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	05/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two (Residents #25 and #218) of eighteen residents reviewed for resident rights and dignity. 1. The facility failed to treat Resident #218 with dignity and respect during the discharge process from the facility to the resident's home. 2. The ADON failed to ensure Resident #25 was provided with a dignified dining experience, when she stood over him as she was assisting him in eating a lunch meal service. This failure could place residents at risk for a loss of dignity, decreased self-worth, and decreased self-esteem. Findings included: 1. Review of face sheet dated [DATE] documented Resident #218 was a [AGE] year-old female previously admitted on [DATE] and currently admitted on [DATE] with diagnoses of Alzheimer's disease, Anemia, Type 2 Diabetes Mellitus with diabetic neuropathy, dementia, legal blindness. Review of Resident #218's Comprehensive MDS assessment, dated [DATE], reflected not being completed. MDS Outcome Summary Report revealed it was In Progress. Review of Resident #218's care plan dated as initiated on [DATE] and revised on [DATE] revealed care areas of requested palliative care, a Full Code status, with a terminal prognosis with an elected hospice agency. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on [DATE] at 1:43 PM with LVN A revealed she was Resident #218's Charge Nurse on the evening she was discharged home and worked from 6:00 PM to 6:00 AM that night. She stated she had only taken care of her that evening. She stated Resident #218 was fine and breathing when she left the faciity on [DATE] at around 10:30 PM and someone later called and said she was not breathing. LVN A stated Resident #218 was supposed to have been discharged earlier that day, but no one had come to pick her up. She stated she took her vital signs when she left but was not sure if she had entered them in the progress notes. She stated she was contacted by the Administrator on [DATE] and asked to provide a statement. She stated she located Resident #218's vital signs on a piece of paper she had at home. LVN A stated they often wrote resident's vital signs on a scrap piece of paper and later entered the information into the chart. She stated the resident's blood pressure was ,d+[DATE] and her pulse was 59. She said she did not know what her respiratory rate was. She stated she used a wrist blood pressure cuff and denied receiving any error readings. LVN A stated she observed the resident during her initial rounds that evening and noted she was already sleeping and was breathing. She stated she did not wake her to complete a full assessment or vital signs and they rarely did that unless there was a reason for concern, and she had moved on to another hall. She stated, when the transportation people arrived to pick her up, the resident was still sleeping. She moved her to a wheelchair with the assistance of one of the transport staff. She described Resident #218 as drowsy but able to sit up. LVN A stated she probably should have documented her vital signs in the computer. She stated she was unaware of any need to complete an assessment because she had never discharged anyone before. Interview on [DATE] at 2:00 PM with the medical transport representative, the representative revealed two of the medical transport employees on [DATE] went to a 10:30 PM scheduled transport for the discharging Resident #218 back the resident's home. Interview on [DATE] at 2:17 PM with the medical transport representative revealed they sent a wheelchair van with two employees to transport Resident # 218 home from the facility. She stated she was unsure why the van was sent so late that night. She stated she was informed by the transportation staff that they had discovered Resident #218 had expired when they arrived at her family member's home. She stated the trip was approximately a ,d+[DATE]-minute drive. When they arrived, the resident's family member questioned whether she was asleep because the resident was usually up all night and that was when they discovered she was not breathing. She stated the hospice nurse was notified who then arrived at the resident's home and confirmed her death. She stated they transported the resident to the facility for respite care on [DATE] and she travelled by stretcher at that time. She stated they were notified by her hospice company not to use a stretcher but to use a wheelchair instead because her family did not wish her to use a stretcher. Interview on [DATE] at 2:30 PM, with Resident #218's Responsible Party revealed when she arrived Resident #218 was slumped over in the wheelchair. The Responsible Party stated she knew something was wrong when she asked Medical Transporter A if Resident #218 had been giving them trouble, due to Resident #218's unusual evening behavior. Responsible Party revealed the medical transport person A stated Resident #218 had been sleeping the entire time of putting Resident #218 in the wheelchair, loading into the medical transport and during the ride home. Medical Transporter A told her she had to hold Resident#218's shoulders to keep the resident from leaning forward in the wheelchair during the transport. The Responsible Party stated it took three people to transfer Resident #218 from the wheelchair to the bed. The Responsible Party stated Resident #218's mouth was open, and her eyes were fixed. She stated Hospice Nurse A arrived at the facility and pronounced Resident #218 deceased . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:45 PM with Medical Transporter A revealed she told LVN A, who was assisting to dress Resident #218, that the resident felt cold. Medical Transporter A revealed LVN A stated Resident #218 was always cold, and they would get Resident #218 another blanket. Medical Transporter revealed she asked if LVN A was going to take the resident's vitals to which LVN A went and got a wrist blood pressure cuff, but it was not working. LVN A stated Resident #218 was fine as she was sleeping. Interview on [DATE] at 3:00 PM with the Administrator revealed staff statements were taken after medical transport personnel returned to the facility on [DATE] and inquired to the Administrator about the status of Resident #218 when Resident #218 was discharged and transported on [DATE]. Interview on [DATE] at 8:24 AM with LVN D revealed she was the daytime charge nurse for Resident #218 on the day she was discharged , and she worked from 6:00 AM to 6:00 PM. LVN D stated caring for a respite patient was just like caring for any other resident. They were checked every two hours for needs such as incontinent care, assistance with food, and bathing. Vital signs were taken as required and would be flagged on their medication administration records, if none were required, they took them as needed if there were any concerns. She stated, if she had assessed her, she would have documented it in the nurses' notes. She stated she recalled Resident #218 was supposed to have gone home on her shift because someone from Admissions had told her. She stated one of her family members had called wanting to know why she was not home yet and she told them no one had arrived to pick her up. She stated the family member told her they would look into it as they were arranging transportation. LVN A stated she had taken care of Resident #218 during her previous stay, and she would often refuse meals and medications. She stated, during the most recent stay, she was much calmer at night and slept a lot. She stated she would occasionally come out to the dining room for meals and always ate in the same spot. She stated she had her paperwork ready for discharge and checked on her before she left on [DATE] and she was sleeping. She stated she had not noticed any end-of-life symptoms or anything unusual that would have prompted her to check her vital signs or perform a further assessment. She stated she passed on report that her ride had not arrived yet. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy reflected: .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . Review of facility's Transfer or Discharge Documentation policy and procedure reflected: .4. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. .b. That an appropriate notice was provided to the resident and/or legal representative. c. The date and time of the transfer or discharge. d. The new location of the resident. e. The mode of transportation. f. A summary of the resident's overall medical, physical, and mental condition. g. Disposition of personal effects. h. Disposition of medications. i. Others as appropriate or as necessary; and j. The signature of the person recording the data in the medical record. 2. Review of Resident #25's Face Sheet, dated [DATE], reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Review of Resident #25's MDS Assessment reflected he had diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), non-Alzheimer's dementia (a more rare type of dementia), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of Resident #25's Care Plan, dated [DATE], reflected he was unable to feed himself and required assistance for all meals. Observation of the lunch meal service in the facility's main dining room on [DATE] at 11:50 AM, revealed the ADON was feeding Resident #25. The ADON was in a standing position while assisting Resident #25 with the meal service. Interview with the ADON on [DATE] at 10:37 AM revealed she typically sat down when assisting a resident with eating, as to make the experience more personal for the resident. She said when she was assisting Resident #25 with eating on [DATE], she did not initially sit down (until the Administrator entered the dining room and reminded her that she needed to have a seat), as she was waiting on another staff member to take over for her. The ADON stated the potential risk of not sitting down when feeding a resident included a lack of dignity. Review of the facility's Assistance with Meals policy, dated [DATE], reflected: .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #35) of 8 residents reviewed for pharmacy services. The facility failed to obtain the routine scheduled pain medication for Resident #35, who was to receive it every 4 hours, from her hospice company. Resident #35 missed 7 doses of her scheduled pain medication placing her at risk for unnecessary pain. The medications were received after surveyor inquiry. This failure could place residents who require pain medication at risk of suffering pain due to lack of medication availability. Findings included: Record review of Resident #35's Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #35's Quarterly MDS assessment dated [DATE] revealed her diagnoses included cancer, cancer related pain, hypertension (high blood pressure), depression, and anxiety. The MDS also reflected she had severe cognitive impairment, she ambulated with a walker, received scheduled and PRN pain medication, and experienced occasional pain. Record review of Resident #35's Care Plan revealed an entry dated 07/11/23 which reflected: Focus: The resident requires pain management chronic pain r/t Malignant neoplasm [cancer] of .bronchus or lung, bil [bilateral-both sides] shoulder pain .Interventions/Tasks: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain .Evaluate the effectiveness of pain interventions (FREQ). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition Record review of Resident #35's Order Summary Report dated 05/08/24 revealed it included the following orders: Oxycodone HCL [narcotic pain medication] Oral Tablet 30 mg give 2 tablet by mouth every 4 hours for pain . Methocarbamol [muscle relaxer] Oral Tablet 500 mg give 2 tablet by mouth three times a day related to neoplasm related pain . Lidocaine external patch [a pain relieving patch] 4% apply to bilateral shoulders topically in the morning for pain wear for 12 hours on then 12 hours off and remove per schedule (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The orders also revealed orders for Morphine sulfate (narcotic pain medication) 20 mg/ml 0.25-1 ml every hour as needed for pain. Record review of Resident #35's MAR dated May 2024 revealed an entry for Oxycodone HCL Oral Tablet 30 mg give 2 tablets by mouth every 4 hours as needed for pain. The doses were scheduled to be administered at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. The doses were initialed as administered from 05/01/24 through 05/06/24 at 12:00 PM. The doses scheduled at the following dates/times were coded with a 9 indicating to see the nurses notes: 05/06/24 at 4:00 PM 05/06/24 at 8:00 PM 05/07/24 at 12:00 AM 05/07/24 at 4:00 AM 05/07/24 at 8:00 AM 05/07/24 at 12:00 PM 05/07/24 at 4:00 PM The MAR reflected Resident #35 had received morphine for pain management between 05/06/24 and 05/08/24. Record review of Resident #35's nursing Progress Notes revealed the following entries: 05/06/24 at 1:05 PM: Resident out of Oxycodone. Hospice notified reminded and promised to bring ASAP Entered by LVN D 05/06/24 at 4:47 PM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery Entered by LVN D. 05/06/24 at 11:24 PM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery Entered by LVN H. 05/07/24 at 3:17 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain Oxycodone is on order, waiting for delivery of the medicine [sic]. Entered by LVN H. 05/07/24 at 7:25 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery. Entered by LVN D. 05/7/24 at 10:57 AM: [Hospice company] called in regard to resident's pain medications and notified that resident is out of medication at this time, response is that the nurse will called and medication will be sent as soon as possible Entered by DON. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/07/24 11:42 AM: oxyCODONE HCl Oral Tablet 30 MG Give 2 tablet by mouth every 4 hours for Pain pending delivery. Entered by LVN D. Observation and interview on 05/07/24 at 10:23 AM revealed Resident #35 ambulating in the hall using her walker, she entered her room and requested to talk. Resident #35 stated she was upset with her hospice company because they have not come through with my medications for 24 hours. She stated she was missing her oxycodone. She stated she knew her roommate received medications on time from a different hospice company and she was frustrated with her company. Resident #35 stated she was receiving morphine for pain which was effective but she preferred to take the oxycodone and use her morphine for breakthrough pain. Resident #35 stated she had spoken with the DON on 5/6/24 about it and he was looking into it. She requested this surveyor to check on it for her and get the DON. Interview on 05/07/24 at 10:36 AM with the DON stated he was the acting DON for the facility and had only been there for five days. He stated the facility's usual DON was on leave due to a family emergency. When asked about Resident #35's pain medications, the DON entered her room and told her, I just checked on you this morning, you said you had a good night. Resident #35 stated she did but was upset that the hospice company had not delivered her medications yet. The DON stated they called the hospice company regarding the medications on 5/6/24 and he was not aware the medications still had not been delivered. The DON stated he would look into the situation. After leaving the room, the DON stated, after speaking with Resident #35 earlier that morning, he thought the medications had arrived and he would check her medication cart. Observation and interview on 05/07/24 at 1:20 PM revealed Resident #35 lying in bed with her eyes closed and opened them upon knocking. She stated she had received some morphine for her pain and wanted to go to sleep. She declined to discuss her pain scale. Interview on 05/07/24 at 1:25 PM with LVN D and the ADON, LVN D stated Resident #35 had run out of her oxycodone during her shift on 5/6/24. She stated she called the hospice company and was told they were working on it. She stated that was her first shift caring for her and she had been told by a previous nurse the medications had been ordered. She stated she believed either LVN E or LVN I had previously contacted the hospice company about the medications. LVN D stated she did not call the pharmacy because the hospice company was responsible for delivering the medications. She stated she did not call the resident's physician because, It's still a hospice order. She stated the resident was receiving other pain medications including morphine which was controlling her pain. LVN D stated Resident #35 rated her pain the same way whether or not she received her oxycodone and they continued to assess her. The ADON stated they did not carry oxycodone in the facility's Ekit [emergency kit of medications kept by the facility]. LVN D stated medications were usually reordered when they reached the last row on the medication card. If a resident was on hospice, they called the provider. If a resident was not on hospice, they medications were reordered through their computer software or the pharmacy could be called. The ADON stated they did not call her physician because, they would just tell us to call hospice. When asked if that was the case when a resident missed any dose of a scheduled medication, the ADON replied, I see your point and stated the physician should be called if a medication was not available and so that they would know doses were missed and could provide guidance. LVN D stated the risk for missing pain medication doses included increased pain and a change in condition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/07/24 at 1:45 PM, LVN E stated she had previously cared for Resident #35 but had not seen her since the previous week as she had transferred to another hall. She stated they did not typically have any issues getting medication refills and she usually called the hospice company before they ran out and they would send them STAT. She stated she had to call the hospice company for Resident #35 a few weeks prior because she was running out of her oxycodone. She stated the resident went through the supply quickly because she was getting them every 4 hours and they only sent about 45 doses at a time. She stated she recalled telling the hospice nurse the last time she saw her she needed to send more and was told she needed to call them every week. She stated the hospice nurse usually checked her cart asked them if they needed any supplies when they came to see the residents. LVN E stated the risk for missing pain medications included the resident suffering severe pain that could not be moderated, and they could possibly need to be sent to the hospital for pain control. She stated she did not typically have issues moderating Resident #35's pain because she was also on muscle relaxers and had PRN medications available. Interview with the DON on 05/07/24 at 2:33 PM, he stated he had spoken with Resident #35's hospice provider again including their Administrator and DON. He stated he also spoke with the NP for Resident #35's attending physician who was in the facility at that time. She told him Resident #35's charge nurse had called and her and she planned to visit the resident. He stated the NP planned to order some from their pharmacy as well. The DON stated he spoke with Resident #35's charge nurse on 5/6/24 and learned she was out of her oxycodone. He stated he had called them as well as the charge nurse and was told they were sending it. He was not aware if had not arrived until speaking with this surveyor and the resident that morning. Interview on 05/07/24 at 2:42 PM, NP J stated she had received a call from Resident #35's charge nurse about her running out of Oxycodone. She stated she had already called the attending physician and ordered some from the facility pharmacy. NP J stated since the medication was ordered from the resident's hospice provider, she would expect the facility staff to contact them initially if a resident ran out of medication. She stated she would expect a call if the hospice company was not providing the ordered medications. NP J stated there were concerns with her ordering the medications because they were controlled and required triplicate prescriptions and there could be a problem with the pharmacy accepting the order if duplicates were sent. NP J stated the risk for residents running out of pain medications included exacerbating the pain making it more difficult to control and they also run the risk of experiencing withdrawal symptoms. She stated, if that were the case, they should have called and let her know. NP J stated, with Resident #35, she was not as concerned because she had other medications available. She stated she was sound asleep and in no distress when she checked on her. She stated she expected the staff to use her as a back-up if they were not getting a proper response from the hospice nurse. Interview with the DON on 05/07/24 at 3:19 PM revealed he spoke with the hospice company again and was told Resident #35's oxycodone had been sent out STAT with an approximate 3 hour delivery window. He stated they never explained why the medication was not sent on 5/6/24 after they were notified. The DON stated medications should be re-ordered a minimum of 72 hours before the last dose. Observation on 05/07/24 at 3:45 PM revealed Resident #35 was ambulating in the hall with her walker following a nurse who was pushing a medication cart. Resident #35 stated she was doing fine and denied complaints. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 05/07/24 at 4:38 PM, he stated the DON had informed him of the events surrounding Resident #35's medications. He stated his usual DON was out of the country for a family emergency and the acting DON had only been there 5 days. The Administrator stated he expected medications to be ordered 5-7 days out whether or not they were dealing with a hospice resident. He stated pain medications could take longer to arrive as they needed special prescriptions. He stated the night nurses were responsible for ensuring medications were reordered and the DON and ADON were responsible for ensuring it was done. He stated anyone could reorder medications at any time. He stated for controlled medications, the pharmacy should be called to see if refills were available and, if not, the physician should be called. The Administrator stated if the resident was on hospice, they hospice nurse should be notified and they were responsible for getting the medications to the facility. He stated he expected the nurses to leave a progress note whenever they were contacting the hospice company. He stated risks of not having pain medications available included increased pain, anxiety, a change in condition and behaviors. Observation and interview on 05/08/24 at 7:13 AM, LVN F stated Resident #35's oxycodone had arrived from hospice the evening before on 5/7/24. Two cards containing 45 doses each were observed in her medication cart. She stated the facility pharmacy had sent a supply as well and it was locked up on another cart. She stated she had received her doses as scheduled beginning at 8:00 PM on 05/07/24. Interview with the DON on 05/07/24 at 7:40 AM, revealed hospice had delivered Resident #35's medications on 5/7/24 at 6:55 PM. Interview on 05/09/24 at 5:57 AM, LVN F stated she had taken care of Resident #35 on 5/3/24 when her hospice nurse had been there to visit the resident. She had also cared for her on 5/5/24. She stated the hospice nurses usually checked the supplies but she could not recall whether they discussed her oxycodone. She stated she still had medications available but went through them quickly because they were administered every 4 hours. She stated they usually ordered the medications when they got down to last section of the card but sooner if they were getting them that often. She stated she did not always document when she communicated with the hospice nurses but would be doing so moving forward. LVN F stated the risk of not having pain medications available included pain getting out of control and the resident could end up in the hospital for relief. Interview on 05/09/24 at 8:09 AM, LVN I stated she had taken care of Resident #35 before she moved out of the secured unit on 05/03/24. She stated they would occasionally run low on medications but had never run out. She stated she made sure to check the supplies when the hospice nurses were there to see if they needed anything from them. She stated she always reordered 7 days ahead especially for pain medications because they could take longer. She did not recall if she had contacted hospice when she worked on 5/3/24 to alert them Resident #35 was within 7 days of running out. She stated the risks for running out of medications included increased pain, behaviors, blood pressure and other symptoms depending on the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Richardson	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Hospice Administrator for Resident #35's hospice company on 05/09/24 at 9:34 AM, she stated she had spoken with the DON. She stated they were notified on 5/6/24 that Resident #35 needed a medication refill and the message was relayed to Hospice RN G. She stated Hospice RN G acknowledged the message and had stated she had been at the facility on 05/03/24 and asked if anyone needed anything. The Hospice Administrator stated Hospice RN G failed to take care of it. She stated they did not receive another call from the facility until 05/07/24. She stated their office manager sent a message that they were working on it and when she was told the ETA was going to take a while, she called their chaplain to have him drive the medications over as soon as possible. The Hospice Administrator stated the hospice nurses were responsible for checking with the facility nurses to see if they needed anything. She stated they just changed their policy and are now requiring the nurses to personally check the medication stocks for both routine and PRN medications. She stated it was both their's and the facility nurses responsibility to ensure the residents had the medications they needed. She stated the risk for not having pain medications available when needed. She stated, fortunately for Resident #35, she had an abundance of PRN pain medications available. She stated they should have known when Resident #35 was going to run out of mediations as they were scheduled. The Hospice Administrator stated she was checked her call log and could see they received a call on 05/06/24 at 4:08 AM and another at 11:00 AM. Interview with Hospice RN G on 05/09/24 at 10:00 AM, she identified herself as being Resident #35's hospice nurse. She stated she always checked with the charge nurse when she visited her residents to see if they needed anything. She stated she visited on Resident #35 on 05/03/24 and she had just moved to her new room. She stated she did check in with her new nurse but could not recall her name. Hospice RN G stated she did not check to see how many medications Resident #35 had remaining during her visit. She stated her company had just implemented a new process and they were directed to physically check the amount of medications available to the resident. When asked why she wouldn't have known the date Resident #35 would run out of a scheduled medication they provided, Hospice RN G stated they recently changed to a new computer system for ordering medications. She stated the previous system would flag if a reorder was needed but she was not used to the new system yet. She stated she did not get the message when the facility called on 5/6/24 at 4 AM. When she received the call later around 9 or 10 AM, she was working in the field and thought her Administrator had taken care of it. She stated she did not find out until the next day that it was never ordered. She stated she was unaware of Resident #35 missing any other medications, she stated she knew she had morphine available and it had been administered. Hospice RN G stated the risk for not having pain medications available would be withdrawal symptoms if no other pain medications were available for them. Record review of the facility's policy and procedure titled Medication Orders and Receipt Records dated Revised April 2007 reflected: Policy Statement: The facility shall document all medications that it orders and receives. Policy Interpretation and Implementation: 1. The Charge Nurse will maintain the medication order and receipt records .3. The Director of Nursing Services will designate individuals to be responsible for completing medication order/receipt forms. 4. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time Record review of the facility's policy and procedure titled, Hospice Program dated revised July 2017 reflected: (continued on next page)

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The Plaza at Richardson	1301 Richardson Dr Richardson, TX 75080

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement: Hospice services are available to residents at the end of life. Policy Interpretation and Implementation: 1. Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so .5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and b. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility .9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including: .e. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: .b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care; .d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observations, interviews, and record reviews the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for one of five residents (Resident #32) reviewed for infection control. CNA C failed to perform hand hygiene while providing incontinence care to Resident #32 and between resident rooms. This failure could place the residents at risk for infection. Findings included: Record review of Resident #32's Admission Record dated 05/09/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #32's Quarterly MDS assessment dated [DATE] revealed he had severe cognitive impairment, he had impaired range of motion of his arm and leg on one side and required maximum assistance with toileting and personal hygiene. The MDS Assessment reflected his diagnoses included hypertension (high blood pressure); peripheral vascular disease or peripheral arterial disease (reduced blood flow to arms and legs); end stage renal disease (kidneys are unable to function properly to remove waste and balance fluids); non-Alzheimer's dementia; and aphasia following cerebral infarction (disability with speech following a stroke). Record review of Resident #32's Care Plan reflected the following entry dated 3/23/23: Focus: [Resident #32] has an ADL Self Care Performance Deficit r/t impaired balance. Goal: [Resident #32] will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene .). Interventions/Tasks: .Toilet Use: The resident requires (X1) staff participation to use toilet .Personal Hygiene: The resident requires (X1) staff participation with personal hygiene and oral care During an observation on 5/9/24 at 4:53 AM, Resident #32 was observed sitting up in bed watching television. He agreed to allow this surveyor to observe care. CNA C entered the room carrying supplies and donned gloves. He informed Resident #32 he was going to change his brief. CNA C removed the resident's blankets, lowered the resident's brief and cleaned him. The CNA assisted Resident #32 to position on his side and continued to clean him and remove his brief. CNA C replaced Resident #32's brief and bagged the trash. CNA C removed his gloves, donned a new pair and covered Resident #32 with his blankets. CNA C removed the bag of trash from the room, entered the spa room, discarded and immediately returned to the hallway. CNA C was observed retrieving a pair of gloves from his pocket, he donned the gloves without washing or sanitizing his hands. He walked down the hall and entered another resident's room. CNA C was observed moving things around the resident's room and speaking with the resident. He removed his gloves and left the room, and returned to the hallway without washing his hands or using the hand sanitizer available in the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/24 at 5:15 AM, CNA C stated he did not use hand sanitizer during or after providing incontinent care for Resident #32 because there was no hand sanitizer in the room. He stated he could just change his gloves. CNA C stated he should wash his hands between resident rooms to prevent the spread of germs. When asked why he did not wash his hands after leaving Resident #32's room and entering another resident's room, he stated he forgot but he did use gloves . During an interview with the DON on 5/9/24 at 6:07 AM, he stated, when providing incontinent care, he expected the CNAs to gather supplies, wash their hands, and put on gloves. He stated they should clean the resident and wash their hands if they became visibly soiled or use hand sanitizer if not heavily soiled. The DON stated the CNAs must wash their hands between residents because they risked spreading infections from resident to resident. During an interview on 5/9/24 at 6:42 AM, the Administrator was asked about his expectation for staff during incontinent care. He stated staff should always wash their hands, gather equipment, explain the care to the resident and don gloves. He stated they should clean the resident in the front, change gloves and sanitize their hands, and clean the back of the resident. The Administrator stated the staff should replace their gloves place a new brief, bag the soiled items, wash their hands and leave. The Administrator stated staff must always sanitize their hands between resident rooms. He stated the risks included spreading infections. The Administrator stated he was a nurse and provided in-service training himself almost every two weeks. Record review of an Inservice Training Report dated 4/17/24 revealed the subject was Perineal Care. The sign-in sheet revealed CNA C was in attendance. The facility's policy/procedure titled Perineal Care revised February 2018 was attached and reflected the following: Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin conditions .Steps in the procedure 1/ Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly . 7. Put on gloves 9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry your hands thoroughly. 12. Reposition the bed covers. Make the resident comfortable. 13. Place the call light within easy reach of the resident. 14. Clean wash basin and return to designated storage area. 15. Clean the bedside stand. 16. Wash and dry your hands thoroughly.