STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676098	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Richardson	1301 Richardson Dr Richardson, TX 75080

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for one of one resident (Resident #1) reviewed for abuse. The facility failed to report an allegation of sexual abuse of Resident #1 that occurred on 03/23/24 by CNA A, to the State Survey Agency within 2 hours of being notified. This failure could place residents at risk of abuse. Findings included: Record review of Resident #1's face sheet, dated 03/28/24, reflected Resident #1 was a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #1 had diagnoses of Parkinson's Disease (brain disease that causes uncontrollable and unintended movements), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (difficulty with talking and language usage), Dementia (impaired ability to remember, think, and made cognitive decisions), Psychotic Disorder with Hallucinations, Brief Psychotic Disorder (sudden onset of psychotic behavior), Depression (depressed mood or loss of pleasure), Insomnia (trouble falling or staying asleep), Essential Hypertension (High blood pressure), Muscle Weakness, Personal history of Malignant Neoplasm of Prostate (prostate cancer), and history of falling. Record review of Resident #1's quarterly MDS assessment, dated 02/16/24, reflected Resident #1 had a BIMS of 11, which indicated Resident #1 was moderately impaired. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/24 at 10:30 AM, Administrator B stated he was working at the facility last Saturday, 03/23/24, when Therapist C told him Resident #1 confided in her and told her CNA A licked and nibbled his ear while giving a shower. Administrator B stated Resident #1 also told Therapist C he felt CNA A rubbed his private area longer than usual. Administrator B stated he started his own investigation. Administrator B stated he spoke with Resident #1, and Resident #1 told him CNA A did not abuse him. Administrator B stated Resident #1 denied telling Therapist C anything regarding CNA A and any type of abuse. Administrator B stated he completed safe surveys with the other residents, and no resident complained of any type of abuse. Administrator B stated Resident #1 never complained of abuse. Administrator B stated he completed his investigation that evening around 7:00 PM, on 03/23/24. He stated CNA A did not work, but he did call CNA A, did not tell CNA A which resident complained, but asked if he remembered any issues while showering the residents. Administrator B stated CNA A denied the allegations of sexual abuse. Administrator B stated since Resident #1 denied the allegations, and no other residents voiced any concerns, CNA A was allowed to return to the facility, but as a precaution, CNA A was not allowed to work on the same hall as Resident #1. Administrator B stated he did not report it to the state, because he completed his investigations with no findings, and Resident #1 denied the allegations. Administrator B stated Resident #1 was alert, his BIMS was around 11, he's an active resident, and no other residents complained of abuse. He stated even though there were no findings he started an abuse and neglect in-service. Administrator B stated he felt there was no risk, because he completed his own investigation and did not find any evidence of abuse. Administrator B stated he would start an incident report and provide the intake number. In a telephone interview on 03/28/24 at 12:08 PM, Therapist C stated during a conversation with Resident #1 on Saturday, 03/23/24, they talked about getting him up more due to Parkinson's Disease, and that was when Resident #1 told her CNA A abused him. She stated Resident #1 stated, Can I tell you something and you promise not to tell anyone. Therapist C stated she told Resident #1 she could not promise she would not tell anyone, but to go ahead and tell her. Therapist C stated Resident #1 told her CNA A had bothered him. Therapist C stated she asked Resident #1 who CNA A was, and he replied, the gay male CNA that came during the day. Therapist C stated Resident #1 told her CNA A had nibbled on his ear. She stated Resident #1 told her CNA A rubbed his private area longer and harder than he felt he needed during the shower. She stated Resident #1 told her he told CNA A he was not gay. Therapist C stated she told Resident #1 even if he was gay, it was not right for CNA to nibble on his ear or touch him in any inappropriate manner. Therapist C stated Resident #1 told her he could handle the issue. Therapist C stated she told Resident #1 someone should be told, because they did not want this to happen with other residents. Therapist C stated she was a contract worker for the facility, so she called her supervisor and let her know what Resident #1 told her. She stated she went to look for the social worker in the facility and saw Administrator B was there, so she told Administrator B what Resident #1 told her about CNA A. Therapist C stated no other residents at the facility alleged abuse during their interactions. Therapist C stated Administrator B asked her to write a statement and stated he would start an investigation. Therapist C stated she knew Resident #1 had Parkinson's Disease, but she felt Resident #1 was not confused. She stated she had not known Resident #1 to be confused. Therapist C stated Administrator B told her Resident #1 denied the allegations when he had a conversation with him. Therapist C stated Resident #1 was religious and was probably embarrassed by the situation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/24 at 2:30 PM, Social Worker D stated Administrator B contacted her on 03/23/24, told her about the allegations and asked her to come to the facility to complete safe surveys. She stated she interviewed Resident #1, and the interview bothered her, because she did not mention any specific employee, but Resident #1 told her, He's a good guy and nothing happened. Social Worker D stated she mentioned to Administrator B this incident should be reported to the state, and he told her he would handle it. Social Worker D stated she told Administrator B he would be infringing on Resident #1's rights if he did not report the alleged abuse to the state. Record review of the facility's policy dated 2001 revised April 2021, titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, reflected the following: Policy Statement All reports of resident abuse (including injuries of unknown origin) neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. 3. 'Immediately' is defined as: a. Within two hours of an allegation involving abuse or result in serious bodily injury; or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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NAME OF PROVIDER OR SUPPLIER The Plaza at Richardson		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Richardson Dr Richardson, TX 75080	

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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 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** 44786 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 measurableobjectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents, (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan was updated to reflect the resident's diagnosis of prostate cancer. This failure could place the residents at risk of not receiving adequate care. Findings included: Record review of Resident #1's face sheet, dated 03/28/24, reflected Resident #1 was a [AGE] year-old male, who admitted to the facility on [DATE]. Resident #1 had a diagnoses which included Parkinson's Disease (brain disease that causes uncontrollable and unintended movements), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (difficulty with talking and language usage), Dementia (impaired ability to remember, think, and made cognitive decisions), Psychotic Disorder with Hallucinations, Brief Psychotic Disorder (sudden onset of psychotic behavior), Depression (depressed mood or loss of pleasure), Insomnia (trouble falling or staying asleep), Essential Hypertension (High blood pressure), Muscle Weakness, Personal history of Malignant Neoplasm of Prostate (prostate cancer), and history of falling. Record review of Resident #1's quarterly MDS assessment, dated 02/16/24, reflected Resident #1 had a BIMS of 11, which indicated Resident #1 was moderately impaired. Record review of Resident #1's Care Plan with an initial date of 12/11/23 and a revision date of 03/03/24, did not address Resident #1's diagnosis of prostate cancer. In an interview on 03/28/24 at 3:00 PM, MDS Coordinator E stated she started working for the facility as the MDS Coordinator in October of 2023. MDS Coordinator E stated she was still trying to get caught up with the duties of the position, and that was why Resident #1's Care Plan did not reflect his prostate cancer diagnosis. She stated she would ensure it was updated before the end of the day. She stated the care plans should be updated annually or after a change in condition. MDS Coordinator E stated one risk of not addressing the diagnosis of prostate cancer on Resident #1's care plan was possible neglect of the resident, because some staff might not be aware of his diagnosis. During the same interview, Administrator B stated one risk of not having the care plan updated was Resident #1 not receiving the best quality of care, because some were not aware of his condition. Record review of the facility's policy, dated 2001 with a revision date of 08/2006, titled Using the Care Plan revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care our services to the resident. 5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made.