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	01/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of three residents (Resident #1) reviewed for pharmacy services. Med Aide B failed to ensure Resident #2's 8 AM medications were given on time on 01/07/26 according to facility policy.Med Aide B failed to document Resident #2's 8 AM medications were given late on 01/07/26. These failures placed residents at risk of not receiving medications timely and as ordered by physician. Findings included: Review of Resident #2's Consolidated Physician Orders dated 01/07/26 reflected diagnoses of hypotension (low blood pressure), Hypertensive Heart Disease with Heart Failure, Atherosclerotic Heart Disease and Type 2 Diabetes. Resident #2 had the following current medication orders:Order date 03/12/25 with start date 03/13/25 for Dapagliflozin Propanediol Oral Tablet 5 MG (Dapagliflozin Propanediol) Give 1 tablet by mouth one time a day for diabetes.Order date 03/12/25 with start date 03/13/25 for MetFORMIN HCl Oral Tablet 1000 MG (Metformin HCl) Give 1 tablet by mouth two times a day for diabetes.Order and start dated of 09/12/25 for Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth two times a day for HypotensionOrder date 03/12/25 with start date 03/13/25 Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium)Give 1 tablet by mouth two times a day for acid refluxObservation on 01/07/26 at 10:18 AM revealed Med Aide B checked Resident #2's blood pressure using the wrist cuff which reflected 104/46. Med Aide B put Resident #2's 8 AM and 9 AM medications of 6 pills including Dapagliflozin Propanediol 5 mg tablet, Pantoprazole sodium 40 mg tablet, Metformin 1000 mg tablet and Midodrine 10 mg in a small cup. At 10:24 AM Resident #2 was given the clear cup with the 6 pills by Med Aide B and Resident #2 took the 6 pills by mouth. Review of Resident #2's Medication Administration Record for January 2026 reflected Resident #2 was given 8 AM medications electronically signed off by Med Aide B on 01/07/26 of Dapagliflozin Propanediol 5 mg, Metformin 100 mg tablet, Pantoprazole 40 mg tablet and Midocrine HCl tablet 10 mg. Review of electronic record for Resident # 2 did not reflected a note of late medication. Interview on 01/07/26 at 12:45 PM with Med Aide B revealed he did give Resident #2's 8 AM and 9 AM medications late this morning. He stated he was supposed to give medications within 1 hour before the prescribed time for Resident # 2 to 1 hour after to ensure medications were within timeframes. Med Aide B did not notify the nurse or document he had given Resident #2's medications for 8 AM and 9 AM medication in the electronic record. He stated he was not aware there was a way to document if medications late. Interview on 01/07/26 at 3:56 PM with the DON revealed she expected Med Aide B to administer 8 AM medications within the time frame on the MAR of 1 hour before and/or 1 hour after. She stated medication times are in place to ensure medications were given on time and as ordered by the physician. She stated Resident #2's pantoprazole should have been given prior to breakfast and after 10 AM Resident #2 had already eaten their breakfast. She stated Med Aide B should notify the charge nurse if Resident #2's medications were not given on (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time. Review of Med Aide B's Medication/Administration Competency reflected it was dated on 06/08/25 which included proper hand hygiene and medication administered at correct time. Review of facility's Policy Medication Administration and General Guidelines dated March 2025 reflected under procedure 10. Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise). Before or after meal orders are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility.12. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation.

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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. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #1) reviewed for infection control. 1. The facility failed to ensure Med Aide B performed hand hygiene while administering medication to Resident #1 on 01/07/26. 2. Med Aid B failed to sanitize the wrist blood pressure cuff prior to checking Resident #2's blood pressure and prior to putting it in the medication cart. These failures could place residents at risk for infection and cross contamination. Findings included: Observation on 01/07/26 at10:18 AM revealed Med Aide B did not sanitize the wrist blood pressure cuff nor did he wash or sanitize hands prior to checking Resident #2's blood pressure cuff on resident's wrist. Med Aide B put the blood pressure cuff on top of his medication cart. Med Aide B did not wash or sanitize hands prior to administering Resident #2's medications. Interview on 01/07/26 at 10:30 AM with Med Aide B revealed he should have sanitized or washed his hands prior to taking Resident #2's blood pressure of and before administering Resident #2's medications. He stated there was not any hand sanitizer on the medication cart or in the medication cart so he was not able to sanitize his hands before and after medication administration. He stated he should have washed or sanitized his hands to prevent cross contamination and infection. Interview on 01/07/26 at 10:40 AM with the DON revealed Med Aide B should have washed or sanitized his hands prior to checking Resident #2's blood pressure, prior to administering medications and after administering Resident #2's medications. She stated not washing or sanitizing his hands during medication administration could place residents at risk of infection control. The DON stated she expected Med Aide B to sanitize the blood pressure cuff before resident use and prior to putting it back into the medication cart. Review of Med Aide B's Medication/Administration Competency reflected it was dated on 06/08/25 which included proper hand hygiene and medication administered at correct time. Review of facility's Policy Fundamentals of Infection Control Precautions undated reflected Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice).Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident bedside was adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 1 of 3 residents (Resident #2) reviewed for residents' call system. The facility failed to ensure Resident #2's call light was not accessible to the resident and within reach. This failure could place residents at risk of a delay in getting assistance and of not having a means of directly contacting staff in an emergency.Findings included: Review of Resident #2's Significant Change MDS dated [DATE] reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of stroke, diabetes and hypertension (high blood pressure). Resident #2 was dependent on staff with ADLs for dressing, hygiene, toileting, bathing, positioning and transfers. Resident #2 was moderately impaired in daily decision making. Review of Resident #2's Comprehensive Care plan last reviewed 12/23/25 reflected Resident #2 was (High) risk for falls r/t Gait/balance problems. Intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on 01/07/26 at 12:58 PM revealed Resident #2's call button was on the floor below Resident #2's bed while Resident #2 was lying in bed with positioning rails on both sides of bed. Interview with Resident #2 revealed she used her call button to get assistance from staff but could not reach it and was dependent on staff for assistance. Interview on 01/07/26 at 1:08 PM with CNA C revealed Resident #2's call button must have fallen off the bed, but it should be within reach of Resident #2 while she is in bed. She stated Resident #2 was dependent on staff for ADLs. Observation revealed CNA C wrapped the call button cord around the right positioning rail within Resident #2's reach. CNA C stated Resident #2 did use her call button when she needed assistance from staff. Interview on 01/07/26 at 3:56 PM with DON revealed she expected resident's call device to be within reach of resident while in the bed. She stated Resident #2 did use her call light for assistance. The facility did not have a policy for call lights per the Administrator on 01/07/26 at 3:39 PM.