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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Park IN Plano	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interview and record review the facility failed to ensure the resident had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 5 of 12 resident rooms (room [ROOM NUMBER], #2, #3, #4, and #5) reviewed for environment. The facility failed to ensure Resident Rooms #1, #2, #3, #4, and #5 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings include: An observation on 01/28/25 at 10:28 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt debris. An observation on 01/28/25 at 10:50 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt debris. The unit's cover appeared to be separating from the wall and black dirt and grime could be observed. A wall near a wastebasket, had dark stains splattered on the lower part of the wall. An observation on 01/28/25 at 10:54 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt debris. An observation on 01/28/25 at 11:03 AM of the Resident room [ROOM NUMBER] reflected the air condition unit had vents filled with black and brown dirt debris. An observation on 01/28/25 at 11:08 AM of the Resident room [ROOM NUMBER] reflected dark stains on the wall alongside the resident's bed. Inside the mini fridge had [NAME] reddish stains on the bottom inside of the fridge. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/30/25 at 08:48 AM, the Housekeeping Supervisor stated it was his second day at the facility. He stated he managed in housekeeping for 7 years. He was shown the pictures of the concerns with Resident rooms #1, #2, #3, #4, and #5, and he stated he would meet with staff to address the concerns. He stated he was unsure if his staff were responsible for cleaning the resident's refrigerators, but he would find out. He stated that risk of the concerns not being addressed could result in infections. In an interview on 01/30/25 at 9:00 AM, Housekeeping/Laundry Aid D stated he had been at the facility a month. He stated the floor technician and himself cleaned the halls, and he cleaned the resident rooms. He stated they were responsible for cleaning the walls, air condition units and refrigerators in the resident rooms. He was shown the pictures of the concerns observed in Resident rooms #1, #2, #3, #4, and #5, and he stated he would take care of the areas mentioned. He stated the risk of not addressing the issue could result in residents having trouble breathing. In an interview on 01/30/25 at 10:05 AM, the Administrator was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, and #5. He stated he had just hired a new housekeeping supervisor and would meet with him to ensure the area of concerns were addressed. He stated the risk of these concerns not being addressed could result in an infection. Record review of the facility's policy on General Cleaning (2021) revealed It is the policy of this facility to maintain cleanliness in an orderly manner. The goal is to keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image. Following cleaning tasks should be completed daily. 2. Resident Room(s) o Each Room (including Closets)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on , interview and record review, 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 nad psychosocial well-being for 1 of 5 residents (Resident #53) reviewed for care plans. The facility failed to ensure Resident #53 was care planned for the weekly psychological services being received based on physician orders dated 11/24/2024. This failure could place residents at risk of not receiving the necessary care and services needed. Findings include: Record review of Resident #53's face sheet, dated 01/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #53 was diagnosed with Post Traumatic Stress Disorder (stressful event). Record review of Resident #53's Quarterly MDS Assessment, dated 11/20/2024, reflected the resident had a severe cognitive impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had an active diagnosis of PTSD. Record review of Resident #53's Physician Order, dated 01/29/25, reflected Evaluate and treat for psychology. Record review of Resident #53's Comprehensive Care Plan, dated 12/06/2024, did not reflect the resident received services for weekly psychological services. In an interview and record review on 01/29/25 at 10:00 AM, the MDS nurse stated Resident #53 saw a psychologist to treat his mental illness. She stated the resident's care plan did not indicate the resident saw a psychologist at least monthly, and it should be care planned to ensure the resident was receiving care. She stated she thought the psychiatrist care planning was sufficient for the mental therapy the resident received. She confirmed that the resident was seeing a psychiatrist and psychologist. In an Interview on 01/29/25 at 09:55 AM, the DON was advised there was no care plan for Resident #53 seeing a psychologist to treat his PTSD. She stated the resident's care plan should indicate the resident saw a psychologist weekly and it should have been care planned to ensure the resident was receiving care. Record review of the facility's, undated, policy, Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan will describe the following - o The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial 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** 45055 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 20 residents (Resident #11, #27, and Resident #29) reviewed for ADL care provided to dependent residents. 1. The facility failed to ensure Resident #11 received proper podiatry care to treat feet. 2. The facility failed to provide fingernail care for Residents #27 and #29. These failures could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Include: 1. Record review of Resident #11's face sheet, dated 01/28/25, reflected an [AGE] year-old male who was originally admitted to the facility on [DATE]. Resident #11 had relevant diagnoses which included need for assistance for personal care, and muscle wasting and atrophy. Record review of Resident #11's Quarterly MDS assessment, dated 12/23/24, reflected the resident had a BIM score of 12, which indicated moderate impairment. The resident was dependent for all personal hygiene needs. Record review of Resident #11's Comprehensive Care Plan, dated 01/09/25, reflected the resident was care planned for having ADL self-care performance deficit and the goal for the resident was The resident will maintain or improve current levels of function in (Specify Bed Mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene). An observation on 01/28/25 at 10:27 AM revealed Resident #11 laying in his bed. The resident's toenails were long and there was thick crust built up on the toenails of both feet. In an interview and resident observation on 01/29/25 at 10:15 AM, LVN V observed Resident #11's toes and stated he needed podiatry care. She stated the nursing staff were to monitor the resident's feet to ensure that it was manicured to avoid his feet from getting an infection. She stated she would contact the podiatrist to schedule an appointment for the resident. In an interview on 01/30/25 at 10:22 AM, the Social Worker stated she was responsible to setting up podiatry appointments. She stated staff, the resident, or family member could request for podiatry to see a resident. She stated no one notified her there was a concern with Resident #11's feet and toes because she would have scheduled for him to see the podiatrist the next time the podiatrist was scheduled to visit the facility on 02/05/25. In an interview on 01/30/25 at 10:22 AM, the DON stated the nurses were to conduct weekly skin assessments from head to toe, and one of the areas observed were the resident's feet. She stated Resident #11 did need to see a podiatrist to ensure his feet were manicured to avoid any infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #27's face sheet, dated 01/30/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #27 had diagnoses which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain) affecting the left side of the body. Record review of Resident #27's Quarterly MDS Assessment, dated 01/07/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident was dependent for personal hygiene. Record review of Resident #27's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had ADL self-care performance deficit and one of the interventions was to assist with personal hygiene. The Comprehensive Care Plan did not indicate the resident was refusing nail care. Record review of Resident #27's Progress Notes, dated 11/672024, to 01/28/2025 reflected no documented attempts or refusals for nail care. Observation and interview with Resident #27 on 01/28/2025 at 10:20 AM revealed the resident was in his bed, awake. It was observed his nails on both hands were long and dirty. When asked when was the last time his nails were cut, the resident did not reply. Observation on 01/28/2025 at 10:20 AM revealed CNA G was walking in the hallway and heard Resident #27 calling for help. CNA G went inside the room to check on the resident and saw the resident was throwing up . She went out of the room and said she would call the nurse. She came back to the room with LVN C behind her. LVN C assessed the resident, raised the head of the bed, and put a pillow on the resident's left side so the resident would be on a semi-side-[NAME]-lying position. She further assessed the resident to check how much was the secretion was and if there were secretions on the resident's body, clothing and beddings. While LVN C was assessing the resident, CNA G went to the bathroom to get a bucket of water and a face towel and said she would clean the resident. Nobody noticed the resident's fingernails were long and dirty. LVN C went out of the room and said she would notify the physician. Observation on 01/29/2025 at 10:16 AM revealed Resident #27's nails were still dirty. 3. Record review of Resident #29's face sheet, dated 01/30/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #27 Parkinsonism (umbrella term for conditions affecting movement). Record review of Resident #29's Quarterly MDS Assessment, dated 11/11/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated the resident was dependent to staff for personal hygiene. Record review of Resident #29's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had an ADL self-care performance deficit and one of the interventions was the resident required one staff participation with personal hygiene. The Comprehensive Care Plan did not indicate the resident was refusing nail care. Record review of Resident #27's Progress Notes, dated from 11/07/2024 to 01/28/2025, reflected no documented attempts or refusals for nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #29 on 01/28/2025 at 9:20 AM revealed the resident was sitting in his wheelchair, awake. When asked if his nails could be seen, the resident raised both hands. It was observed the resident's nails were visibly dirty with a black unknown substance under some of the nails. When asked when the last time was his nails were cut, the resident shrugged his shoulders. Observation on 01/29/2025 at 10:18 AM revealed Resident #29's nails were still dirty. Observation and interview with LVN C on 01/29/2025 at 10:19 AM, LVN C stated nail care checks should be done by everyone and nails were mostly checked during showers but could also be done in between showers when the nails were seen dirty. LVN C went inside Resident #29's room and looked at Resident #29's fingernails and saw the dirty fingernails. She said the resident's hands and fingernails should always be clean because the resident would sometimes pick-up his food. She said the resident might have stomach issues when he picked up food with dirty fingernails. She said she would get a trimmer and nail filer and would take care of Resident #29's nails. LVN C then went inside Resident #27's room and checked on the resident's fingernails. She said Resident #27's fingernails were long and dirty. LVN C said she did not notice the resident's fingernails were dirty when she assessed the resident the day before. She said long and dirty nails could lead to skin infections if the dirty nails were used to scratch the skin. She said she would take care of Resident #27's nails after she was done with Resident #29's nails. She said the nurses and the aides were responsible in ensuring the nails of the residents were clean. In an interview with CNA F on 01/30/2025 at 10:38 AM, CNA F stated basic nail care could be done by nurses or CNAs. CNA F said if the resident was diabetic or required more than basic nail care, she would notify a nurse. She said nail checking was done during showers . She said the nails should be clean because sometimes the residents picked their food or scratched their skin. She said dirty nails could result to stomach or skin problems. She said she was the CNA assigned for Resident #27 and #29. She said she would check the resident nails . In an interview with CNA G on 01/30/2025 at 11:33 AM, CNA G stated nail care was provided by CNAs, but the nurses would do the nail care if the resident was diabetic. She said she assisted LVN C when Resident #27 was throwing up two days before. She said she did not notice the resident's fingernails were long and dirty. She said if the fingernails were long and dirty, it should be trimmed and cleaned even if the resident was not scheduled for shower. In an interview with the DON on 01/29/2025 at 12:12 PM, the DON stated fingernail care should be provided by the CNAs during shower days. She said nails should be checked, trimmed, and cleaned especially if residents scratch themselves. She said the CNAs could provide nail care to residents who were not diabetic. She said long and dirty fingernails not only affected the dignity of the residents because their visitors could see that their fingernails were dirty and could also be a cause of infection. The DON said diabetic residents' fingernails were cut by the nurses or the podiatrist. She said her expectation was for staff to check the nails and do nail care as appropriate. She said if a CNA saw dirty nails of diabetic residents, at least let the nurses know so the nurses could take care of it or put them on the list for the podiatrist. She said the nails should be checked during showers. She said she would do an in-service regarding ADLs specific for nail care and would also check the nails of the other residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 01/30/2025 at 8:34 AM, the Administrator stated the expectation was for the staff to do nail care. He said he would coordinate with the DON regarding the nail care issue. Record review of the facility's, undated, policy Dressing and Personal Grooming Nursing Policy & Procedure, reflected Purpose: The purposes of this procedure . promote cleanliness

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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** 47743 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 and restore continence to the extent possible for one of three residents (Resident #5) reviewed for Incontinent Care. The facility failed to ensure CNA D used proper technique to clean Resident 5's perineal area (area between the legs) on 01/29/2025. This failure could place residents at risk of cross-contamination and development of urinary tract infections. Findings include: Record review of Resident #5's face sheet, dated 01/30/2025, reflected an [AGE] year-old female who was admitted on the facility on 06/03/2024. Resident #5 had a diagnosis which included generalized muscle weakness. Record review of Resident #5's Comprehensive MDS Assessment, dated 12/24/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated Resident #5 was incontinent for bowel and bladder. Record review of Resident #5's Comprehensive Care Plan, dated 12/31/2024, reflected the resident was incontinent for bowel and bladder and one of the interventions was to provide peri care after each incontinent episode. Observation on 01/29/2025 at 8:23 AM revealed CNA D was about to assist Resident #5 to go to the bathroom for a bowel movement. She sanitized her hands and put on a pair of gloves. She transferred the resident from the bed to the wheelchair and ushered the resident to the bathroom. CNA D then transferred the resident from the wheelchair to the toilet bowl and waited for the resident to be done with her bowel movement. When the resident was done with her bowel movement, CNA D instructed the resident to stoop forward so she could clean her bottom. The wipes used to clean the bottom had feces on it. After cleaning the resident's bottom, she washed her hands and changed her gloves. CNA D instructed the resident to stand up and hold on the arm rest of the wheelchair. She took a couple of wipes and cleaned the resident's perineal area. She cleaned the perineal area from back to front, from front to back, and then back to front again using the same wipes. She took some more wipes and did the same thing. She then took a brief and put it on the resident. In an interview with CNA D on 01/29/2025 at 8:38 AM, CNA D said the proper way of cleaning a female resident was from front to back to prevent whatever germs from the bottom to go the perineal area and cause infection. She said she cleaned Resident #5's bottom first but the probability the bottom still had feces was high. She said she should still clean the perineal area from front to back and not the other way around. She said she would be mindful with incontinent care to not compromise the residents' health. (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 with the DON on 01/29/2025 at 12:12 PM, the DON stated the proper way to clean the bottom was from front to back to prevent the contaminants from the bottom to eventually come in contact with the resident's perineal area. She said cleaning the perineal area from back to front could cause urinary tract infections. The DON said the expectation was for the staff to do the proper perineal care to prevent infections. She said she would do an in-service about perineal care. In an interview with the Administrator on 01/30/2025 at 8:34 AM, the Administrator stated the staff should follow the right procedure in cleaning the residents to prevent cross contamination and infection. He said he would collaborate with the DON on how to go about the said issue. He said the staff would be monitored closely. Record review of facility policy, Perineal Care Policies and Procedure created 04/25/2022 reflected Purpose: This procedure aims . providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . Procedure Content . 17. Gently perform perineal care, wiping from clean,' urethral area, to 'dirty,' rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY! . Female resident: Working from front to back.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #52) of two residents reviewed for feeding tube (a way of providing nutrition directly to the stomach). The facility failed to ensure LVN A cleaned the syringe and flushed the g-tube during Resident #52's medication administration through gastrostomy tube (G-tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) on 01/28/2025. These failures could place residents with G-tubes were at risk for infection, dehydration, and drug-to-drug interaction. Findings included: Record review of Resident #52's Face Sheet dated 01/28/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #52's Comprehensive MDS Assessment, dated 12/13/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach). Record review of Resident #52's Quarterly Care Plan, dated 12/24/2024, reflected the resident required tube feeding related to dysphagia and one of the interventions was see orders for water flushes. Record review of Resident #52's Physician Order, dated 10/13/2023, reflected every shift Flush tube with 30 ml water before and after medication and feedings. Record review of Resident #52's Physician Order, dated 10/13/2023, reflected every shift Flush with at least 5mls of water between each medication. Record review of Resident #52's Physician Order, dated 12/26/2024, reflected Baclofen Oral Tablet 5MG (Baclofen). Give 1 tablet via G-Tube two times a day for MUSCLE SPASMS. Record review of Resident #52's Physician Order, dated 12/26/2024, reflected Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa). Give 1 tablet via G-Tube three times a day for Parkinson's Disease (a disorder in the brain that affect movement). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/28/2025 at 12:03 PM revealed LVN A was about to give Resident #52 his 12 PM medication. She said the resident will have baclofen and carbidopa. LVN A sanitized her hands, put each of the medication on a small plastic cup, crushed them one by one, and returned each crushed medication to their respective cups. She went inside the room to get the water that the resident's family provided for the resident's use. She poured 20 ml to a plastic calibrated cup. She said she would incorporate 10 cc to each medication to dissolve it. She did not sanitize her hands before preparing the medications. She put on a gown and a pair of gloves, took the stethoscope hanging on the laptop stand of the medication cart, went inside the resident's room with the cups of crushed medication and the 20 ml water, and placed them on the resident's overbed table. She took a 60 ml piston syringe from the resident's side table and placed it also on the overbed table. The barrel of the syringe was observed with residuals. She put 10 ml to one cup and put the other 10 ml to the other cup. She disconnected the g-tube from the formula, pulled the plunger of the syringe, took the stethoscope from around her neck and placed the diaphragm of the stethoscope on the resident's abdomen. She then attached the syringe on the g-tube, pushed the plunger of the syringe to check for placement, and pulled the plunger to check for residual. After checking for the residual, she detached the syringe, pulled the plunger of the syringe, and attached again the syringe to the g-tube. She then poured the medication one at a time. After pouring the medications, she detached the syringe and connected the g-tube to the formula. She placed the syringe inside its plastic bag. LVN A did not flush the g-tube before giving the medications, in between each medication, and after administering the medications. She washed her hands and left the room. LVN A left the syringe on overhead table and did not clean it after she used it. During an observation and interview with LVN A on 01/28/2025 at 12:32 PM, LVN A stated she used the same syringe on Resident #52's morning medications and she was not sure if she cleaned it. She said the syringe should be cleaned after every use to prevent bacterial growth inside the syringe. She said she forgot to clean the syringe again after the 12 PM medications. She said she would get a new syringe. She said the g-tube should be flushed to prevent clogging and to ensure the medications were pushed throughout the tube. She opened the Resident #52's profile and saw the orders for flushing before and after medications, as well as flushing in between medications. In an interview with the DON on 01/29/2025 at 12:12 PM, the DON stated the syringe should be cleaned after every use to prevent contamination and potential infection. She said cleaning the syringe after use could also prevent build-up of residual on the syringe. She said the g-tube should be flushed to prevent clogging, to separate the medications just in case there was a drug-to-drug interactions, and to ensure the tube was patent and functioning properly. She also said the amount of water used for the residents with g-tube were calculated to prevent dehydration. She said the expectation was for the staff to clean the syringes after every use and to flush the g-tube accordingly. She said she would do an in-service about g-tube. In an interview with the Administrator on 01/30/2025 at 8:34 AM, the Administrator stated the expectation was for the staff to follow the procedure in administering medications through g-tube. He said he would collaborate with the DON with regards to doing an in-service about g-tube. (continued on next page)

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	675113	A. Building B. Wing	01/30/2025

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The Park IN Plano	3208 Thunderbird LN Plano, TX 75075

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Enteral (food or medication administration directly through the digestive system) Medication Administration Pharmacy Policy & Procedure manual revised 1/25/13 revealed 7. Flush the tube with 30 ml water or according to physician order . 8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered . 12. Change the medication syringe as directed by the manufacturer's label. If the syringe is used for 24 hours, clean after each use.

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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 observation, interview, 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 one (Resident #18) of twelve residents reviewed for Respiratory Care. The facility failed to ensure Resident #18's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored when not in use on 01/28/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Record review of Resident #18's Face Sheet, dated 01/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #18 was diagnosed with coronary heart disease (the blood vessels supplying blood to the heart get blocked). Record review of Resident #18's Comprehensive MDS Assessment, dated 12/04/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had coronary heart disease. Record review of Resident #18's Comprehensive Care Plan, dated 12/24/2024, reflected the resident had coronary artery disease and one of the interventions was to monitor for shortness of breath. Record review of Resident #18's Physician Orders, dated 01/27/2025, reflected May use oxygen @ 2 l/m via nasal canula every shift. Observation on 01/28/2025 at 9:27 AM revealed Resident #18 was not inside his room. An oxygen concentrator was observed at bedside with a nasal cannula connected to it. The nasal cannula was sitting on top of the oxygen concentrator and was not bagged. Observation and interview with LVN H on 01/28/2025 at 9:48 AM, LVN H stated the nasal cannula should be inside the bag to prevent cross contamination and respiratory infection. She went inside Resident #18's room and saw the nasal cannula sitting on top of the oxygen concentrator. She disconnected the nasal cannula and threw it on the trash can. She went out of the room, went to the storage room and took a plastic bag and a new nasal cannula. She said Resident #18 had an amputation and needed assistance during transfer. She said whoever transferred the resident should have made sure the nasal cannula was stored properly. (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 Resident #18 on 01/29/2025 at 8:16 AM revealed the resident was sitting in his bed, awake. It was observed that the resident had an above the knee amputation and was on oxygen administration via nasal cannula. The resident stated he used oxygen on a need basis only. He also said that he needed assistance during transfer from bed to wheelchair. He said whoever assisted him during transfers had also assisted him in taking off his nasal cannula. He said whoever assisted him should put the nasal cannula in the plastic bag tied to the railing of his bed. In an interview with the DON on 01/29/2025 at 12:12 PM, the DON stated the nasal cannulas should be bagged when the residents were not using them to prevent cross contamination and probable respiratory infection. She said whoever was caring for Resident #18 should check if the nasal cannula was bagged when not in use or needed to be changed because it touched something dirty. She said the expectation was for the nasal cannula be bagged when not in use. She said she would do an in-service about bagging the nasal cannula. In an interview with the Administrator on 01/30/2025 at 8:34 AM, the Administrator stated the nasal cannula should be properly stored to prevent respiratory infections. He said he would coordinate with the DON about doing an in-service regarding respiratory care. Review of facility policy, Oxygen Administration Nursing Policy & Procedure manual 2003 revised March 21, 2023 revealed Goals 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. 2. The resident will maintain an effective breathing pattern with administration of oxygen. 3. The resident will be free from infection.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45055 Based on observation, interviews and record review the facility failed to store, prepare, distributed, and serve in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the date the product was received from the vendor or date the product was stored after being used. 2. The facility failed to ensure the food stored in the freezer was properly sealed from air-borne contaminants. 3. The facility failed to ensure the ice machine in the dining area was cleaned. 4. The facility failed to cover a large trash can stored in the kitchen area. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations on 01/28/25 from 9:22 AM to 9:25 AM in the facility's only kitchen revealed: The ice machine door had white and brown dirt stains inside the door and a white plastic piece located above the ice had black dirt on them. One large trash can, which contained food and trash, in the kitchen area, was uncovered. One large zip locked bag of cooked meat, stored in the refrigerator, did not have the month, date and year the food was stored after use. Two bags of tortillas stored in the refrigerator, did not have the month, date, and year the food was stored when received from the vendor. One container of pie shells, stored in the freezer, did not have the month, date, and year the food was stored when received from the vendor. One large box of frozen sausages, located in the freezer, was unsealed and exposed to airborne contaminants. Two loaves of French bread, located in the freezer did not have the month, date, and year product was received from the vendor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/29/25 at 01:35 PM, the DM stated he had been the DM for nearly 4 months. He was shown pictures of the concerns observed in the kitchen area. He stated he cleaned the ice machine at least once a month but would check it for cleanliness more frequently. He stated the trash can in the kitchen area should have been covered to avoid airborne contaminants. He stated he worked with staff to ensure all foods were dated and labeled properly but still had some items that may have been overlooked. He stated he would get with his team to remind them of the need for the complete month, date, and year when storing foods. He stated the following concerns could result in food contamination. In an interview on 01/30/25 at 10:05 AM, the Administrator was shown pictures of the concerns observed in the facility's only kitchen. He stated this was his first week as the Administrator at the facility, but he would follow up with the DM to address the concerns. He stated the concerns observed could result in residents experiencing food contamination. Record review of the facility's policy on Dietary Services Policy & Procedure Manual 2012, revealed 4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened .6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a 'best by' or 'use by' date . If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year . All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Packaged Food shall be labeled as specified in LAW, including 21 CFR 101 food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. Record review of Title 21--Food And Drugs Chapter I--Food And Drug Administration Department Of Health And Human Services Subchapter b - Food For Human Consumption part 110 -- current good manufacturing practice in manufacturing, packing, or holding human food.

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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** 47743 Based 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 nine (Resident #5, Resident #6, Resident #18, Resident #26, Resident #27, Resident #33, Resident #39, Resident #43 and Resident #52) of eighteen residents reviewed for Infection Control. 1. The facility failed to ensure CNA G performed hand hygiene before checking on Resident #27 on 01/28/2025. 2. The facility failed to ensure LVN A did not bring the whole container of test strips used for checking blood sugar inside Resident #33's room on 01/28/2025. 3. The facility failed to ensure LVN A sanitized the diaphragm of the stethoscope before checking for Resident #52's g-tube placement during medication administration on 01/28/2025. 4. The facility failed to ensure LVN B sanitized her hands and the blood pressure cuff while administering medications to Residents # 6, #18, #26, #39, and #43 on 01/29/2025. 5. The facility failed to ensure CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #5 on 01/29/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #27's Face Sheet, dated 01/30/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #27 was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain) affecting the left side of the body. Record review of Resident #27's Quarterly MDS Assessment, dated 01/07/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident was dependent for activities of daily living. Record review of Resident #27's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had ADL self-care performance deficit and one of the interventions was to assist with personal hygiene. Observation on 01/28/2025 at 10:20 AM revealed CNA G was walking in the hallway and heard the Resident #27 calling for help. CNA G went inside the room to check on the resident, put on a pair of gloves, and saw the resident was throwing up. She went out of the room and said she would call the nurse. She removed her gloves before going out of the room. She came back to the room and put on a pair of gloves. She did not do hand hygiene before providing care. She assisted the nurse in placing the resident in a side lying position to prevent aspiration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA G on 01/30/2025 at 11:33 AM, CNA G stated hand hygiene should be done before providing care to a resident. She said hand hygiene was done to avoid infection. 2. Record review of Resident #33's Face Sheet, dated 01/30/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #33's Comprehensive MDS Assessment, dated 05/01/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin injections. Record review of Resident #33's Comprehensive Care Plan, dated 12/27/2024, reflected the resident had diabetes mellitus and one of the interventions was to acquire the fasting serum blood sugar (test that measures the amount of sugar in the blood) as ordered. Record review of resident #33's Physician Order, dated 09/15/2022, reflected FSBS checks two times a day related to DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITHOUT COMPLICATIONS. Observation and interview with LVN A on 01/28/2025 at 11:32 AM, LVN A said she was going to check Resident #33's blood sugar. She sanitized her hands and prepared the things needed to check the resident's blood sugar. LVN A sanitized the glucometer, prepared two alcohol wipes, a push button safety lancet, and the container of test strips. LVN A went inside Resident #33's room and told the resident she would be checking her blood sugar. LVN A brought with her the wipes, the push button safety lancet, the glucometer, and the whole container of the test strips inside Resident #33's room and placed them on the resident's overbed table. LVN A put on a pair of gloves, took a strip from the container, and inserted it on the glucometer. She wiped the resident's left index finger, waited for it dry up, and then pricked the left index finger with the push button safety lancet. LVN A scooped a drop of blood from the resident's index finger with the tip of the test strip that was inserted in the glucometer. After scooping the blood, the glucometer displayed 168. She went back to her cart and put the container of strips on top of her cart. She turned on her computer and checked the resident's order for insulin. She said the resident would get 5 units of insulin. In an interview with LVN A on 01/28/2025 at 11:39 AM, LVN A said she brought with her the container of the test strips in case she needed another test strip. She said she should have left the container of test strips on top of the cart and just brought with her 2 strips in case the glucometer displayed error. She said bringing an item inside the resident's room, putting it on the resident's table, and then putting it on the cart again could result to cross contamination. She said she would make sure she would not bring the container of strips inside the room of the residents. 3. Record review of Resident #52's Face Sheet dated 01/28/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #52's Comprehensive MDS Assessment, dated 12/13/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's Quarterly Care Plan, dated 12/24/2024, reflected the resident required tube feeding related to dysphagia and one of the interventions was check for placement. Record review of Resident #52's Physician Order, dated 10/13/2023, reflected check for placement. An observation on 01/28/2025 at 12:03 PM revealed LVN A was about to give Resident #52 his 12 PM medication. LVN A sanitized her hands, prepared the medications and the water needed for medication administration through g-tube. She put on a gown and a pair of gloves, took the stethoscope hanging on the laptop stand of the medication cart, and went inside the resident's room. She took the stethoscope from around her neck and placed the diaphragm of the stethoscope on the resident's abdomen. She did not sanitize the diaphragm of the stethoscope before placing it on the resident's abdomen to check for placement. During an observation and interview with LVN A on 01/28/2025 at 12:32 PM, LVN A stated the diaphragm of the stethoscope should be sanitized as because it was used on other residents. She said the blood pressure cuff and the pulse oximeter should be sanitized to prevent cross contamination and infection. 4. Record review of Resident #43's Face Sheet, dated 01/30/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with hypertensive emergency (very high blood pressure). Record review of Resident #43's Comprehensive MDS Assessment, dated 11/08/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had hypertension (high blood pressure). Record review of Resident #43's Comprehensive Care Plan, dated 12/24/2024, reflected the resident had hypertension and one of the interventions was to monitor for signs and symptoms of hypertension. Record review of Resident #43's Physician Orders, dated 09/24/2024, reflected Hydralazine HCl Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth one time a day related to HYPERTENSIVE EMERGENCY. HOLD IF SBP<110, DBP<60, P<60. Observation on 01/29/2025 at 6:54 AM revealed LVN B was preparing Resident #43's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #43. She did not sanitize the blood pressure cuff and did not do hand hygiene before preparing the medications. Review of Resident #6's Face Sheet, dated 01/30/2025, reflected resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertensive heart disease. Review of Resident #6's Comprehensive MDS Assessment, dated 11/30/2024, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's Comprehensive Care Plan, dated 12/24/2024, reflected resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Review of Resident #6's Physician's Order, dated 01/28/2025, reflected Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth every day shift for Hypertension Hold for SBP less than 110, DBP less than 60 and HR less than 60. Observation on 01/29/2025 at 7:12 AM revealed LVN B was preparing Resident #6's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #6. She did not sanitize the blood pressure cuff and did not do hand hygiene before preparing the medications. Record review of Resident #18's Face Sheet, dated 01/28/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #18 was diagnosed with hypertension. Record review of Resident #18's Comprehensive MDS Assessment, dated 12/04/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #18's Comprehensive Care Plan, dated 12/24/2024, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications as ordered. Record review of Resident #18's Physician Orders, dated 01/27/2025, reflected Vital signs every shift Notify provider for temp >101, pulse >110, or SBP < 90 Observation on 01/29/2025 at 7:41 AM revealed LVN B was preparing Resident #18's medication. Before she went inside the room, the Director Of Rehabilitation (DOR) approached LVN B and gave her a container of sanitizer. She took the container of sanitizer and put it on the last drawer of the nurse's cart. She picked up the other blood pressure cuff from the medication cart and went inside Resident #18's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #18. She did not sanitize the blood pressure cuff and did not do hand hygiene before preparing the medications. Review of Resident #39's Face Sheet, dated 01/28/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with depression. Review of Resident #39's Comprehensive MDS Assessment, dated 05/01/2024, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #39 had depression. Review of Resident #39's Comprehensive Care Plan, dated 12/01/2024, reflected resident had potential had depression and interventions were administer medications as ordered and observe side effects like hypotension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #39's Physician's Order, dated 06/21/2023, reflected Bupropion HCl ER Oral Tablet Extended Release 12 Hour 150 MG (Bupropion HCl) Give 1 tablet by mouth one time a day related to DEPRESSION, UNSPECIFIED. Observation on 01/29/2025 at 7:56 AM revealed LVN B was preparing Resident #39's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #39. She did not sanitize the blood pressure cuff and did not do hand hygiene before preparing the medications. Review of Resident #26's Face Sheet, dated 01/30/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Review of Resident #26's Comprehensive MDS Assessment, dated 05/01/2024, reflected Resident #26 had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had hypertension. Review of Resident #26's Comprehensive Care Plan, dated 01/16/2025, reflected the resident had hypertension and one of the interventions was give anti-hypertensive medications. Review of Resident #26's Physician's Order, dated 05/21/2024, reflected Amlodipine Besylate Tablet 5 MG. Give 1 tablet by mouth one time a day for Hypertension hold for systolic <110, Diastolic <60, pulse < 60. Observation on 01/29/2025 at 8:16 AM revealed LVN B was preparing Resident #26's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, LVN B placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #26. She did not sanitize the blood pressure cuff and did not do hand hygiene before preparing the medications. In an interview with LVN B on 01/29/2025 at 8:53 AM, LVN B stated she obtained the blood pressures of the residents before giving the medication for hypertension to know if the medication needed to be held or not. LVN B said the proper thing to do was to wash or sanitize her hands before and after giving medications. LVN B said the blood pressure cuff should be sanitized as well after using it and before using it on another resident. LVN B then acknowledged she forgot to sanitize the blood pressure cuff in between residents when she passed the medications. LVN B stated not sanitizing the blood pressure cuff in between residents could cause infection to transfer from one resident to another. LVN B added if a resident already had an infection, that infection could be transferred to another resident because the reusable item was not sanitized. In an interview with DOR on 01/30/2025 at 8:10 AM, the DOR stated she gave LVN B the sanitizer so she could use it to sanitize her blood pressure cuff and pulse oximeter. She said that was what they do in therapy. They sanitized the blood pressure cuff in between residents to prevent cross contamination and infection. (continued on next page)

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	01/30/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #5's Face Sheet, dated 01/30/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Review of Resident #5's Comprehensive MDS Assessment, dated 05/01/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Review of Resident #5's Comprehensive Care Plan, dated 12/24/2024, reflected the resident was incontinent for bladder and bowel and one of the interventions was provide peri care after each incontinent episode. Observation on 01/29/2025 at 8:23 AM revealed CNA D was about to assist Resident #5 to go to the bathroom for a bowel movement. CNA D sanitized her hands and put on a pair of gloves. She transferred the resident from bed to wheelchair and ushered the resident to the bathroom. CNA D then transferred the resident from wheelchair to the toilet bowl and waited for the resident to be done with her bowel movement. When the resident was done with her bowel movement, CNA D instructed the resident to stoop forward so she could clean her bottom. After cleaning the resident's bottom, she washed her hands and changed her gloves. CNA D instructed the resident to stand up and hold on the arm rest of the wheelchair. She took a couple of wipes and cleaned the resident's perineal area. After cleaning the resident's perineal area, she took the brief that she hung by the railing and put it on the resident. She did not do hand hygiene before touching the new brief. In an interview with CNA D on 01/29/2025 at 8:38 AM, CNA D stated she washed her hands before incontinent care and sanitized her hands when she changed her gloves. She said after cleaning Resident #5's perineal area she was not able to change her gloves before touching the new brief. She said she was supposed to change her gloves from dirty to clean. She said her gloves were already considered soiled because she used them to clean the bottom of the resident. She said she would be mindful with incontinent care to not compromise the residents' health and cause infection. In an interview with the DON on 01/29/2025 at 12:12 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after any care. She said the staff should not bring the container of strips for blood sugar check inside the resident's room. She said the staff could bring two or three strips inside and then discard what were not used. She added the blood pressure cuff and the diaphragm of the stethoscope should be sanitized before using or every after use. She said gloves should be changed after cleaning the resident's perineal area and before touching the new brief. She said there might be no policy regarding sanitizing the blood pressure cuff and stethoscope or about not bringing the container of strips inside the room, but they were obviously infection control issues. She said the above issues could cause cross contamination and different kinds of infections. She said the expectations were for the staff to be mindful with how they take care of the residents. She said she would do an in-service regarding infection control and would specifically focus on the issues mentioned. In an interview with the Administrator on 01/30/2025 at 8:34 AM, the Administrator stated the staff should follow the policies and procedures of any procedure to prevent infection. He said he would collaborate with the DON with regards to infection control. (continued on next page)

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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Park IN Plano	3208 Thunderbird LN 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 facility policy, Hand Hygiene, undated, revealed Hand hygiene continues to be the primary means of preventing the transmission of infection. When to perform hand hygiene . Upon and after coming in contact with a resident's intact skin Record review of facility policy, Perineal Care Policies and Procedure created 04/25/2022 revealed Purpose: This procedure aims . providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . Procedure Content . 10) Perform hand hygiene 11) [NAME] gloves . 24) Doff gloves and PPE . 25) Perform hand hygiene. Record review of facility policy, Infection Control Plan: Overview Infection Control Policy & Procedure Manual 2019 updated 3/2023 revealed Infection Control: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination . Fundamentals of Infection Control Precautions . Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection . Before and after assisting a resident with personal care . After contact with a resident's mucous membranes and body fluids or excretions . After removing gloves . Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves . Resident care equipment . Non-invasive resident care equipment is cleaned daily or as need between use.