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	11/06/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #1 and Resident #5) of twenty residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light was in reach and accessible for Resident #1 and Resident #5 on 11/05/2024. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Review of Resident #1's Face Sheet, dated 11/05/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #1's pertinent diagnoses included metabolic encephalopathy (changes in how the brain works due to underlying conditions) and history of falls. Review of Resident #1's Quarterly MDS Assessment, dated 09/02/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident required dependent for toileting, dressing, and personal hygiene and the resident had highly impaired vision, but eyes could follow objects. Review of Resident #1's Comprehensive Care Plan, dated 09/02/2024, reflected the resident was at risk for fall and one of the interventions was to a safe environment with a working and reachable call light. Observation on 11/05/2024 at 9:28 AM revealed Resident#1 was in his bed, sleeping. It was observed that the resident's call light was on the floor, behind his roommate's side table. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER The Park IN Plano		STREET ADDRESS, CITY, STATE, ZIP CODE 3208 Thunderbird LN Plano, TX 75075	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA C on 11/05/2024 at 9:39 AM revealed CNA C went inside Resident #1's room and saw the resident's call light was behind his roommates. CNA C pulled Resident #1's call light and placed it beside the resident. She said she did not notice the resident's call light was not with the resident. She then said the resident did not need the call light because the resident was blind. When asked to repeat what she said, CNA C repeated the resident did not need the call light because the resident was blind. She said the resident was being assisted in feeding and every time she would assist him, she would put the resident's glass of juice on the same spot and the resident would know where his drinks would be. When asked if this technique would be applicable with the call light, CNA C did not answer. In an interview with LVN B on 11/05/2024 at 9:46 AM, LVN B stated Resident 1's vision was diminished, but he could still see. She said she already gave the resident his medications but did not notice the resident's call light was also on the floor when she was with the resident. She said the call light should be in a place accessible to the residents because the residents needed them to call the staff. LVN B said if the call lights were not within reach, the residents would not be able to call the staff and their needs would not be met. She said the call lights should be with the residents, regardless of their conditions. In an interview with the Interim Administrator on 11/06/2024 at 7:48 AM, the Interim Administrator stated the call lights should not be on the floor because the residents needed them to call the staff. The Administrator said the residents might be having an emergency and staff would not know. The Administrator said the staff should make sure the call lights were within reach every time they leave the room. The Administrator said he would coordinate with the DON regarding call lights and would constantly remind them to make sure the call lights were with the residents. The Administrator concluded that they would re-educate the staff about call lights within reach. In an interview with the DON on 11/06/2024 at 8:15 AM, the DON stated call lights were important for the residents and they should be placed where the residents could reach them. The DON said, for most residents, the call lights were their mode of security, that if they needed something, they could call the staff. She said the call lights should be the residents even the residents seldom use them. She said the call lights were for the dependent and independent residents, blind or not. She said all the staff were responsible in ensuring that the call lights were within reach of the residents. The DON said the expectation was for the staff would be mindful that every time they leave the residents' room, the call lights were within reach. The DON said she would conduct an in-service and check-off about the call lights for all the staff of the facility. Review of Resident #5's Face Sheet, dated 11/06/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #5 was diagnosed with left non-dominant side hemiplegia (paralyzed on one side of the body) following a stroke (blood flow to brain is blocked), cognitive deficits following a stroke, and repeated falls. Review of Resident #5's Quarterly MDS Assessment, dated 09/27/2024, reflected the resident had moderate cognitive impairment with a BIMS score of 10. Section GG indicated that the resident was dependent on staff for personal hygiene needs, toileting, and mobility. Review of Resident #5's Comprehensive Care Plan, dated 10/30/2024, reflected the resident was at high risk for falls related to left side hemiplegia. One intervention was to keep call light in reach at all times. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/05/2024 at 9:30 AM revealed Resident #5's call light on the floor near the head of her bed. Resident #5 was lying in bed and stated she had just finished eating breakfast. Resident #5 stated that sometimes they move the call light where she can't reach it. Resident #5 stated that she feels safe here and they take great care of me. During an interview on 11/05/2024 at 11/06/24 at 9:33 AM, CNA C stated that the resident's call light should not have been on the floor. She stated that resident should be able to call the staff anytime she needs something. CNA C stated that it might cause a resident to feel neglected if they need us and cannot reach their call light. In an interview 11/06/24 at 11:05 AM, LVN B stated that keeping the call light within the resident's reach can save a life. She stated that if a resident is short of breath, they should be able to grab their call light. LVN B stated that some of their residents are forgetful, and staff must remind them where the call light was and how to call if they need anything. During an interview 11/06/24 at 11:18 AM, the DON stated that the call light should have been placed where the resident could reach it. She stated that staff should only move a call light when they are providing care for the resident and then put it back before leaving the resident's room. She stated that her expectation was for staff to ensure the residents' call lights are always within reach so residents can let staff know if they need anything. Facility's policy for call light requested on 10/05/2024 but was not provided prior to exit. The Interim Administrator said in his email on 11/06/2024 at 7:44 AM revealed The company does not have a specific policy on call lights.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45055 Based on interviews and record reviews the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #4) of 4 residents reviewed for (ADLs) care provided to dependent residents. The facility failed to ensure Resident #4 received scheduled bed baths reviewed from October 1, 2024 - October 31, 2024. This failure placed the resident at risk of not receiving necessary services to maintain good personal hygiene, skin breakdown, and decreased self- esteem. Findings included: Record review of Resident #4's Face Sheet, dated 11/06/2024, revealed she was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included muscle weakness, history of falling, and unsteadiness on feet. Record review of Resident #4's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, she had a Brief Interview for Mental Status (BIMS) score of 12 (moderate impairment) and for ADL care it stated, for transfers, toileting, and bathing, the resident required total assistance. Record review of Resident #4's Comprehensive care plan dated 07/15/24 revealed the resident was care planned for potential for ADL selfcare performance, and an intervention included the resident requiring Limited Assist by 1 staff with showering on Monday, Wednesday, and Friday on shift 6:00 AM-2:00 PM and as necessary. In an interview on 11/06/24 at 12:00 PM, Resident #4 stated that she was scheduled to receive three showers a week, but she was lucky to get just one or two a week. She stated she had concerns with not getting her three showers a week. Resident #4 appeared to be clean without any odors at the time of the interview. Record review of the facility's shower sheet for Resident #4 from 10/01/24 to 10/31/24 reflected the following shower sheets: 10/14/24 10/16/24 10/21/24 10/23/24 10/25/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/06/24 at 10:54 AM, CNA S stated she had been at the facility for a month. She stated she did provide Resident #4 some of her scheduled showers but she was only at the facility on an as-needed-basis. She stated the resident was scheduled to receive her showers on Monday, Wednesday, and Friday. She stated she normally completed the resident's shower first thing in the morning. She stated the resident never refused any showers with her. She stated the CNA were required to complete shower sheets for all residents, regardless of if a shower was provided or refused. She stated she did not know why the resident only had 5 shower sheets on file for the month of October. She stated she risk of the resident not receiving her scheduled showers could result in bacteria growth, skin breakdown, and staff infections. In an interview on 11/06/24 at 11:08 AM, LVN C stated she was the nurse for the hall of Resident #4. She stated she had been at the facility since February 2024, and she was familiar with the resident. She stated she resident was scheduled to receive her showers on Monday, Wednesday, and Friday. She was advised that the resident was only showing five shower sheets on file for the month of October. She stated that during her shift, the resident often was not ready for her showers, but none of the CNAs went back to check with her later in the day. She stated the CNAs were required to complete shower sheets for all residents when they were scheduled. She stated the risk of the resident not receiving her showers could result in skin breakdown and she could get an infection. In an interview on 11/06/24 at 11:26 AM, The DON stated she was advised of Resident #4 not receiving her scheduled showers for the month of October 2024. She stated the resident would sometimes refuse showers because she may not be ready. She stated the CNAs were required to complete shower sheets for all residents, regardless of if they received a shower or refused a shower. She stated she did not know why the resident only had 5 shower sheets on file for the month. She stated the risk of the resident not receiving her showers could result in skin breakdown and it was a dignity issue. The facility's policy Bath, Tub/Shower (2003), reflected Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 (unknown Resident) of 68 residents at the facility reviewed for accident prevention . The facility failed to secure a coffee station on 11/06/24 that allowed for residents to self-serve coffee, which could result in skin burns. This failure could prevent residents from having an environment that was free and clear of accidents and hazards. Findings included: In an observation on 11/06/24 at 8:25 AM, an unknown resident was observed walking to a cart in front of the nurse's station, which contained hot coffee, and poured herself a cup of coffee (no lid) and walked away. The coffee at the station was poured into a cup for a temperature check using the index finger and withdrawn within seconds because of the heat. The coffee was not Lukewarm. In an interview and observation on 11/06/24 at 8:27 AM, Staffing Coordinator/CNA R stated the cart with the hot coffee had been placed there for resident to self-serve since she had been at the facility, which was one year. She stated they had not had a resident burn themselves since she was here. She stated the kitchen was supposed to check the temperature to ensure that it would not be too hot for the resident, but the nursing staff did not recheck the temperature to ensure that it was safe for the resident. She stated the risk of not checking the temperature of the coffee prior to allowing resident to get the coffee could result in the resident burning themselves. In an interview and observation on 11/06/24 at 8:30 AM, the DON stated that she had been at the facility for over a year and the self-serve coffee cart was always there and so far no resident had burned themselves. She stated the kitchen was responsible for checking the temperature to ensure that it was not a risk to the resident. She stated they did not have lids for the cups, and she stated they did have residents with skin integrity concerns and lacked coordination. She stated staff served those residents. She was advised that a resident was observed serving herself and no staff member was around. She stated they had removed the coffee cart from being in front of the nurse's station to now being located behind the nurse's stated where it would be more secured from the residents and prevent them from burning themselves. In an interview and observation on 11/06/24 at 9:00 AM, the Interim Administrator and Administrator in Training was advised of the self-serve coffee cart was left unsecured from residents that could potentially burn themselves. They advised that they had spoke with the DON and was advised that the coffee cart was moved to a more secured location that would prevent residents from burning themselves. Review of the facility's policy Guidelines on Serving Coffee in the Nursing Facility (undated), reflected (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. As there is no published federal or state regulation for minimum or maximum coffee temperature, the decision as to the temperature at which to serve the coffee rests with the administration of each facility, based on their resident's stated preferences, and the physical layout of their building, but balanced against the safety of their individual residents and their physical and mental limitations. 2. The standard for coffee service will be 140 degrees, unless the facility's residents have stated an overwhelming preference for coffee to be served at a higher temperature and additional safety measures have been implemented, or the safety of residents warrants a lower temperature. If coffee is served at 140 degrees, it will cool to 135 degrees when dispensed into a room-temperature coffee cup or mug, and per Time and Temperature Relationship to Serious Burns from the American Burn Association website, this temperature will allow approximately 15 seconds before a serious burn will occur, based on the physical condition of the individual person. 3. Any residents who have risk factors for coffee burns, such as significant cognitive impairment or extreme shaking may be evaluated for additional safety precautions using a hot beverage risk assessment. Safety precautions may include but are not limited to additional supervision when consuming coffee, insulated or non-insulated coffee mugs with sippy lids, coffee service at lower temperatures, or restricted coffee availability. 4. If coffee is served and held at a temperature lower than 140 degrees, then it will be discarded after four hours and its dispenser cleaned and sanitized before fresh coffee is added. 5. An investigation and evaluation will be performed for any resident who receives a coffee burn, and a plan to reduce this resident's risk of receiving future burns will be developed and implemented. 6. If local, state, or federal regulations or guidance for coffee temperatures are developed and/or published, then these standards will become the practice at the facility. Until that time, the facility administration must honor the resident's right to make risky decisions but balances these decisions against individual safety.

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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** 47743 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #2 and Resident #6) of twelve residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #2's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored on 11/05/2024. 2. The facility failed to ensure that Resident #6's oxygen concentrator (machine that produces oxygen) had a humidification bottle (adds moisture to reduce nasal irritation) connected to it on 11/05/2024. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #2's Face Sheet, dated 11/05/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident #2's Comprehensive MDS Assessment, dated 10/06/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. Resident #2's Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #2's Comprehensive Care Plan, dated 10/23/2024, reflected the resident had COPD and one of the interventions was give oxygen therapy as ordered. Review of Resident #2's Physician Order, dated 06/19/2023, reflected O2 . NC @ HS + prn if O2 drops < 90% or c/o SOB. Observation and interview on 11/05/2024 at 9:16 AM revealed Resident #2 was in her wheelchair, awake. It was observed that there was an oxygen concentrator inside the room and a nasal cannula was connected to the oxygen concentrator. The nasal cannula was coiled on top of the oxygen concentrator and was not bagged. Resident #2 said she was the one using the oxygen. She said she seldom use it. She said she never saw a plastic bag for her nasal cannula and said it was not her responsibility to put the nasal cannula inside the bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN A on 11/05/2024 at 11:43 AM, LVN A stated Resident #2 was not on continuous oxygen and would only sometimes use it at night. LVN A entered the resident's room and saw the resident's nasal cannula coiled on top of the oxygen concentrator. LVN A proceeded to disconnect the nasal cannula, threw it in a trash can, and said she would get a new one and would make sure it would be inside a bag when the resident was not using it. She said she did not notice the nasal cannula was not inside a bag and was just placed on top of the oxygen concentrator. She said a dirty nasal cannula could result to more respiratory issues. In an interview with the Interim Administrator on 11/06/2024 at 7:48 AM, the Interim Administrator stated the nasal cannula should be kept clean to prevent any respiratory infection. He said he would coordinate with the DON regarding the needed in-service about respiratory care. He said the expectation was for the staff to bag the nasal cannula every time the resident was not using it. In an interview with the DON on 11/06/2024 at 8:15 AM, the DON stated the nasal cannula should be stored properly when not in use to keep them clean. She said if the nasal cannula was not bagged, exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, and compromised oxygen administration. She said the expectation was for the staff to be mindful in making sure that the nasal cannula was properly stored. She said she would make an in-service and re-educate the staff about storing the nasal cannula was properly. She concluded it was the responsibility of the staff to make sure the nasal cannula was stored properly and not the residents. 2. Review of Resident #6's Face Sheet, dated 11/05/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #6 was diagnosed with chronic respiratory failure (airway to lungs becomes narrow and damaged) with hypoxia (low oxygen level) and dependence on supplemental air. Review of Resident #6's Comprehensive MDS Assessment, dated 10/10/2024, reflected the resident had moderate cognitive impairment with a BIMS score of 12. Resident #6's Comprehensive MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #6's Comprehensive Care Plan, dated 10/23/2024, reflected the resident had COPD (a chronic lung disease) and one of the interventions was to give oxygen therapy as ordered by the physician. Review of documentation in Resident #6's Progress Notes, dated 11/05/24 at 9:09 AM, reflected The resident takes off her oxygen humidifier when one was put to her oxygen. Review of Resident #6's Physician Order, dated 06/04/24, reflected the resident may use oxygen at 3 liters per minute via nasal cannula every shift related to acute and chronic respiratory failure with hypoxia. An observation on 11/05/2024 at 9:05 AM revealed Resident #6 sitting on the side of her bed eating breakfast. Resident #6 was wearing the nasal cannula and receiving oxygen. The oxygen concentrator did not have a humidifier bottle attached to it. Resident #6 was unable to answer questions appropriately because of her cognitive status. An observation on 11/05/24 at 10:30 AM revealed a humidifier bottle was connected to Resident #6's oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 11:05 AM, LVN B stated there should have been a humidifier bottle attached to Resident #6's oxygen concentrator. She stated the moisture is needed so the resident does not get nose and throat dryness. She stated that she was told the resident removed it. She stated that residents cannot be forced to do anything, so the facility care plans a concern like that. During an interview on 11/06/24 at 11:18 AM, the DON stated that Resident #6's oxygen concentrator was supposed to have a humidifier bottle connected to it. She stated that this adds moisture and purifies the oxygen. She stated that the resident removed the humidifier bottle from the oxygen concentrator. She stated that staff educated the resident and told her the nurse is the only one that can do that. The DON stated that the resident doesn't remember, and that staff was responsible for monitoring the resident. Record review of facility's policy, Oxygen Administration Nursing Policy & Procedure Manual 2003 rev February 13, 2007, revealed Goals . 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen . 3. The resident will be free from infection. Facility's policy for bagging the nasal cannula requested on 10/05/2024 but was not provided prior to exit. The Interim Administrator said on his email on 11/06/2024 at 7:44 AM revealed The company does not have a specific policy about bagging the nasal cannula.

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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** 47743 Based on observations, interviews, and record review, the facility failed to ensure that one (Resident #3) of five residents were provided medications and/or biologicals and pharmaceutical services to meet their needs. The facility failed to ensure LVN A did not leave Resident #3's medications inside the resident's room on 11/05/2024. This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Review of Resident #3's Face Sheet, dated 11/05/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included type 2 diabetes mellitus and pain to right and left arm. Review of Resident #3's Quarterly MDS Assessment, dated 09/19/2024, reflected resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment also indicated Resident #3 had type 2 diabetes mellitus (high blood sugar) and pain to right and left arm. Review of Resident #3's Comprehensive Care Plan, dated 10/30/2024, reflected the resident had impaired cognitive function or impaired thought process and one of the interventions was to supervise as needed. Resident #3's Comprehensive Care Plan did not indicate that the resident could self-administer his medications. Review of Resident #3's List of Assessments on 11/05/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage his own medications. Review of Resident #3's Physician Order for Neurontin, dated 03/14/2022, reflected Neurontin Capsule 300 MG (Gabapentin). Give 1 capsule by mouth two times a day for PAIN. Review of Resident #3's Physician Order for cyanocobalamin, dated 03/14/2022, reflected Cyanocobalamin Tablet 500 MCG. Give 4 tablet by mouth one time a day for SUPPLEMENT. Review of Resident #3's Physician Order for multivitamin, dated 6/12/2024, reflected Multivitamin Adult (Minerals) Oral Tablet (Multiple Vitamins w/ Minerals). Give 1 tablet by mouth one time a day for Vitamin. Review of Resident #3 's Physician Order for docusate sodium, dated 03/31/2023, reflected Docusate Sodium Tablet 100 MG. Give 1 tablet by mouth one time a day for constipation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER The Park IN Plano		STREET ADDRESS, CITY, STATE, ZIP CODE 3208 Thunderbird LN Plano, TX 75075	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3 's Physician Order for metformin, dated 06/12/2024, reflected Metformin HCl Oral Tablet 500 MG (Metformin HCl). Give 1 tablet by mouth one time a day for type 2 diabetes mellitus. Observation and interview with Resident #3 on 11/05/2024 at 9:11 AM revealed the resident was in his bed, awake. It was observed that a small plastic cup with eight pills inside was noted on top of the resident's side table. According to Resident #3, his nurse left it with him a moment ago and he would take them as soon he was finished with what he was doing. Resident #3 then changed his mind and said he would take the medications. Resident #3 sat at the side of his bed, took the cup of medications from his side table, and took his medications. The resident said it was not the first time that his medications were left with him. He said all he could remember was his morning pills included his vitamins, medication for diabetes, and his pain pill. In an interview with LVN A on 11/05/2024 at 10:12 AM, LVN A stated she was the one who gave Resident #3's medication. She said she left the resident's morning pills with him. She said she should have stayed with the resident until the resident had taken the medications. He said the pills should not be left with the resident because the resident might not take them, throw them, or choke while taking them and no one would know. She said he would check if the resident took the medications. In an interview with the Interim Administrator on 11/06/2024 at 7:48 AM, the Interim Administrator stated staff should not leave medications unattended because of the risk of the resident not taking them or the pills not taken on time. He said he would coordinate with the clinicians on how to go forward to prevent untoward outcomes of leaving the medications with a resident. He said the expectation was for the staff to wait until the resident was done with their medications. In an interview with the DON on 11/06/2024 at 8:15 AM, the DON stated staff should never leave the medications at the bedside for the resident to take later. She said the staff must ensure the resident took his medications before leaving the room. She said if the resident was not yet ready for the medications, the staff should take them with them when they leave the room. She said it would be better to ask the residents if they were ready for their medications. She said the resident could hoard or hide the pills to avoid taking them. She said the residents could overdose on hoarded pills. The DON said she would do an in-service pertaining to not leaving the medications with a resident. In an interview with LVN A on 11/06/2024 at 8:46 AM, LVN A said the pills that she left with Resident #3 were four pink B12, one white metformin, one white stool softener, one red multivitamins, and one yellow Neurontin. She stayed with the resident until he was done with his medications. Record review of facility policy, Medication Administration Procedures Pharmacy Policy & Procedure Manual 2003 revised 10/25/17 revealed 1 . All medications are administered by licensed medical or nursing personnel . 4. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered . 5. After the resident has been identified, administer the medication.

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NAME OF PROVIDER OR SUPPLIER The Park IN Plano		STREET ADDRESS, CITY, STATE, ZIP CODE 3208 Thunderbird LN Plano, TX 75075	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to 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 one (Resident #4) of eight residents reviewed for Infection Control. The facility failed to ensure that CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #4 on 11/06/2024. This failure could place the residents at risk of cross-contamination and development of infections. Findings included: Review of Resident #4's Face Sheet, dated 11/06/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #4 was diagnosed with need for assistance with personal care. Review of Resident #4's Comprehensive MDS Assessment, dated 08/29/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 03. Resident #4's Quarterly MDS Assessment indicated the resident was always incontinent for bowel and bladder. Review of Resident #4's Comprehensive Care Plan, dated 09/12/2024, reflected the resident was incontinent and the interventions were clean peri-area with each incontinence episode and hand washing before and after delivery of care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/06/2024 at 7:12 AM revealed CNA D was about to provide Resident #4's incontinent care. CNA D took with her same pairs of gloves, wipes, and a brief inside the room and placed them on the resident's overbed table. She put on a pair of gloves and then pulled the trash can beside her. She did not wash her hands before incontinent care and did not change her gloves after touching the trash can. She raised the bed and lowered the head of the bed. She unfastened the resident's brief and pushed it between the resident's legs. She cleaned the resident's front part from back to front. She assisted the resident to roll towards the wall and started to clean the resident's bottom. While in the process of cleaning the bottom, the resident had a bowel movement. When the resident was done, CNA D continued to clean the resident's bottom. After cleaning the resident's bottom, she rolled the soiled brief, pulled it, and threw it in the trash can. She cleaned the bottom some more when she noticed the resident's bottom was still soiled. She then took the new brief and placed it under the resident. She did not change her gloves before touching the new brief. She removed her gloves and went out of the room to get some cream from the nurse. She put on a new pair of gloves when she came back to the resident's room and put some cream on the resident's bottom. She did not do hand hygiene before putting on a new pair of gloves. After putting the cream on the resident's bottom, she changed her gloves, rolled back the resident, and fixed her brief. she did not wash her hands after incontinent care and was about to go out of the room. She stated hands should be washed before and after incontinent care. She said gloves should be changed after touching the trash can and after cleaning the resident's bottom. She said hands should be sanitized in between changing of gloves. She said she forgot to sanitize her hands when she changed her gloves. She said not washing her hands, not changing her gloves and not sanitizing in between could result to cross contamination and infection. She said she knew the reasons why the staff needed to do hand hygiene but forgot to do so. In an interview with the Interim Administrator on 11/06/2024 at 7:48 AM, the Interim Administrator stated staff should wash their hands, change their gloves after touching anything soiled and sanitize their hands before putting on new gloves. He said not washing the hands, not changing the gloves after touching soiled items, and not sanitizing the hands, could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the DON to in-service the staff about infection control. In an interview with the DON on 11/06/2024 at 8:15 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said staff should wash their hands before and after incontinent care. She said gloves should be changed after touching the soiled brief and after touching the trash to prevent transfer of microorganisms to any clean items. She said the staff should do hand hygiene before putting on a new pair of gloves. She said the expectation was for the staff to change their gloves when going from dirty to clean and to do hand hygiene when changing the gloves. She said she would do an in-service and skills check-off for infection control and hand hygiene. In an interview with LVN A on 11/06/2024 at 9:23 AM, LVN A stated hand hygiene was included in all the procedures of any care. She said the staff should do hand hygiene before and after any care, and in between changing of gloves. She said gloves should be changed after cleaning the residents' bottoms, after touching the trash can, before getting a new brief. She said not changing the gloves after touching soiled items, or after touching soiled body parts could result in cross contamination and probable infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Handwashing Dietary Services Policy & Procedure Manual 2012, undated, revealed We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing. Review of facility policy, Perineal Care Female Nursing Policy and Procedure Manual 2003 rev December 8, 2009 revealed Purpose: To clean the female perineum without contaminating the urethral area . Procedural Guidelines . H. Wash hands and put on clean gloves for perineal care . I. Gently wash perineal area . AT ANYTIME YOUR GLOVES BECOME CONTAMINATED WITH FECES, CHANGE GLOVES . c. Continue to wash the rest of the perineal area . d. Change gloves . J. Cleaning the rectal and buttocks area . b. Gently wash the rectal area and buttocks . c. Change gloves . K. Closing steps . a. If gloved, remove and discard gloves. Wash hands.