STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675175	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of McKinney	1801 Pearson Ave McKinney, TX 75069

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident or the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for one of two residents (Resident #1) reviewed for discharge notices. The facility failed to notify Resident #1 in writing of his transfer/discharge to home due to his behaviors of exit seeking, the reason for the discharge, the right to appeal and they failed to send a copy of the notice to the Ombudsman as soon as practicable. This failure could place residents at risk of being transferred or discharged , and not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings included: Record review of Resident #1's face sheet, dated 03/18/25, reflected the resident was a [AGE] year-old male. The face sheet was incomplete. No admission date, No discharge date , no admitting diagnosis. Record review of an E-Mail sent by the Administrator to the facility management staff on 01/20/25 with an attachment, reflected Resident #1's family had toured the facility and were planning on admission of Resident #1 for long term care placement. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Attachment provided in the E-mail on 01/20/25 reflected a Neuropsychological Evaluation completed on Resident #1 with dates of services on 10/22/24, 11/01/24, 11/04/24, and 11/05/24. The evaluation reflected, [Resident #1] .was referred for a neuropsychological assessment due to concerns of dementia and history of seizures. [Resident #1] and his family served as primary informants for the current examination. The latter is also his assigned power of attorney .Upon a comprehensive review of [Resident #1's] medical records, diagnostic, functional status, and neuropsychological testing performed; it appears that [Resident #1] presents with a Major neurocognitive disorder due to vascular disease. Psychologically, meets criteria for adjustment disorder with mixed anxiety and depressed mood due to a slight elevation in sadness .During testing, [Resident #1] had trouble remembering what he wanted to say. He needed frequent repetition of instructions. He was slim for his height. Hygiene was unkempt. He was ambulatory. He was distractible and needed refocusing. He seemed depressed and anxious .was reportedly getting lost in familiar places .has feeling that a word is on the tip of his tongue, difficulty understanding others or following conversation, difficulty with naming objects, and has difficulty with expressing his thoughts . Record review of Resident #1's Nurses Notes by LVN A at 09:58 a.m., dated 02/16/25, reflected the following: Resident walked into the facility by his [POA] and [Family member] for admission into the facility. Resident to be admitted per services of [MD B]. Resident alert and confused stating several times that he didn't know why he was here and that he was ready to leave. Spoke with the family in the lobby for a short time collecting information from the family. Family asked did resident have exit seeking tendencies and family confirmed that he did. Resident and family taken to his room to meet his roommate and get oriented to his room. Again, resident is asking which door, he could use to get out of. Called MD on call service and got a return call from [NP C]. Went over home meds which NP agreed with. She also gave an order for labs to be drawn, and a speech consult due to family stating that the resident had swallowing issues. Resident spent a short time in his room then was taken to the dining room by his family. Family stayed until meal was served then left. Resident ate his lunch then continuously asked other residents and staff how to get out to the parking lot so he could go home. At approximately 1:15 pm resident redirected from the front door as he tried to exit the facility. Resident became belligerent and started to curse stating he could leave when he wanted to. Reality orientation given several times with unsuccessful results. Resident then brought to the unit and informed again that all doors on the hall were locked. Resident very upset stating he would throw a chair through the door and leave. Administrator and DON made aware of resident activity. Administrator informed this writer to contact family and ask them to come and pick the resident up recommending a locked unit for safety. At 2:35pm the family notified and told they needed to pick the resident up. The family was very upset stating that's not what they were told, and it was an inconvenience for them. Writer apologized for the inconvenience, but they still had to pick him up. [Family member] stated they could be here in an hour. While writer waited for family, resident continued to exit seek walking up to every door and pushing on it setting off the alarms. Resident ushered into the tv room and monitored one on one to ensure he remained in the building. Family asked, So what are we supposed to do with him? Writer advised a dementia type unit. Family asked if I could call the ambulance to come and pick him up. Writer stated there was no clinical reason for staff to call EMS. Family packed resident belongings and exited the facility. Record review of Resident #1's clinical record reflected there was no documentation showing the resident, the resident's POA and the Ombudsman were notified in writing of the resident's discharge or the reason for the resident's discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #1' Family member on 03/17/25 at 4:23 p.m. she stated Resident #1 was living at home with his POA who had noticed how advanced Resident #1's dementia had become. She stated they took him to a neurologist in November 2024 who diagnosed him with advanced Vascular dementia. She stated his POA got to where she could not handle him anymore, so she started looking for a place. She stated she visited several places and decided on this facility. She stated she sent all of Resident #1's medical paperwork to the Administrator and arranged for an admission date. She stated the Administrator had told them admissions during the week were better, but if the weekend worked better for them, he would have someone there to assist with the admission. She stated they agreed on a Sunday 02/16/25. She stated when they got to the facility, Resident #1 immediately said he did not like it here and was going to escape. She stated they stayed with him through lunch and thought he had agreed to give it a week. She stated they left and within 3 hours got a call from LVN A who told them they had to come get him. She stated he was kicking the doors, and screaming and was uncontrollable. She stated when they got to the facility, he was highly agitated and they wanted to send him to the hospital, but LVN A said she could not call an ambulance and said they could not call an ambulance from inside the facility. She stated if they wanted to call an ambulance they would have to take him outside. She stated they got him in their car and took him to the hospital where he spent the night in the psych ward. She stated they had to sedate him because he was so angry and aggressive. She stated the hospital then transferred him to a Behavioral health hospital. She stated she did get a call from the Administrator on that Monday (02/17/25) and he apologized that it did not work out. She stated she understood staff should not be physically and verbally abused by residents but stated it was such a negative experience for them. She stated Resident #1 had not been an elopement risk while at home. Family member stated he would go outside but always come back in. She stated Resident #1 is now in a locked unit at another facility and it seems to be going well. Family member stated they were not provided any written discharge information related to their rights or how to appeal the discharge or contact the ombudsman. In an Interview with DON on 03/18/25 at 01:09 p.m. she stated she was out of town the weekend Resident #1 came in. She stated usually she reviewed any of the clinicals on any new admission, but stated since she was out of town it would be the MDS nurse or the marketer who would review any clinicals. She stated she did not know much about what had taken place on the day of Resident #1's admission other than he was exit seeking and they do not have a locked unit. She stated she thought he had only been her about an hour. She stated as to the staff calling an ambulance, she stated 911 will not transport for behaviors only, and will only transport if there is a clinical need. She stated in reading the nurses progress note, most likely the ambulance would not have taken him to the hospital. She stated in hindsight, if the family was not able to stay with the resident, they should have placed him on one on one until the physician could have evaluated him, or he started to adjust, or they ensured a proper transfer or discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview with LVN A on 03/18/25 at 01:26 p.m. on speaker phone in the presences of the Administrator and the DON, she stated she was not aware she was getting a new admission [DATE]. She stated she worked the long-term care hall and did not get a lot of admission on her side. She stated she did not know until the resident and his family arrived at the facility that Sunday (02/16/25). She stated the family gave her a bag of his medications when they arrived around 9:30 a.m. She stated she called the MD on call to get admission orders and took him to his room and gave him a tour and introduced him to his roommate. She stated the family stayed with him through lunch and then left. She stated he visited a little while and then got up and told his roommate he had to get his stuff and go. She stated they tried to do reality orientation on him, but he kept getting more and more agitated. She stated she called the family and let them talk to him and he calmed down a little, but then around 2:00 p.m. he was going to the doors trying to leave, threatening to throw a chair and break the door to get out. She stated she called the Administrator, and he told her to call the family and tell them they had to come get him that they could not meet his needs. She stated she called the family and asked if they could come sit with him and they stated they could not. She stated she told the family they would have to take him back that they did not have a secured unit that they could keep him safe. She stated the family was very upset and wanted her to call an ambulance and she told them there was no clinical reason to call an ambulance. She stated the resident had calmed down once the family got there. She stated the family gathered up his belongings and left with him. She stated she had not been able to get any of his admission paperwork completed. In an interview with the Administrator on 03/18/25 at 01:35 p.m., he stated he had initiated the tour and conversation with Resident #1's family member and had taken her for a tour of the building. He stated there was nothing mentioned about him being an elopement risk. He stated he had told her weekdays were better for admissions but stated they take admission 7 days a week 24 hours a day. He stated he had sent the information to the MDS nurse to determine if he would meet medical necessity. He stated looking back it appeared the admission process fell thought the cracks. He stated they had a new admission person who had just started in January 2025. He stated typically all the initial information that goes on the face sheet is started in the systems along with any other clinicals they may have. He stated it just did not get done. He stated when he got the call from LVN A, he assumed sending Resident #1 back home was the best solution since he did not want to be there. He stated they should have given them a copy of their discharge rights and stated they should have given them a discharge notice due to safety concerns related to his exit seeking behaviors. He stated going forward they would be putting systems in place, especially for residents admitting from home, to ensure they were able to meet the needs of the resident prior to accepting them. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Admission, Transfer and Discharge dated January 2022, reflected, It is the policy of this facility that each resident will remain in the facility, and not be transferred or discharged unless the discharge or transfer is appropriate as per the existing criteria. When the Facility transfers or discharges a resident, the Facility shall ensure that the transfer or discharge is documented in the residents' medical record and appropriate information is communicated to the receiving health care institution or provider .The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the Facility unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility .If the resident exercises his or her right to appear a transfer or discharge notice, the Facility shall not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer wound endanger the health or safety of the resident or other individuals in the Facility. The facility shall document the danger that failure to transfer, or discharge would pose .If the transfer or discharge is necessary for the resident's welfare and the residents' needs cannot be met in the facility, the resident's physician shall document the following in the resident's medical record a. the specific resident need(s) that cannot be met; b. Facility attempts to meet the resident needs; and c. The service available at the receiving Facility to meet the need(s) .A physician shall document if the transfer or discharge is necessary because the safety of individuals in the Facility is endangered due to the clinical or behavior status of the resident .