STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676145	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Estates	1350 Main St Frisco, TX 75034

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** 42283 Based on interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for one (Resident #3) of five residents reviewed for resident rights. The facility failed to ensure Resident #3 provided proper consent to a facility affiliated insurance company. This failure could place residents at risk for decreased dignity. Findings included: Review of Resident #3's Admission MDS assessment dated [DATE] revealed she was an [AGE] year-old female who was admitted to the facility 12/01/23. Her diagnosis included: hypertension, gastroesophageal reflux disease, urinary tract infection, non-Alzheimer's Dementia, and depression. Her BIMs score of 6 indicating she was severely cognitively impaired. She understood others and was understood by others. Review of Resident #3's Patient Choice Form dated 12/05/23 revealed the facility was affiliated with an insurance company, home health agency, and hospice agency. The form revealed she gave LBSW verbal consent to receive information from the affiliated companies as part of her plan of care. Review of Resident #3's face sheet dated 07/31/24 revealed her responsible party was her family member A. In an interview with Resident #3 on 07/31/24 at 4:18 PM revealed she did not respond to the surveyor when asked about providing verbal consent to receive information from the affiliated companies as part of her plan of care. Resident #3 appeared to be confused. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #3's family member B on 08/01/24 at 10:28 am revealed he and family member A were her responsible parties. He stated Resident #3 did not have mental capacity to consent to receiving information from the insurance company. He stated he was contacted by the insurance company regarding their benefits. He stated based off the information provided by the insurance company; he switched Resident #3's insurance plan. He stated after investigating the insurance company, services promised were not rendered. He stated Resident #3 was exploited by the facility because he, family member A, and resident did not consent to receiving information from the facility affiliated insurance company. He stated Resident #3's information should never have been released by the facility. Interview with the Administrator on 07/31/23 at 1:59 pm revealed he was the interim Administrator for the building and had worked at the facility for about a week. He stated he was unfamiliar with the facility affiliated insurance company, home health agency, and hospice agency. He stated facility affiliated companies cannot have access to residents' information without consent. He stated every resident should have a completed patient choice form in their admission packet. Interview with LBSW on 07/31/24 at 2:35 pm revealed she was unaware the patient choice form allowed a facility affiliated insurance company, home health agency, and hospice agency to contact the resident with information and to have access to their personal information. She stated she never read the form. She stated she also never read the forms to any resident. She stated she signed the forms herself and selected verbal consent. She stated Resident #3 was cognitively impaired and could not provide consent. LBSW stated she falsely documented residents' verbal consents on patient choice forms because she felt pressured from the previous administrator and corporate. She stated the administrator and corporate did not tell her to falsify the forms. She stated the previous administrator and corporate pressured her to complete a certain number of patient choice forms in hopes of increasing referrals to the facility affiliated companies. LBSW stated the residents rights were being violated and they were being exploited because she falsified the patient choice forms. Interview with the Chief Population Health Officer on 07/31/24 at 3:04 pm revealed he was a part of the corporate managing group for the facility. He stated the insurance company was one of six programs associated with the facility that he oversaw. He stated the patient choice form allowed the insurance company to have access the resident's information. He stated the insurance company would never contact the resident or responsible party without consent. Interview with the Administrator on 07/31/24 at 6:00 pm revealed he was unaware a staff member was falsifying patient choice forms. He stated he needed to know which employees were falsifying information because their employment needed to be terminated. He stated he needed to protect the residents at the facility. Review of facility policy, Resident Rights, dated February 2021, reflected, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic to all residents of this facility. These rights include the resident's right to: .be informed of, and participate in, his or her care planning and treatment .The unauthorized release, access, or disclosure of resident information is prohibited. Inquiries concerning residents' rights should be referred to the social services director.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 28637 Based on observations, interviews, and record reviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 (Resident #1 and Resident #2) of 8 residents reviewed for environment. The facility failed to ensure the wheelchairs used by Resident #1 and Resident #2 were clean and sanitary. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: 1. An observation on 7/30/24 at 10:25 AM revealed Resident #1 was sitting in a wheelchair in the doorway to her room located on the 700 Hall. Both back wheels on her wheelchair had a thick buildup of dust and debris on all of the spoke surfaces. The metal frame of her chair along the sides and beneath her seat and surface of her brake lever were covered with a thick layer of dirt and debris. The areas surrounding the hardware on her seat were filled with a dried, thick, white substance. Resident #1 was unable to say how long her chair had looked or when it was last cleaned for her other than to say, it's been a while. She was unable to answer other general questions about her care. An observation and interview on 7/30/24 at 4:50 PM, the DON was shown Resident #1's wheelchair and asked about cleaning procedures. The DON stated the chairs were cleaned regularly. She stated Resident #1 had a habit of carrying food between her room and the dining room and was sometimes resistant to leaving her chair. She stated she would get it cleaned as soon as possible. An interview with the DON on 7/31/24 at 8:00 AM, she stated the nursing staff were responsible for monitoring the wheelchairs and could wipe them down. She stated the facility driver took the chairs outside and power washed them when needed for heavy cleaning. The DON stated there was no set schedule made for the cleaning as some were more heavily used than others, but a request could be made to herself or any unit manager for a deep cleaning. She stated everyone was responsible for ensuring the chairs were cleaned and she felt the facility maintained good communication. She stated she did not feel there was any risk to the residents as they still had a means of locomotion, and it did not interfere with the use of the wheelchairs. 2. An observation on 7/31/24 at 9:06 AM, Resident #2 was observed in her room on the 700 Hall, sitting in her wheelchair sipping water. Her wheelchair had a dried, thick, beige substance along her lower right side and streaks of what appeared to be the same substance spattered on her wheel. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 9:15 AM, RN A stated it was everyone's responsibility to monitor the wheelchairs for cleanliness. She stated, when the wheelchairs were dirty, they could wipe them down or ask housekeeping or maintenance staff to power wash them. She stated she could make an entry into the maintenance log kept at the nurses' station or just tell them. RN A stated Resident #1 had a habit of going and grabbing food and putting it in her chair. She stated they kept telling her to let them help but even when we clean her wheelchair, it became dirty quickly. RN A stated she could not explain the buildup of dust and debris on the wheels. During an interview on 7/31/24 at 9:36 AM, LVN B stated resident's wheelchairs should be checked daily and cleaned as needed. She stated if the chairs were heavily soiled, they could borrow a replacement chair from the therapy department and request a power wash. She stated the facility kept a maintenance log at the nurses' station for any requests or they reported it to management staff. In an interview on 7/31/24 at 9:45 AM, MA C stated anyone could request a wheelchair cleaning. She stated they could make a request to management, and someone would come, and power wash the wheelchairs. During an interview on 7/31/24 at 12:36 PM, the Maintenance Director stated they assisted with the maintenance and function of the wheelchairs and would sometimes take them out and power wash them when asked. He stated the staff utilized the maintenance logbooks or contacted management when needed. During an interview on 7/31/24 at 1:09 PM, CNA D stated everyone should monitor the wheelchairs to make sure they were clean. She stated they could let maintenance know by using the logbook or let a manager know if cleaning was needed. CNA D stated they had struggles with Resident #1 at times because she wanted food with her. She stated the resident did not want her chair taken from her room. She was unable to say when the chair was last reported as needing to be cleaned. When shown Resident #2's chair, CNA D stated she was surprised because the chair had just been cleaned the week before. She stated it looked like a milkshake may have been spilled and they would get it cleaned. Record review of the Maintenance Repair Log entries dated from 6/10/24 through 7/31/24 located at the nurse's station for Halls 500, 600, 700, 800, and 900 revealed there was only one entry requesting a wheelchair clean. The entry was dated 6/10/24 and was not related to Resident #1 or Resident #2. Record review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated Revised July 2014, reflected, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and OSHA Bloodborne Pathogens Standard .