Area of Focus: Elopement, dated reviewed 11/19/24, reflected . Elopement occurs when a resident leaves the premises or a safe area without authorization . and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle . Residents will be assessed for unsafe wandering and elopement indicators upon admission, readmission, change in condition, quarterly and with any unsafe wandering or elopement event utilizing the Elopement Risk Evaluation UDA (Universal Design for Assessment) in PCC (Point Click Care) (an electronic medical health record program) . Elopement drills will be conducted at least quarterly . Record review of the facility's policy for elopement prevention, titled Unsafe Wandering and Elopement Prevention, revised 03/04/25, reflected The facility will ensure that residents are assessed to determine risk for elopement in accordance with current standards of practice and implement interventions as appropriate to mitigate the risks identified . Record review of the facility's policy for an actual elopement, titled Missing Residents/Actual Elopement Event, dated reviewed 04/03/25 reflected .It is the responsibility of all associated to report any resident who is suspected of being missing to the nurse manager immediately . 11. When the resident is found, the charge nurse or designee will assess the resident's physical, mental, emotional, and cognitive state and notify the physician and responsible party. The resident will be monitored as deemed necessary by the interdisciplinary team . 12. An incident (event) report will be completed by the charge nurse or designee to include witness statements .13. The Executive Director or designee will report the event to all appropriate agencies as well as the regional and divisional team . The Administrator and DON were notified of PNC IJ on 04/24/25 at 3:32 PM and PNC IJ template was provided to the facility at this time. In an interview on 04/24/25 at 11:27 AM the Maintenance Director said on 03/18/25 the Administrator texted him to inform him about Resident #329 had eloped and he needed to go pick him up. He stated he went at 3:55 PM on 03/18/25 with a wheelchair and the Housekeeping Supervisor assisted him to go pick up Resident #329. He stated Resident #329 was wearing a t-shirt and sweatpants but could not recall if he had shoes on. He stated Resident #329 was confused stating he had come from another city. He stated he considered this incident an elopement drill but did not do an elopement drill like he usually did where the staff had to find a resident who was missing and implement code yellow which was missing resident. He stated he just discussed with staff to ensure they are aware of where their residents are. He stated he did check all the doors ensuring they were alarming and working properly. He had no issues with any of the doors on 03/18/25. He stated he did not complete his usual elopement drill which was done quarterly until later in December 2024. In an interview on 04/24/25 at 11:50 AM the Housekeeping Supervisor said she went with Maintenance Director to go get Resident #329 who had been found at a neighboring apartment complex. She stated the apartment complex was separated by a grass median in front of the facility, so they walked there to get him taking the wheelchair with them and they pushed him in the wheelchair back to the facility. She stated Resident #329 had on a t-shirt, sweatpants and shoes. She stated Resident #329 was confused but did not have any visible injuries. She stated it took about 15 minutes for them to get Resident #329 and bring him back in the wheelchair. She stated they brought him back to the facility about a few minutes after 4 pm. She stated she was in-serviced on missing residents and elopement protocol. She was knowledgeable of facility's policy and what to do if a resident reported missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/24/25 at 12:02 PM RN G said she was notified Resident #329 had eloped out of the facility by the Administrator. She stated she went to the floor a few minutes past 4 pm. She stated she and charge nurse went to assess Resident #329. She stated Resident #329 had no signs of heat exhaustion. Resident #329 was confused and could not remember leaving the facility. She stated vital signs were within normal limits and there were no injuries. She stated she assisted the charge nurse and ensured Resident #329 was safe. She stated she notified the physician and responsible party for Resident #329. She stated the physician ordered for the facility to start initiating a discharge to a facility with a secure unit since Resident #329 had eloped and facility had no current secure unit for resident safety. She initiated the in-service for elopement and abuse and neglect on 03/18/25 on the 2 pm to 10 pm shift and continued education with all shifts until 03/19/25 to get the last shift on the 6 am to 2 pm shift. She stated Resident #329 was placed on 1:1 until he was discharged to another facility with secure unit for resident safety. Observations on 04/24/25 from 12:52 PM to 1:05 PM with the Maintenance Director revealed all exit doors were working properly. Observations revealed all exit doors alarmed when pressed on and if held 15 seconds would continue to alarm. The front door alarmed when pressed on and if held for 15 seconds would alarm until the code was put in. In a follow-up interview on 04/24/25 at 12:58 PM the Maintenance Director said there was grass between the facility and the building Resident #329 was at. He stated he pushed the wheelchair across the grass. He stated he went to the front of the building. He stated Resident #329 had no visible injuries and was very confused. He did not know that he was a resident at the facility. The Maintenance Director stated Resident #329 was cooperative and they took him back in the wheelchair. He stated they used a side street to take Resident #329 back in the wheelchair. He stated they returned with Resident #329 at 4:10 PM. The noncompliance was identified as Past Noncompliance (PNC) Immediate Jeopardy (IJ). The noncompliance began on 03/18/25 and ended on 03/31/25. The facility had corrected the noncompliance before the Incident investigation began on 04/08/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of three residents (Resident #32) reviewed for catheter and incontinence care. The facility failed to ensure CNA D and Restorative Aide I maintained the foley catheter drainage bag below Resident #32's bladder while they transferred the resident with a mechanical lift on 04/09/25. This failure could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections. Findings included: Record review of Resident #32's Admission MDS assessment, dated 03/17/25, reflected an [AGE] year-old female with an admitted [DATE]. Resident #32 had a BIMS of 5 which indicated she was severely cognitively impaired. She required total assistance for ADL care and had a foley catheter and was always incontinent of bowel. Active diagnoses included diabetes (chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar), traumatic brain injury (disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury), respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in your body), and neurogenic bladder (disruption in the nervous systems connection to the bladder) Record review of Resident #32's Physician Order Summary, dated 04/10/25, reflected .Keep urinary drainage bag below the level of the bladder . with a start date of 03/13/24. Record review of Resident #32's care plan, initiated on 03/14/25, reflected, The Resident (indwelling) catheter .Goal .Will have no complications related to indwelling catheter use .Interventions .Catheter care every shift In an observation on 04/09/25 at 01:30 p.m. CNA D and LVN E were observed placing Resident #32 on a mechanical lift sling. CNA D unhooked the foley catheter drainage bag from the bed rail and hooked onto the mechanical lift sling. Restorative Aide I raised the lift which placed the catheter drainage bag higher than the resident's bladder. Urine was observed in the tube fluctuating back and forth. Restorative Aide I positioned Resident #32 over the wheelchair, then unhooked the foley drainage bag from the lift sling and placed it on the resident's lap and then lowered the resident into her wheelchair. CNA D then unhooked the sling and LVN E picked up the drainage bag and hooked it onto the wheelchair. In an interview on 04/09/25 at 01:40 p.m. Restorative Aide I stated he usually placed the urinary drainage bag in the resident's lap and stated he thought that was how they were supposed to do it. He stated he knew it was supposed to be below the bladder, but stated he was not very sure how they were supposed to manage the bag during a mechanical transfer. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/09/25 at 01:42 p.m. with CNA D she stated she knew the drainage bag was supposed to be below the bladder, but stated they really had not been shown how to handle the drainage bag while transferring with a mechanical lift. Both CNA D and Restorative Aide I stated if the urinary bag was above the bladder there was a risk of the urine back flowing causing an infection. In an interview on 04/10/25 at 09:35 a.m. with the DON he stated the urinary drainage bag was always supposed to be below the bladder. He stated they teach the staff that, but stated they probably need to add the process of how to handle the drainage bag during a mechanical lift transfer. He stated the risk of having it above the bladder is urinary tract infections. In an interview on 04/10/25 at 04:02 p.m. RN G who is the facilities Infection Preventionist, she stated she educated the staff to always keep the urinary bag below the bladder. She stated she had done education with the staff for residents with mechanical lift transfers which required one of them to hold the drainage bag below the bladder during the transfer. She stated she would have to do some additional education with the staff to ensure they were always keeping the urinary bag below the bladder and keeping it secure during a transfer. She stated the risk for not keeping it below the bladder was the back flow of urine into the bladder which could lead to an infection. Record Review of CNA D's Nurse Aide Proficiency skills check reflected she was competent in the care of indwelling catheters as of 10/31/24. Record Review of Restorative Aide I's Nurse Aide Proficiency skills check off reflected he was competent in the care of indwelling catheters as of 12/07/24. Record review of the facility's policy, Indwelling Urinary Catheter (Foley) Management, dated September 2024, reflected, Maintain unobstructed urine flow .Keep the catheter and collecting tube free from kinking . Keep the collecting bag below the level of the bladder at all times .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences for two of three (Resident #32, and Resident #289) reviewed for respiratory care. 1. The facility failed to ensure LVN E performed hand hygiene during tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) care and failed to maintain sterile technique during tracheostomy care for Resident # 32 on 04/09/25. 2. The facility failed to obtain Physician orders for Resident #289's continuous oxygen with the number of liters to administer. These failures could place residents at risk for respiratory infections, an incorrect amount of oxygen and the risk of lung infections. Findings include: 1. Record review of Resident #32's Admission MDS assessment, dated 03/17/25, reflected an [AGE] year-old female with an admitted [DATE]. Resident #32 had a BIMS of 5, which indicated she was severely cognitively impaired. She required total assistance for ADL care and had a foley catheter and was always incontinent of bowel. Resident #32's active diagnoses included diabetes, traumatic brain injury, respiratory failure, and neurogenic bladder (disruption in the nervous systems connection to the bladder). In Section O-Special Treatments, Procedures, and Programs reflected the resident required tracheostomy care (a surgical opening in the neck providing a direct airway through the trachea), suctioning, and oxygen therapy during the 14 days look back period. Record review of Resident #32's Physician orders summary, dated 01/10/25, reflected Trach care daily with cannula change, with a start date of 03/14/25 Record review of Resident #32's care plan, revised on 03/20/25, reflected .The resident has a tracheostomy related to impaired breathing mechanics, surgery. At risk for dislodging the trach site .Goal .The resident will have clear and equal breath sounds bilaterally through the review date .Interventions .Suction as necessary . Use universal precautions as appropriate (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/09/25 at 08:35 a.m. revealed LVN E entered Resident #32's room to provide tracheostomy care. LVN E placed paper towels on top of the bedside table and placed the unopened tracheostomy kit on top. She then placed a bottle of unopened sterile normal saline beside the unopened trach kit. LVN E donned a gown and gloves without performing hand hygiene and removed the old stoma dressing from under the trach flange (device that holds the trach secure) and the inner cannula and discarded both into the trash. LVN E then opened the tracheostomy care kit (holds sterile supplies for cleaning tracheostomy), the package held a new disposable trach and opened the bottle of sterile saline. LVN E put on the sterile gloves without performing hand hygiene and removed the sterile drape (used to create a sterile field for tracheostomy cleaning supplies) and placed it on the resident's chest. LVN E reached for the bottle of saline with her right hand and touched the bottle (which was not sterile), then changed to her left hand, and picked up the bottle and poured the saline into the tracheostomy tray to moisten the 4x4 gauze. LVN E took the moistened gauze and cleaned around the stoma and under the trach flange. LVN E stated she messed up and forgot to open a package for the new stoma dressing. LVN E removed her sterile gloves and put on utility gloves without performing hand hygiene and retrieved a package of stoma dressings and a new tracheostomy kit and placed them on the bedside table. LVN E opened the stoma dressing package and the tracheostomy kit. She removed her utility gloves and proceeded to put on the sterile gloves from the kit without performing hand hygiene. LVN E retrieved the stoma dressing and placed it around the stoma and under the trach flange using both hands. LVN E picked up the disposable cannula and re-inserted it into the trach. LVN E removed her gloves and gowns and performed hand hygiene. In an interview with LVN E on 04/09/25 at 09:00 a.m., she stated she was supposed to perform hand hygiene before and after every glove change. She stated she knew the procedure was supposed to be a sterile procedure to reduce the risk of cross contamination. She stated she knew she was supposed to keep her dominant hand sterile and realized she should had picked up the bottle of normal saline with her left hand. She stated she had been checked off on tracheostomy care and even re-watched the video last night. She stated she was so nervous she just forgot to sanitize her hands. In an interview with the DON on 04/10/25 at 09:30 a. m. revealed hand hygiene was to be performed anytime a staff member went from a dirty procedure to a clean procedure. He stated trach care was to be an aseptic/sterile technique. He stated they had a Respiratory therapist who came to the facility weekly and provided hands on training with the staff. He stated they did at bedside training as well as practiced on a mannequin. He stated in addition RN G, who was the infection preventionist, did observations of care with the staff. He stated failure for the staff to follow proper procedures could result in infections. In an interview with RN G on 04/10/25 at 10:10 a.m., she stated she reviewed the skills with the staff, but the Respiratory therapist provided most of the hands-on training for trach care. She stated they taught it as a sterile procedure. She stated she made rounds with the nurses randomly to observe skills and compliance with infection control. She stated hand hygiene was always required after the removal of gloves to prevent the risk of infection. Record review of LVN E skills check list reflected she was skills checked on 07/25/24 and again on 03/12/25 on tracheostomy care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Tracheostomy Care' Policy, dated September 2024, reflected . Tracheostomy care will be performed daily and PRN unless otherwise noted by the physician. This procedure should be performed using sterile technique and includes the cleaning of the stoma and neck, cleaning or replacing inner cannula (depending on type of trach tube-disposable or reusable) and replacing the tracheostomy tube holder and drainage sponge .Place the equipment and supplies on a clean table or stand near the patient's bed. Open the tracheostomy care kit using sterile technique. Using sterile technique, pour sterile normal saline solution, sterile water, or other cleaning solution recommended by the manufacturer .into one of the sterile solution containers.If you must replace the disposable inner cannula, open the package containing the new inner cannula while maintain sterile technique .Perform hand hygiene . Put on gown and gloves .Assess the patients respiratory status .Remove the patients tracheostomy dressing, inspect it for drainage, and then discard it .Remove and discard your gloves .Perform hand hygiene .Put on sterile gloves .Using non-dominant hand .unlock the tracheostomy tubes inner cannula by rotating it counterclockwise .Remove the inner cannula .Remove and discard your gloves .Perform hand hygiene .Put on clean gloves .With your dominant hand, moisten a sterile gauze pad with the sterile normal saline solution .then wipe the patients neck under the tracheostomy tube flanges and tracheostomy ties .Dry the area thoroughly with additional sterile gauze pads .Apply a new sterile tracheostomy dressing .Discard used supplies .Remove and discard your, gloves .Perform hand hygiene 2. Record review of Resident #289's face sheet dated 04/10/25 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #289 had diagnoses which included enterocolitis due clostridium difficile (inflammatory condition that affects both the small and large intestines), acute respiratory failure, morbid obesity, and muscle weakness. Record review of Resident #289's 5-day MDS assessment, dated 04/02/25, reflected Resident #289 had a BIMS of 13, which indicated she was cognitively intact. The MDS did not reflect Resident #289 was on oxygen therapy while at the facility. Record review of Resident #289's Comprehensive Care Plan, dated 04/03/25, reflected the following: Focus: [Resident #289] ADL assistance and therapy services needed to maintain or attain highest level of function . Interventions/Tasks: Assist with mobility and ADLs as needed. There was no indication of Resident's need for Oxygen Therapy. Record review of Resident #289's Physician's Order summary report, dated 04/10/25, reflected no physician's order for oxygen use. Observation and interview on 04/08/25 at 2:16 p.m. revealed Resident #289 was lying in bed on oxygen via nasal cannula with the oxygen concentrator next to her bed. The concentrator was observed on with the oxygen being infused through the nasal cannula. The oxygen concentrator was set to deliver 2 liters per minute. Resident #289 stated she had been receiving oxygen since being admitted to the facility. Interview with LVN L on 04/10/25 at 11:31 a.m. revealed there should have been a physician order for oxygen in place for Resident #289 prior to administering. She stated the risk to Resident #289 would be getting to much or too little oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 04/10/25 at 12:06 p.m. revealed he expected Resident #289 to have a physician's order for oxygen and the nurses were responsible for making sure there was one prior to oxygen being administered. He stated his expectation was for every medication and oxygen to have physician orders in place. He stated the risk to Resident #289 was not getting the correct oxygen dose. Record review of the facility's policy, Oxygen Administration, dated September 2024, reflected To ensure that oxygen is administered and stored safely .Respiratory care .The facility must ensure that a resident who needs respiratory care .is provided such care, consistent with professional standards of practice and comprehensive person-centered care plan .Oxygen order should be written for specific liter flow required by the resident 49837

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd Plano, TX 75075

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for one of nine (Resident #64) residents reviewed for pharmacy services. The facility failed to ensure facility staff re-ordered medications in a timely manner for Resident #64 which resulted in a missed dose of levothyroxine 50 mcg (used to treat low thyroid) on 04/09/25. The facility failed to keep medications secure when LVN H borrowed a medication from another resident to administer to Resident # 64. This failure could place residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings include: Record review of Resident #64's face sheet, dated 04/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #64's 5-day MDS Assessment, dated 02/08/25, reflected he had BIMS score of 13, which indicated he was cognitively intact. The 5-day assessment reflected the resident had diagnoses which included malnutrition and seizure disorder. Record review of Resident #64's Physician order Summary Report, dated 04/10/25, reflected Levothyroxine Sodium Oral Tablet 50 mcg 1 time a day for low thyroid, with a start date of 03/28/25. Record review of Resident #64's MAR for April 2025 reflected on 04/09/25 the 06:00 a.m. administration for Levothyroxine 50 mcg was coded as 7 (which indicated see progress note) by LVN H. There were no other missed doses for April 2025. Record review of Resident #64's progress notes did not reflect any documentation by LVH H for 04/09/25. During a medication observation and interview on 04/09/25 at 06:25 a.m. revealed LVN H at the medication cart in front of Resident #64'sroom. LVN H pulled up the Medication Profile for Resident #64. She looked in the medication cart to obtain the residents Levothyroxine and stated there was none on the cart. She stated she would have to retrieve the medication from the E-Kit. LVN H pushed the Medication cart to the next room. LVN H was never observed going to the medication room to retrieve the Levothyroxine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/09/25 at 10:00 a.m. with Unit Manager F, revealed the facility had a computer coded pharmacy dispensing unit (E-Kit) for on demand supply of routine medications. Unit Manager F stated they must contact the pharmacy to retrieve information on what was pulled from the system and who pulled it. Unit Manager F contacted their contracted pharmacy and verified no Levothyroxine for Resident #64 was pulled today (04/09/25). In a telephone interview with LVN H on 04/09/25 at 10:05 a.m., LVN H stated she borrowed a Levothyroxine 50 mcg tablet from another resident's medication supply and administered it to Resident #64 before she left. She stated she was running late and had an appointment she needed to get to and just did not go to the other hall where the E-Kit was located to retrieve the necessary medications. She stated she was not sure why the medications had not been re-ordered timely. In an interview with LVN E, charge nurse for the 6 a.m. to 2 p.m. shift, on 04/09/25 at 10:15 a.m. she stated, LVN H had not mentioned anything to her when they counted the medication cart at change of shift about Resident #64's Levothyroxine needing to be ordered. She stated each nurse was responsible to re-order the resident's medication when they had a 7-day supply left. She stated the re-ordering was done through the electronic record and it was as simple as pushing the re-order button in the system. She stated if the medication did not come in on the next day shipment from the pharmacy, they had to call the pharmacy and follow up. She stated Levothyroxine was almost always given by the night shift charge nurse since it was usually ordered to be taken before meals. She stated the night shift charge nurse would be responsible for re-ordering those medications for which they gave routinely. She stated in the event a medication did not get re-ordered or was delayed they always had access to the E-Kit. In an interview with the facility's contracted pharmacy, on 04/10/24 at 8:45 a.m., revealed the facility sent a re-order request to the pharmacy on 04/09/25 for Resident #64's Levothyroxine 50 mcg. The pharmacy representative stated the procedure for any re-order for medications was to submit the request when the resident had 5-7-day supply on hand. In an interview with the DON on 04/10/25 at 09:25 a.m., the DON stated it was never acceptable to borrow a medication from another resident and the staff member would be counseled. He stated there was no excuse for this since they had an E-Kit that had most of the common medications the residents took. He stated the re-ordering process was a very simple process and the staff all knew they were to re-order when a resident had a 7-day supply on hand. He stated whoever administered the medication and saw the 7-day mark was responsible for re-ordering the medication. He stated the staff were responsible for following up with the pharmacy in the event the medication was not delivered. He stated there was no excuse for this. Record review of the facility's policy, Reordering, Changing, and Discontinuing Medication Orders, dated July 2024, reflected Facilities are encouraged to reorder medications electronically or by fax whenever possible . Facility staff should re-order medications using an electronic list of residents and medications due or by use of barcode technology .Facility staff should review the transmitted re-orders for status and potential issues and pharmacy response

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34918 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 (Hall E) medication carts reviewed for medication storage. The facility failed to ensure LVN H kept medications secured and the E Hall medication cart locked and/or secured. LVN H failed to ensure medication pill was not loose on the E-Hall medication cart. This failure could place residents at risk of gaining access to unlocked medications that were not prescribed to them. Findings include: During a medication observation on 04/09/25 at 06:20 a.m. revealed LVN H at the medication cart in front of Resident #43's room. A medication cup with a small tan pill was observed on top of the E-Hall medication cart. LVN H stated she was waiting for Resident #43 to finish in the bathroom. LVN H put on gloves and entered Resident #43's room and bathroom and assisted him back to bed. The medication cup with the pill was left on top of the unlocked medication cart out of the sight of the LVN. LVN H returned to the medication cart and pushed the Medication cart to the next room. LVN H pulled Resident #1's medication and entered the room, leaving the medication cart unlocked and out of her sight while in the room administering Resident #1's medications. In an interview on 04/09/25 at 06:35 a.m., LVN H stated she had gotten distracted with Resident #43 when he needed to go to the bathroom. She stated she had punched his protonix (treats acid reflux) out twice and the one in the cup was extra. She stated she should have destroyed the pill. She stated she should never leave medication on top of the cart or leave the medication cart unlocked because anyone could take medication that was not intended for them. In an interview on 04/10/25 at 9:25 a.m. with the DON, he stated if a medication cart was left unlocked a resident or anyone else could get into it and take any of the medication, which could result in a resident taking medication not prescribed for them which could make them sick or cause harm. He stated all the staff were trained on medication storage and the expectation of keeping medication carts locked and secured and were never to leave medication on top of the cart unsecured and if it should have been destroyed instead of placed back into the cart. Record review of the facility's policy, Storage and Expiration Dating of Medications and Biologicals, August 2024, reflected Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of one kitchen and 2 (Dietary Manager and Dietary [NAME] O) of 4 Dietary Staff reviewed for Food and Nutrition Services. 1. The facility failed to ensure food items in the walk-in refrigerator and freezer were dated, labeled and sealed. 2. The facility failed to ensure 2 chest freezers had a thermometer while in use and failed to ensure temperature logs were maintained for the chest freezers. 3. The facility failed to ensure the Dietary Manager had a facial hair restraint for his mustache and used proper hand hygiene while handling and serving food during the lunch meal preparation and service on 04/09/25. 4. The facility failed to ensure the Dietary [NAME] O had an effective hair restraint during meal preparation on 04/09/25. These failures could place residents at risk for food-borne illness and food contamination. Findings include: 1. Observations on 04/08/25 in the walk-in refrigerator revealed the following: -at 10:19 AM, bell peppers in a box, dated 04/01 with 3 bell peppers revealed the skin was wrinkling, soft with white spots were on it -at 10:20 AM, Chicken noodle soup revealed plastic wrap was not covering the food on 1 side, open a couple of inches. Observations on 04/08/25 at 10:25 AM of the walk-in freezer revealed the following: -the garlic bread bag was torn and opened, not sealed about 3 inches -Hash browns were in a torn plastic bag and not sealed -Beef steak patties were in an open box and were not sealed -2 packages of shrimp were not dated when received, and were undated. -Brussel sprouts had a best if used by dated 04/06/25. It was not dated when received. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Dietary Manager on 04/08/25 at 10:22 AM revealed the refrigerator items should be dated when received if taken out of the original container and when opened. He stated the items should be sealed. Observation revealed the Dietary Manager covered the chicken noodle soup back with the plastic wrap and showed it had a date of 4/07/25. He stated he was responsible to ensure items were dated, labeled and sealed properly. Interview on 04/08/25 at 10:27 AM with the Dietary Manager revealed the shrimp was delivered on Friday (04/04/25). The Dietary Manger stated he was not sure when the brussels sprouts were received. He stated he was going to use them and cook them. He stated the best if used by date was not an expiration date. He stated he would throw out the hash browns and garlic bread. These items should be sealed and dated . 2. Observation on 04/08/25 at 10:28 AM of 2 chest freezers in the kitchen revealed one of the freezers had chocolate ice cream cups. The ice cream cups appeared to be still frozen. The other freezer had a gallon of ice cream and boxes of frozen items. There were no thermometers found in either chest freezer. The chest freezers had ice accumulation on the sides of both. Interview on 04/08/25 at 10:30 AM with the Dietary Manager revealed he could not find thermometers in the chest freezers. The Dietary Manager stated he did not have any temperature logs for the chest freezers . He started moving the items out. He stated there should be a thermometer in the chest freezer. Interview on 04/09/25 at 04:32 PM with the Maintenance Director revealed he was not aware Dietary was still using the 2 chest freezers the facility had gotten those in the past when the kitchen had issues with the freezer not working. He stated he had not defrosted the chest freezers recently. He stated the freezers should have a thermometer in them to ensure freezer item temperatures maintained. Record review of the facility's policy Food Safety effective, date of 11/28/17 and last reviewed 05/01/24, reflected Food is store and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth .6. Food is labeled with the date received if not already indicated on the item .2. Ambient temperatures in freezers remain at 0 degrees F or lower and all food is frozen solid. 3. Temperatures are recorded at least twice daily on the refrigerator/freezer temperature log using an inside thermometer place near the door which is the warm part of the refrigerator .10. Leftovers are dated properly and discarded after 72 hours unless otherwise indicated 3. Observation on 04/09/25 from 12:00 PM to 12:42 PM for the lunch meal preparation and serving revealed the following: -at 12:00 PM, the Dietary Manager was in the kitchen plating food for the lunch meal trays with no facial hair restraint for his mustache which was about 1/2 inch thick with 2 inches length. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-at 12:04 PM, the Dietary Manager took his gloves off, did not wash his hands and put new gloves on. He started plating food for resident meal trays and touched the inner part of the resident plate. At 12:07 PM, the Dietary Manager touched the cornbread with his gloved hand on the sides with a spatula. He was not wearing a facial hair restraint. At 12:11 PM, he touched the mashed potatoes and cauliflower with his gloved hand when scooping it onto the resident plate with his gloves touching the inner part of the resident plate. -At 12:13 PM, the Dietary Manager got clean plates with his gloved hands. At 12:15 PM, he touched the cornbread with his gloved hand on the sides with a spatula. The Dietary Manager continued plating the food with his gloved hands. -At 12:27 PM, the Dietary Manager took off both gloves, did not wash his hands and put on new gloves. He continued plating food and touched, with his gloved hands, the inner part of the plate and food with his gloved hands. He continued plating food for the resident meal trays. The Dietary Manager did not wash his hands and finished with all resident meal trays . 4. Observation on 04/09/25 at 12:29 PM, revealed Dietary [NAME] O cutting up turkey meat with 3/4 inch of hair not covered by her hat and 1/2 inch hair on both sides in front of her ears were not covered by her hat. Interview on 04/09/25 at 12:46 PM with Dietary [NAME] O revealed she was not aware the back of her hair and sides of her hair were uncovered. She stated she was aware she should have her hair covered while in the kitchen. Interview on 04/09/25 at 12:52 PM with the Dietary Manager revealed he did not wash his hands between glove use because when he washed his hands and put on new gloves it was difficult to put on the gloves. He stated the gloves were large on the box but they were tight fitting. He was aware he should wash hands when changing gloves. He stated the risk to not washing hands was contamination of the food. He stated he did not wear a facial restraint for his mustache. He said he only needed it if he had a beard. He stated the importance of wearing the hair restraints or hats were to cover the hair and to keep hair from getting in the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/10/25 at 10:15 AM with Dietitian revealed the bell peppers needed to be removed when it showed signs of spoiling and should be thrown away. She stated the facility had gotten the 2 chest freezers when the walk-in freezer was having repairs. She stated there should be a thermometer in each chest freezer and temperature log should be kept for each chest freezer. She stated not monitoring the chest freezer temperatures could place residents at risk for issues with temperature which included freezer items not being at proper temperatures. She stated she had discussed with the Dietary Manager about the importance of the temperature logs and having a thermometer. She stated food items in the refrigerator and freezer should be dated and sealed. She stated leftovers were good for 3 days and then thrown out after the 3 days if not used. She stated not having labels, date on the items and unsealed could place food items at risk of potential hazards and critical control points not kept. She stated these food items were at risk for bacteria and contamination of food. She stated using the Brussel sprouts before the best use by date of 04/06/25 ensured flavor was kept. She stated food items in the refrigerator and freezer should be dated for when received and when opened. She stated she had in-serviced dietary staff which included the Dietary Manager about the facility's policy including facial restraints and hair restraints. She stated she educated the Dietary Manager about ensuring proper hand hygiene for dietary staff. She stated Dietary staff not washing their hands could pass along germs and contamination in the food and it could place residents at risk who ate the food. Interview on 04/10/25 at 03:28 PM with the Administrator revealed he expected the chest freezers to be maintained with thermometer and temperatures log if using. He stated he expected dietary staff to wash hands. Record review of the facility's in-service by the Dietary Manager, dated 02/05/25, reflected he in-serviced dietary staff on handwashing and how to properly wash hands. Record review of the facility's policy Associate Conduct and Dress Code, last revised 04/30/24, reflected The facility will ensure all foodservice associates adhere to the company's established code of conduct and dress code .Hair Restraints .-Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food .e. All facial hair including moustaches and beards should be trimmed and covered .3. The food and Nutrition Services associates wear a hair covering, which covers all unpinned hair, including all facial hair while on duty a. According to the Food Code, food service staff must wear hairnets when cooking, preparing, or assembling food . Record review of the U.S Department of Health and Human Services Food Code, dated 2022, reflected 3-202.15 Package Integrity .Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. Record review of the Food and Drug Administration Food Code, dated 2022, reflected the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food .3-305.11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety . 2-301.11 Clean Condition. The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code. Even seemingly healthy employees may serve as reservoirs for pathogenic microorganisms that are transmissible through food. Staphylococci, for example, can be found on the skin and in the mouth, throat, and nose of many employees. The hands of employees can be contaminated by touching their nose or other body parts. 2-301.12 Cleaning Procedure. Handwashing is a critical factor in reducing fecal-oral pathogens that can be transmitted from hands to RTE food as well as other pathogens that can be transmitted from environmental sources

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of eight residents (Resident #60, Resident #32, and Resident #179) reviewed for infection control. 1. The facility failed to ensure CNA D performed hand hygiene during incontinence care for Resident #60 on 04/08/25. 2. The facility failed to ensure LVN E sanitized the glucometer before and after with an EPA approved germicide after performing a FSBS on Resident #32 on 04/08/25. 3. The facility failed to ensure LVN J performed hand hygiene after obtaining a FSBS for Resident #179 on 04/08/25. 4. The facility failed to ensure the Treatment Nurse performed hand hygiene during wound care and incontinence care on Resident #32 on 04/09/25 These failures could place residents at risk for infection and cross contamination. Findings include: 1. Record review of Resident #60's face sheet, dated 04/10/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included infection and inflammatory reaction due to internal right knee prosthesis, (artificial joint), chronic osteomyelitis (inflammation to the bone caused by infection) and diabetes. In an observation on 04/08/25 at 10:45 a.m., revealed CNA D entered Resident #60's room to provide incontinence care. CNA D put on gloves without performing hand hygiene. She unfastened the brief and provided peri-care wiping from front to back and changing the wipes with each stroke. CNA D assisted to resident onto his side, which revealed he had a moderate soft bowel movement. CNA D wiped from front to back until all bowel movement was removed. CNA D removed her gloves and without performing hand hygiene, reached into her pants pocket and retrieved another pair of gloves and put them on. CNA D then applied barrier cream to the resident's buttocks and placed the clean brief under the resident and had him roll back onto his back, where she applied barrier cream on his groin and peri-area. CNA D fastened the brief, removed her gloves, gathered the trash, and then performed hand hygiene. In an interview on 04/08/25 at 10:50 a.m., CNA D stated she was supposed to perform hand hygiene before and after care. Then she stated she should have performed hand hygiene on her hands when she changed her gloves when going from dirty to clean. She stated the risk of not performing hand hygiene was infection and the spread of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #32's face sheet, dated 04/10/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had a diagnosis which included type 2 diabetes mellitus. Observation during medication pass on 04/08/25 at 11:30 a.m. revealed LVN E prepared to obtain fingerstick blood sugar for Resident #32. LVN E pulled a glucometer out of the medication cart and wiped it down with an alcohol prep pad. LVN E entered the resident's room and obtained a fingerstick blood sample. LVN E disposed of the lancet and test strip, and returned to the medication cart where she opened another alcohol prep pad and wiped down the glucometer. In an interview with LVN E on 04/08/25 at 11:35 a.m., she stated she was supposed to wipe the glucometer down with a Sani-wipe (EPA approved germicide) but stated she did not have any on her cart when she was doing the blood sugar checks. LVN E then walked down the hall into a supply room and retrieved a bottle of Sani-wipes and re-cleaned the glucometer. She stated failure to sanitize the glucometer appropriately could result in transmission of blood borne pathogens. 3. Record review of Resident #179's face sheet, dated 04/10/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #179 had a diagnosis which included type 2 diabetes mellitus. During a medication administration observation on 04/08/25 at 11:45 a.m., revealed LVN J obtained a fingerstick blood sample for Resident #179. LVN J disposed of the lancet and test strip and returned to the medication cart. LVN J removed her gloves, re-applied gloves without performing hand hygiene and cleaned the glucometer with a Sani-wipe. LVN J removed her gloves and without performing hand hygiene, opened the medication cart and retrieved the resident's insulin pen. LVN J then attached a needle to the pen, primed the pen and then dialed in 4 units. LVN J performed hand hygiene and re-entered the resident's room and administered the insulin. In an interview with LVN J on 04/08/25 at 11:52 a.m., she stated she was supposed to sanitize her hands after the completion of the FSBS and before giving insulin. She stated she realized she should have sanitized before and after cleaning the glucometer, and prior to retrieving the insulin pen. She stated the risk of was cross contamination. 4. Record review of Resident #32's face sheet, dated 04/10/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had a diagnosis which included pressure ulcer of the sacral region, stage 2. (continued on next page)

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd Plano, TX 75075

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/09/25 at 01:15 p.m. revealed the Treatment Nurse and CNA D entered Resident #32's room to provide wound care. Both staff performed hand hygiene and put on gowns. The Treatment Nurse opened the resident's brief, and the staff rolled the resident on her side, which revealed a small open area on the resident's sacral area that was almost completely closed. The Treatment Nurse cleaned the wound cleanser and applied Triad paste (helps maintain moist wound healing). The resident's labia was noted to be red. The Treatment Nurse asked Restorative Aide I to ask the Charge Nurse to bring in some Nystatin powder for the red area. The resident began to have a bowel movement. The staff rolled the resident back onto her back to let her finish with the bowel movement. CNA D then provided peri care and catheter care wiping down each groin and down the middle and cleaning the catheter tubing downward and changed the wipe with each stroke. The resident was rolled back onto her side and the Treatment Nurse wiped the anal area from front to back, which resulted in the removal of the triad paste. Once the bowel movement was removed the Treatment Nurse removed her gloves and put on new gloves without performing hand hygiene. The Treatment Nurse cleaned the area of the pressure ulcer with normal saline and re-applied triad paste. The Treatment Nurse stepped aside, LVN E entered the room, performed hand hygiene, and put on gloves and gowns and applied the nystatin powder (used to treat yeast) to the labia area. LVN E and CNA D positioned the clean brief and the mechanical sling under the resident. The resident was rolled back onto her back and the brief was secured. The Treatment Nurse gathered up the trash, removed her gloves and performed hand hygiene. In an interview on 04/09/25 at 01:50 p.m., the Treatment Nurse stated she should have performed hand hygiene when she finished cleaning the resident and before she re-cleaned and treated the wound. She stated the risk of not performing hand hygiene was cross contamination and infection concerns. In an interview with the DON on 04/10/25 at 09:35 a.m., he stated staff were to change their gloves and perform hand hygiene after they performed incontinence care and before applying the clean brief and always before going from clean to dirty, especially during wound care. He stated by not following proper hand hygiene it placed residents at risk of urinary tract infections and increased the risk of wound infection. He stated they had done extensive in-services with the staff on infection control, especially hand hygiene and the use of PPE. He stated in addition they made rounds and watched care to ensure the staff were following correct procedures. He stated the staff had also been trained on the proper sanitizing of glucometers and when to perform hand hygiene during glucose monitoring. He stated alcohol was not an approved germicide for sanitizing glucometers. He stated the staff were to use the EPA approved Sani-wipes to clean the glucometers and staff were to always perform hand hygiene after any procedure, before moving to the next procedure. He stated the risk of not following the proper procedures were cross contamination and potential for the spread of blood borne pathogens. Record review of the facility's policy titled, Cleaning and Disinfection of Non-critical Patient Care Equipment, dated June 2024, reflected .Disinfection should be performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA-registered disinfectant products must be followed .Intermediate-level disinfection is traditionally defined as destruction of all vegetative bacteria .Given the broader spectrum of activity, intermediate-level disinfection should be considered for non-critical equipment that is visibly contaminated with blood (continued on next page)

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	455864	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd Plano, TX 75075

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Hand Hygiene, dated June 2024, reflected, .Associates perform hand hygiene (even if gloves are used) in the following situations .Before and after contact with the resident . After contact with blood, body fluids, or visibly contaminated surfaces .After removing personal protective equipment (e.g., gloves, gown .) .Before performing a procedure such as an aseptic task .dressing care