STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675113	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Park IN Plano	3208 Thunderbird LN 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity for 1 of five (Resident #2) residents reviewed for dignity in that: The facility failed to ensure staff did not stand over Resident #2 while assisting the resident with her meal in the dining area on 08/21/2024 This failure could affect residents who require assistance with activities of daily living and placed them at risk for psychosocial harm due to a diminished quality of life. The findings were: Review of Resident #2's electronic face sheet printed 08/22/24 reflected a [AGE] year-old-female admitted on [DATE] with diagnoses including but not limited to senile degeneration of brain (cognitive decline in older people, particularly memory loss), dysphagia oropharyngeal phase (difficulty swallowing), and unspecified lack of coordination. Review of Resident #2's Quarterly MDS assessment, dated 06/09/2024 reflected the BIMS score was not completed. Review Resident #2's MDS section GG functional abilities and goals was not completed. Review of Resident #2's Care Plan revised 06/12/2024 reflected the following problems: The resident had potential for altered nutritional status regarding Dementia with interventions to include maintain adequate nutritional status and provide serve, diet as ordered and observe food intake. Review of Resident #2's physician order for diet dated 05/14/2024 revealed regular diet, pure texture. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/21/24 at 12:03 PM in the dining hall revealed LVN A was observed standing over Resident #2 and assisting her with feeding her the meal by placing food in her mouth with a utensil. There was no vacant chair. Interview with LVN A revealed she was assisting Resident #2 because she was not wanting to feed herself. LVN A stated there was no chair available which was why she decided to stand. Nurse A stated she was trying to get Resident #2 started with eating due to her putting her hands in the plate. LVN A stated Resident #2 did not normally need assistance with eating but she was not feeding herself. LVN A gave the spoon to Resident #2 and she began feeding herself. LVN A stated she was aware that she should have been sitting while assisting the resident with eating. Interview on 08/21/2024 at 2:48 PM with the Director of Nursing revealed if staff were assisting residents during meals, then the staff should be sitting down. She stated she saw LVN A standing over Resident #2 and immediatley in- serviced regarding resident dignity. The Director of Nursing stated the risk of staff standing over the resident while assisting with meals would be a resident right violation and dignity could be violated. Interview on 08/21/2024 at 2:45 PM with the Administrator revealed staff should not stand while assisting residents during meals. The Administrator stated the risk of staff standing would be the residents rights could be violated. Record review of the policy Resident rights revised 11/28/2016 A facility must treat each resident with respect and dignity and care for each resident in a manner and an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for one (Resident #1) of three residents reviewed for medication errors in that: The facility failed to administer Resident #1's blood pressure medications as ordered by the physician. This failure could place residents at risk of medical complications and a decrease in therapeutic dosages of their medications as ordered by the physician. Findings included: Review of Resident #1's electronic face sheet dated printed 08/21/2024 revealed a [AGE] year- old female initially admitted to the facility on [DATE] and re- admitted [DATE] with diagnosis that included but not limited to metabolic encephalopathy(a group of neurological disorders that cause brain dysfunction due to chemical imbalances in the blood), Venous insufficiency(a condition that occurs when veins in the legs have trouble pumping blood back to the heart), hypertension(high blood pressure) Review of Resident's care plan last reviewed 06/03/2024 revealed Resident #1 had hypertension and reflected the following: Focus: [Resident #1] has hypertension and is on lisinopril, metoprolol and amlodipine besylate Goal: Resident #1 will remain free of sign and symptoms related to hypertension through review date. Interventions: give anti-hypertensive medications as ordered. Review of Resident #1's annual MDS stated 05/13/2024 revealed a BIMS score of 04 which indicated the resident was cognitively impaired. Review of Resident #1's physician's order dated 10/26/2023 for metoprolol tartrate table revealed give 12.5 milligrams by mouth two times a day related to hypertension, hold for SBP less than 110, DBP less than 60, P less than 60. Review of Resident #1's MAR for the month of August 2024 reflected Resident #1's Metoprolol Tartrate was administered when out of parameters on the following days: - 08/12/2024 at 8:00 PM Resident #1's DBP was 56 and LVN C administered the medication outside of parameters. -08/14/2024 at 8:00 PM Resident #1's DBP was 56 and LVN C administered the medication outside of the parameters. -08/19/2024 at 8:00 PM Resident #1's DBP was 56 and LVN C administered the medication outside of the parameters (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 08/21/2023 at 8:00 AM Resident #1's DBP was 58 and LVN B administered the medication outside of the parameters. Review of Resident #1's physician's order dated 05/21/2024 for hydralazine HCl oral tablet 100 MG revealed give 1 tablet by mouth every 12 hours related to hypertension, hold for systolic <110 or diastolic <60 or pulse<60. Review of Resident #1's MAR/ for the month of August 2024 reflected Resident #1' was administered hydralazine when out of parameters on the following days: - 08/08/24 at 8:00 PM Resident #1's DBP was 57 and LVN B administered the medication outside of parameters. -08/12/24 at 8:00 AM Resident #1's DBP was 56 and LVN C administered the medication outside of parameters. -08/13/24 at 8:00 PM Resident #1's DBP was 59 and LVN B administered the medication outside of parameters. -08/14/24 at 8:00 PM Resident #1's DBP was 56 and LVN B administered the medication outside of parameters. -08/21/24 at 8:00 AM Resident #1s DBP was 58 and LVN C administered the medication outside of parameters. Review of Resident #1's nurses' notes for the dates of 08/01/24 through 08/21/24 revealed there were not any notes related to Resident #1's blood pressure on 08/08/24, 08/12/24, 08/14/24, 08/19/24, 08/21/24. Interview was attempted on 08/21/2024 at 11:15 AM with Resident #1 however was unsuccessful. Interview on 08/21/2024 at 1:23 PM with LVN C revealed blood pressure was checked each shift before medication was given. She stated if blood pressure was outside of parameters, she would call the doctor to determine if the medication should be given. LVN C stated she would not give the medication if the blood pressure was outside of the parameters. LVN stated regarding Resident #1's medication being given outside of the parameter, she would have called the doctor and documented. However, she could not recall why it was not done. LVN B was not interviewed. In an interview on 08/21/2024 at 2:48 PM with the DON revealed if a resident's blood pressure was outside of parameters, then the physician should have been notified. The DON stated the ADON should have checked the MAR to ensure medication was being administered properly. However, she was not sure how often it was being done. The DON stated she was not aware of the blood pressure medication being given outside of the parameters. She stated the nursing notes were reviewed in the morning meeting. However, if issues with blood pressures were not being documented then it could have been overlooked. The DON stated the risk of giving medication outside of the parameters would be that the resident blood pressure could drop. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Medication administration procedures , last revised 10/25/17 did not discuss properly administering medication according to physician orders.