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	09/27/2024

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for 3 residents (Resident #1, Resident #2, and Resident #3) of 4 residents reviewed for discharge planning. -The facility failed to provide or document sufficient preparation for an orderly discharge of Resident #1 to a private residence and Resident #2 and Resident #3 to a nursing facility. This failure could place residents at risk of not receiving care and services to meet their needs upon discharge, which could cause physical and emotional harm. Findings included: Record review of Resident #1's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: vascular dementia (loss of memory and thinking caused by a stroke), depressive episodes (mood disorder), heart disease, cerebral infarction (stroke), chronic kidney disease, hemiplegia and hemiparesis (partial paralysis), and muscle weakness. Record review of Resident #1's Admission MDS assessment, dated 09/02/24, reflected the resident had a BIMS score of 9 which indicated moderate cognitive impairment. The MDS assessment reflected Resident #1 was independent with most ADLs; however, the resident required moderate assistance and/or supervision with eating, hygiene, and upper body dressing. Further review reflected Resident #1 had a behavior of rejecting evaluation or care. Record review of Resident #1's care plan, dated 08/28/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #1's discharge summary, dated 09/16/24, reflected in part the following: [Resident #1's] Date of discharge: 09/16/24; Condition on discharge: Good; discharged to: Home-with home health. Record review of Resident #1's progress note, dated 09/13/24 at 1:29 PM by the SW reflected: DC Date: 9/15/24 (continued on next page)

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

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DC Time: Unknown DC Destination: [private residential address] w/[RP] PCP : The [RP] will schedule an appointment with [personal MD] on 9/16/24. Home Health: [Home Health Agency] Transportation: Arranged by the [RP] Record review of Resident #1's progress note, dated 09/12/24 at 4:56 PM by LVN A reflected: NOMNC received from Managed Care with LCD of 9/14/2024. [RP] not in [Resident#1's] room, 3 calls placed with no answer. Voicemail left informing [RP] of NOMNC with LCD right to appeal, informed that appeal must be filed by noon on 09/13/2024 to number [PHONE NUMBER], also informed that if she does not DC on 9/15/2024 financial liability begins for [Resident #1] on that date. Since unable to contact via phone, NOMNC also emailed to email address on file. Record review of Resident #2's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: dementia (loss of memory and thinking), hemiplegia and hemiparesis (partial paralysis), type II diabetes, hypertension (high blood pressure), heart disease, and non-traumatic subarachnoid hemorrhage (brain bleed). Record review of Resident #2's Quarterly MDS assessment, dated 09/17/24, reflected the resident's BIMS score was 0 which indicated severe cognitive impairment. The MDS assessment reflected Resident #2 required maximal assistance with most ADLs. Further review reflected Resident #2 had a behavior of wandering. Record review of Resident #2's care plan, dated 06/18/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #2's discharge summary, dated 09/19/24, reflected in part the following: [Resident #2's] Date of discharge: 09/19/24; Condition on discharge: Good; discharged to: Other staffed facility. Record review of Resident #2's progress note, dated 08/20/24 at 01:30 PM by the SW reflected: The social worker (SW), the Business Office Manager (BOM) & the Administrator spoke to the daughter, [RP] on the phone & in person. The SW, the BOM & the Admin spoke to [RP] that the [Resident #2] was five days past the DC date. [RP] was informed that corporate has issued a hard DC date for 8/23/24. The SW, the BOM, & the Administrator discussed multiple options with [RP] regarding [Resident #2] safe DC. However, [RP] declined all options & refused to cooperate with the facility for the [Resident #1's] DC. Record review of Resident #2's progress note, dated 09/11/24 at 4:17 PM by the SW reflected: (continued on next page)

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[SW] spoke to [RP] at [phone number]. The SW informed [RP] that [resource agency] found three group homes at [three other cities] The SW offered those choices to [RP]. [RP] stated those locations were 'too far' [sic] for [Resident #2]. Record review of Resident #2's progress note, dated 09/19/24 at 03:31 PM by the SW reflected: DC Date: 9/20/24 DC Time: Between 12 PM-2 PM DC Destination: [Nursing Facility] Transportation: Arranged by the receiving facility Family Member Informed? Yes; Left a VM for [RP] Record review of Resident #2's progress notes reflected it was not documented that the SW informed Resident #2's RP of nursing facilities that accepted her, only group homes. Record review of Resident #3's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: Parkinson's Disease (nervous system disorder), cerebral aneurysm (bulging blood vessel in brain), major depressive disorder (mood disorder), and osteoporosis (weak bones). Record review of Resident #3's Annual MDS assessment, dated 08/02/24, reflected the resident's BIMS score was 10 which indicated moderate cognitive impairment. The MDS assessment reflected Resident #3 was independent with all ADLs. Further review reflected Resident #3 did not have any behaviors. Record review of Resident #3's care plan, dated 06/18/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #3's discharge summary, dated 08/26/24, reflected in part the following: [Resident #3's] Date of discharge: 08/26/24; Condition on discharge: Good; discharged to: Other staffed facility. Record review of Resident #3's progress note, dated 08/21/24 at 10:49 AM by the SW reflected: As per the [RP] request, a referral was sent & received by [Nursing Facility]. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/24 at 5:15 PM, Resident #2's RP stated the resident discharged on [DATE]. The RP stated the facility accepted Resident #1 without her having insurance in place then later admitted it was a mistake. The RP stated once the facility realized she was unable to get approved for Medicare, they began harassing her about picking the resident up; however, she explained that she was unable to care for Resident #2 at her home. The RP stated she had multiple conversations with the SW about different facility options, but they were all too far from the family or they were group homes, which she did not feel was a good fit for the resident due to her medical condition. The RP stated she felt rushed to find placement for Resident #1 because the facility wanted her to leave quickly because they were not getting paid. The RP stated before she could decide, the SW called her one day and told her to come to the facility because they were preparing to transfer Resident #2 to a different facility. The RP stated the facility chose a different nursing facility without her knowledge and it was an hour away from the family. The RP stated she felt like she had no other choice but to allow the facility to transfer Resident #2 to the facility they had chosen. The RP stated she had a care plan meeting with the facility that morning before Resident #2 discharged and they discussed her services/care. The RP stated the SW also talked about Resident #2's discharge, but the SW did not state that Resident #2 was discharging on that day, so it was a surprise when she got the call to come help move the resident later that day. During an interview on 09/26/24 at 05:21 PM, the SW stated she worked at the facility since 08/01/24. The SW stated discharge planning starts the day a resident admits to the facility. The SW stated the residents'/RP's preferences and residents' care needs were considered when planning, and clinical notes and any changes were documented throughout the residents' stay. The SW stated she knew Resident #1 from previous facilities, and they did not have a good relationship, so she decided to work in the background and not deal directly with the resident/RP. The SW stated Resident #1 had a history of being homeless and used the local hospitals and nursing facilities as shelter. The SW stated the facility discussed discharging Resident #1 because she was refusing care and was not participating in therapy, and during the planning, the insurance issued a NOMNC. The SW stated Resident #1's RP was informed about the NOMNC and told that Resident #1 had a discharge date on 09/15/24. The SW stated Resident #1/RP gave a private residence as the discharge location, and she set up home health services at that address through an agency that Resident #1 previously used. The SW stated although Resident #1 was known to be homeless, she accepted the address provided and confirmed that it was a house through an online map search. The SW initially stated she confirmed with the home health agency that they had the same address on file, then later stated they refused to disclose the address they had on file. The SW stated Resident #1/RP refused an appeal and was okay with leaving on 09/15/24. The SW stated Resident #2/RP had been issued a 30-day notice before she started working at the facility and she was working hard with the family to find safe placement; however, the RP was not cooperating. The SW stated she offered the RP several options and she refused them. The SW stated Resident #2 had a care plan meeting on 09/19/24 and a representative from a nursing facility happened to be in the building and was invited to be a part of the meeting. The SW stated she presented that nursing facility as an option to the RP and the RP stated she was okay with it. The SW stated there were 2 other nursing facilities that accepted Resident #2 and those were also presented to the RP. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 09:30 AM with the Administrator and the DON, the Administrator stated he had been at the facility for about 2 weeks and had not been a part of the discharge planning for Resident #1, #2, or #3. The Administrator stated the expectation for discharge planning was for the SW to remain in close contact with the residents/families to ensure involvement during the entire process. The DON stated she had only been at the facility for about 2 weeks also. The DON stated she was aware of Resident #1's situation because she was discharged on the day she started working; however, she was not involved in Resident #2's discharge and was not at the facility when Resident #3 discharged . The DON stated the facility's hope was that all residents were being truthful when providing them with the discharge addresses as they cannot demand proof or follow each resident to the locations. The DON stated each discharge process was case-by-case and if a resident was known to be homeless, she would take extra steps to ensure they were discharging to a safe location such as confirming last known address with previous providers, and she was not sure if the SW did that. The DON stated for all residents, the facility was responsible for collecting information from the residents/families to set up services to ensure clinical needs continue to be met. The DON stated the risk of not having a proper discharge planning meeting with the resident/RP could be an unsafe discharge and the resident's clinical needs not being met. During an interview on 09/27/24 at 10:48 AM, Resident #3's RP stated the resident discharged to a different skilled nursing facility on 08/26/24 due to her being dissatisfied with the care Resident #3 was receiving. The RP stated she was able to choose the new nursing facility; however, the discharge process was not good. The RP stated the SW did not communicate with her well during the process and she did not have a discharge meeting to go over transition process, medications, or other clinical information to provide to the new facility. The RP stated because of this, there were issues with Resident #3's medication orders when they arrived. During further interview on 09/27/24 at 01:22 PM with the SW, she stated she was a part of Resident #3's discharge process. The SW stated Resident #3's RP was upset about the resident not being showered at the times she liked, so she decided to move her to a nursing facility that the RP chose herself. The SW stated she sent out the referral and the nursing facility accepted Resident #3. The SW stated Resident #3 discharged from the facility on 08/26/24 and her RP transported her to the new facility. The SW stated she was in communication with the RP and followed the facility's discharge procedures. The SW stated they don't always have a sit-down discharge meeting, but she remained in contact at least via phone or email with the families. The SW stated the risk of discharging residents without proper planning could have a negative effect on their health and psychosocial status . During an interview on 09/27/24 at 06:15 PM, Resident #1's RP stated she was informed on 09/13/24 that the resident was being discharged due to her not wanting to socialize with anyone or take her medication because she did not trust the facility. The RP was informed that Resident #1 had to leave the facility on 09/15/24. The RP stated she was offered the option to appeal but declined due to being unhappy with the care Resident #1 was receiving and how rude the staff were. The RP stated the SW did not want to have any direct contact with her or Resident #1 from previous encounters, so she received all discharge information from another staff. The RP stated she provided the facility with a discharge address; however, they ended up at a different address. The RP stated she never contacted the facility to update ethe address and she never heard anything from a home health agency. She stated Resident #1 was currently living with another family member. Review of the facility's policy title Discharge Planning Process Policy, revised 11/28/20216, revealed in part the following: (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing facility must complete discharge planning when you anticipate discharging a resident to a private residence, another nursing facility or skilled nursing facility, or another type of residential facility. Discharge Planning includes: A) Assessing the resident's continuing care needs, including: 1. Consideration of the resident's and family/caregiver's preferences for care; 2. How services will be accessed; . B) Developing an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver education needs. .

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interviews and record review, the facility failed to develop and implement an effective discharge planning process that focused on a resident's discharge goals and allowed the resident to be an active partner in the transition and development of a discharge plan for 3 residents (Resident #1, Resident #2, and Resident #3) of 4 residents reviewed for discharge planning. - The facility failed to prepare and involve Residents #1, #2, and #3 and responsible parties in an effective discharge planning process. This failure could place all residents at risk of not being an active part in their goals and discharge planning process, which could result in an unsafe discharge, and decreased quality of life. Findings included: Record review of Resident #1's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: vascular dementia (loss of memory and thinking caused by a stroke), depressive episodes (mood disorder), heart disease, cerebral infarction (stroke), chronic kidney disease, hemiplegia and hemiparesis (partial paralysis), and muscle weakness. Record review of Resident #1's Admission MDS assessment, dated 09/02/24, reflected the resident had a BIMS score of 9 which indicated moderate cognitive impairment. The MDS assessment reflected Resident #1 was independent with most ADLs; however, the resident required moderate assistance and/or supervision with eating, hygiene, and upper body dressing. Further review reflected Resident #1 had a behavior of rejecting evaluation or care. Record review of Resident #1's care plan, dated 08/28/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #1's discharge summary, dated 09/16/24, reflected in part the following: [Resident #1's] Date of discharge: 09/16/24; Condition on discharge: Good; discharged to: Home-with home health. Record review of Resident #1's progress note, dated 09/13/24 at 1:29 PM by the SW reflected: DC Date: 9/15/24 DC Time: Unknown DC Destination: [private residential address] w/[RP] PCP : The [RP] will schedule an appointment with [personal MD] on 9/16/24. Home Health: [Home Health Agency] Transportation: Arranged by the [RP] (continued on next page)

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress note, dated 09/12/24 at 4:56 PM by LVN A reflected: NOMNC received from Managed Care with LCD of 9/14/2024. [RP] not in [Resident#1's] room, 3 calls placed with no answer. Voicemail left informing [RP] of NOMNC with LCD right to appeal, informed that appeal must be filed by noon on 09/13/2024 to number [PHONE NUMBER], also informed that if she does not DC on 9/15/2024 financial liability begins for [Resident #1] on that date. Since unable to contact via phone, NOMNC also emailed to email address on file. Record review of Resident #2's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: dementia (loss of memory and thinking), hemiplegia and hemiparesis (partial paralysis), type II diabetes, hypertension (high blood pressure), heart disease, and non-traumatic subarachnoid hemorrhage (brain bleed). Record review of Resident #2's Quarterly MDS assessment, dated 09/17/24, reflected the resident's BIMS score was 0 which indicated severe cognitive impairment. The MDS assessment reflected Resident #2 required maximal assistance with most ADLs. Further review reflected Resident #2 had a behavior of wandering. Record review of Resident #2's care plan, dated 06/18/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #2's discharge summary, dated 09/19/24, reflected in part the following: [Resident #2's] Date of discharge: 09/19/24; Condition on discharge: Good; discharged to: Other staffed facility. Record review of Resident #2's progress note, dated 08/20/24 at 01:30 PM by the SW reflected: The social worker (SW), the Business Office Manager (BOM) & the Administrator spoke to the daughter, [RP] on the phone & in person. The SW, the BOM & the Admin spoke to [RP] that the [Resident #2] was five days past the DC date. [RP] was informed that corporate has issued a hard DC date for 8/23/24. The SW, the BOM, & the Administrator discussed multiple options with [RP] regarding [Resident #2] safe DC. However, [RP] declined all options & refused to cooperate with the facility for the [Resident #1's] DC. Record review of Resident #2's progress note, dated 09/11/24 at 4:17 PM by the SW reflected: [SW] spoke to [RP] at [phone number]. The SW informed [RP] that [resource agency] found three group homes at [three other cities] The SW offered those choices to [RP]. [RP] stated those locations were 'too far' [sic] for [Resident #2]. Record review of Resident #2's progress note, dated 09/19/24 at 03:31 PM by the SW reflected: DC Date: 9/20/24 DC Time: Between 12 PM-2 PM DC Destination: [Nursing Facility] (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Transportation: Arranged by the receiving facility Family Member Informed? Yes; Left a VM for [RP] Record review of Resident #2's progress notes reflected it was not documented that the SW informed Resident #2's RP of nursing facilities that accepted her, only group homes. Record review of Resident #3's face sheet, dated 09/27/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: Parkinson's Disease (nervous system disorder), cerebral aneurysm (bulging blood vessel in brain), major depressive disorder (mood disorder), and osteoporosis (weak bones). Record review of Resident #3's Annual MDS assessment, dated 08/02/24, reflected the resident's BIMS score was 10 which indicated moderate cognitive impairment. The MDS assessment reflected Resident #3 was independent with all ADLs. Further review reflected Resident #3 did not have any behaviors. Record review of Resident #3's care plan, dated 06/18/24, did not reflect the resident's preferences for discharge planning. Record review of Resident #3's discharge summary, dated 08/26/24, reflected in part the following: [Resident #3's] Date of discharge: 08/26/24; Condition on discharge: Good; discharged to: Other staffed facility. Record review of Resident #3's progress note, dated 08/21/24 at 10:49 AM by the SW reflected: As per the [RP] request, a referral was sent & received by [Nursing Facility]. During an interview on 09/26/24 at 5:15 PM, Resident #2's RP stated the resident discharged on [DATE]. The RP stated the facility accepted Resident #1 without her having insurance in place then later admitted it was a mistake. The RP stated once the facility realized she was unable to get approved for Medicare, they began harassing her about picking the resident up; however, she explained that she was unable to care for Resident #2 at her home. The RP stated she had multiple conversations with the SW about different facility options, but they were all too far from the family or they were group homes, which she did not feel was a good fit for the resident due to her medical condition. The RP stated she felt rushed to find placement for Resident #1 because the facility wanted her to leave quickly because they were not getting paid. The RP stated before she could decide, the SW called her one day and told her to come to the facility because they were preparing to transfer Resident #2 to a different facility. The RP stated the facility chose a different nursing facility without her knowledge and it was an hour away from the family. The RP stated she felt like she had no other choice but to allow the facility to transfer Resident #2 to the facility they had chosen. The RP stated she had a care plan meeting with the facility that morning before Resident #2 discharged and they discussed her services/care. The RP stated the SW also talked about Resident #2's discharge, but the SW did not state that Resident #2 was discharging on that day, so it was a surprise when she got the call to come help move the resident later that day. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/26/24 at 05:21 PM, the SW stated she worked at the facility since 08/01/24. The SW stated discharge planning starts the day a resident admits to the facility. The SW stated the residents'/RP's preferences and residents' care needs were considered when planning, and clinical notes and any changes were documented throughout the residents' stay. The SW stated she knew Resident #1 from previous facilities, and they did not have a good relationship, so she decided to work in the background and not deal directly with the resident/RP. The SW stated Resident #1 had a history of being homeless and used the local hospitals and nursing facilities as shelter. The SW stated the facility discussed discharging Resident #1 because she was refusing care and was not participating in therapy, and during the planning, the insurance issued a NOMNC. The SW stated Resident #1's RP was informed about the NOMNC and told that Resident #1 had a discharge date on 09/15/24. The SW stated Resident #1/RP gave a private residence as the discharge location, and she set up home health services at that address through an agency that Resident #1 previously used. The SW stated although Resident #1 was known to be homeless, she accepted the address provided and confirmed that it was a house through an online map search. The SW initially stated she confirmed with the home health agency that they had the same address on file, then later stated they refused to disclose the address they had on file. The SW stated Resident #1/RP refused an appeal and was okay with leaving on 09/15/24. The SW stated Resident #2/RP had been issued a 30-day notice before she started working at the facility and she was working hard with the family to find safe placement; however, the RP was not cooperating. The SW stated she offered the RP several options and she refused them. The SW stated Resident #2 had a care plan meeting on 09/19/24 and a representative from a nursing facility happened to be in the building and was invited to be a part of the meeting. The SW stated she presented that nursing facility as an option to the RP and the RP stated she was okay with it. The SW stated there were 2 other nursing facilities that accepted Resident #2 and those were also presented to the RP. During an interview on 09/27/24 at 09:30 AM with the Administrator and the DON, the Administrator stated he had been at the facility for about 2 weeks and had not been a part of the discharge planning for Resident #1, #2, or #3. The Administrator stated the expectation for discharge planning was for the SW to remain in close contact with the residents/families to ensure involvement during the entire process. The DON stated she had only been at the facility for about 2 weeks also. The DON stated she was aware of Resident #1's situation because she was discharged on the day she started working; however, she was not involved in Resident #2's discharge and was not at the facility when Resident #3 discharged . The DON stated the facility's hope was that all residents were being truthful when providing them with the discharge addresses as they cannot demand proof or follow each resident to the locations. The DON stated each discharge process was case-by-case and if a resident was known to be homeless, she would take extra steps to ensure they were discharging to a safe location such as confirming last known address with previous providers, and she was not sure if the SW did that. The DON stated for all residents, the facility was responsible for collecting information from the residents/families to set up services to ensure clinical needs continue to be met. The DON stated the risk of not having a proper discharge planning meeting with the resident/RP could be an unsafe discharge and the resident's clinical needs not being met. During an interview on 09/27/24 at 10:48 AM, Resident #3's RP stated the resident discharged to a different skilled nursing facility on 08/26/24 due to her being dissatisfied with the care Resident #3 was receiving. The RP stated she was able to choose the new nursing facility; however, the discharge process was not good. The RP stated the SW did not communicate with her well during the process and she did not have a discharge meeting to go over transition process, medications, or other clinical information to provide to the new facility. The RP stated because of this, there were issues with Resident #3's medication orders when they arrived. (continued on next page)

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	09/27/2024

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During further interview on 09/27/24 at 01:22 PM with the SW, she stated she was a part of Resident #3's discharge process. The SW stated Resident #3's RP was upset about the resident not being showered at the times she liked, so she decided to move her to a nursing facility that the RP chose herself. The SW stated she sent out the referral and the nursing facility accepted Resident #3. The SW stated Resident #3 discharged from the facility on 08/26/24 and her RP transported her to the new facility. The SW stated she was in communication with the RP and followed the facility's discharge procedures. The SW stated they don't always have a sit-down discharge meeting, but she remained in contact at least via phone or email with the families. The SW stated the risk of discharging residents without proper planning could have a negative effect on their health and psychosocial status . During an interview on 09/27/24 at 06:15 PM, Resident #1's RP stated she was informed on 09/13/24 that the resident was being discharged due to her not wanting to socialize with anyone or take her medication because she did not trust the facility. The RP was informed that Resident #1 had to leave the facility on 09/15/24. The RP stated she was offered the option to appeal but declined due to being unhappy with the care Resident #1 was receiving and how rude the staff were. The RP stated the SW did not want to have any direct contact with her or Resident #1 from previous encounters, so she received all discharge information from another staff. The RP stated she provided the facility with a discharge address; however, they ended up at a different address. The RP stated she never contacted the facility to update ethe address and she never heard anything from a home health agency. She stated Resident #1 was currently living with another family member. Review of the facility's policy title Discharge Planning Process Policy, revised 11/28/20216, revealed in part the following: Nursing facility must complete discharge planning when you anticipate discharging a resident to a private residence, another nursing facility or skilled nursing facility, or another type of residential facility. Discharge Planning includes: A) Assessing the resident's continuing care needs, including: 1. Consideration of the resident's and family/caregiver's preferences for care; 2. How services will be accessed; . B) Developing an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver education needs. .