STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676002	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Edgemere	8502 Edgemere Dallas, TX 75225

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 (Residents #1 and #2) of 5 residents reviewed for quality of care. The facility failed to ensure Resident #1 and Resident #2 did not develop wounds due to ill-fitting (too small) briefs for both, and the use of a mechanical lift sling that was too small for Resident #1. This failure could place residents at risk for pain and infection.Findings included: 1. Record review of Resident #1's admission MDS Assessment, dated 03/05/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were moderately impaired. The resident was always incontinent of urine and frequently incontinent of stool. Her diagnoses included heart failure, diabetes, and end-stage kidney disease. Record review of Resident #1's Care Plans reflected:03/19/26 The resident was incontinent of bladder.Facility Goal: The resident will remain free from skin breakdown due to incontinence and brief use.There were no interventions listed. Record review of Resident #1's Order Summary Report, dated 03/16/26, reflected:Cleanse non-pressure wound to left posterior upper thigh with wound cleanser; pat dry, apply calcium alginate, cover with dry dressing change daily and as needed. Record review of Resident #1's progress notes dated, 03/16/26 at 1:34 PM, authored by the WCN reflected:Notified by night nurse that resident had an open area to buttock, physician here, assessment done. Per resident open wound is due to [mechanical] lift. New order from physician to cleanse non-pressure wound to left posterior thigh with wound cleanser, pat dry apply calcium alginate cover with dry dressing change daily and as needed. Review of wound care notes for Resident #1, dated 03/24/26, reflected:Non - Pressure Wound of the left, posterior, upper thigh, full thickness.Wound Size (L x W x D): 0.5 x 1.2 x 0.2 cmWound progress: Improved evidenced by decreased surface area An observation and interview on 03/26/26 at 11:00 AM with Resident #1 revealed the WCN was preparing to do wound care. Resident #1 said she did not know how the wound developed and she did not know how long she had the wound. The resident had a linear, open area surrounded by redness, on the back of her left thigh. The brief was the appropriate size for the resident. 2. Record review of Resident #2's admission MDS Assessment, dated 02/11/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were intact. The resident was always incontinent of urine and stool. The resident's diagnoses included heart failure and diabetes. Record review of Resident #2's Order Summary Report dated 03/10/26 reflected:Cleanse right ischium non-pressure wound with wound cleanser, pat dry, apply calcium alginate, cover with dry dressing, change daily and as needed.Record review of Resident #2's Care Plans reflected:02/27/26 The resident was incontinent of bladder.Facility Goal: The resident will remain free from skin breakdown due to incontinence and brief use.Facility interventions: Brief use - The resident used disposable briefs. Change per schedule and as needed.3/27/26 Wound Management Wound: Right Ischium (back part of hip) Non-PressureFacility interventions included: Provide wound care per treatment order. Record review of Resident #2's progress notes dated 03/03/26 at 12:34 PM authored by the WCN reflected:Notified by floor nurse that (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	resident had a shallow open area to right ischium. Physician here and notified. Resident seen by wound for multiple skin tears (old) and right ischium wound. New order for non-pressure wound to right ischium to apply xeroform gauze cover with dry dressing change daily and as needed. Review of wound care notes for Resident #2, dated 03/24/26, reflected:Non - Pressure Wound of the left, posterior, upper thigh, full thickness.Wound Size (L x W x D): 6 x 4.2 x 0.4 cmWound progress: At Goal An interview on 03/26/26 at 12:30 PM with Resident #2 revealed he said he developed a wound because he was wearing a brief that was too small. He said the WCN was taking care of it. He said that his briefs were now the correct size. An interview on 03/26/26 at 12:10 PM with the WCN revealed Resident #1 developed her wound due to the brief being too small and the small mechanical lift sling. The WCN said Resident #2 had a wound due to him having a very small brief. She said it was a non-pressure wound to the right ischium. She said it developed on 03/03/26. An interview on 03/26/26 at 3:45 PM with the DON revealed Resident #1 and Resident #2 had briefs that were tight and had areas that were really red. The DON said the staff changed the briefs to a larger size. The DON said the nurses and CNAs were responsible for ensuring the resident had the right sized brief. Record review of the facility's policy, Wound Treatment Management, revised 01/02/26, reflected: Policy:To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Record review of the facility policy, Resident Rights, dated 2026, reflected:8. Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.