| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676145 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Prairie Estates | 1350 Main St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychological needs that were identified in the comprehensive assessment for one of five residents (Resident #1) reviewed for care planning.1. The facility failed to ensure Resident #1's care plan had a person-centered approach to address her evolving medical and dietary needs.2. The facility failed develop a care plan to address a hospitalization for pneumonia and a return the facility with continued textured diet orders, aspiration precautions and additional antibiotic treatment.These failures could place residents at risk of being inconsistently monitored, possible delayed identification of swallowing difficulty, and lack of coordinated food/dietary interventions during meals.Findings included:Record review of Resident #1's Face Sheet, dated 01/30/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses with an onset date of 12/13/24 which included: lobar pneumonia (primary diagnosis-a type of lung infection that affects one or more lobes of the lungs, primarily caused by bacterial infections, leading to inflammation and fluid buildup), acute kidney failure (when the kidneys suddenly stop functioning and cannot filter waste and toxins from the blood), gout (painful form of inflammatory arthritis), mononeuropathy (pain, tingling, numbness, or muscle weakness in specific body areas), diabetes (a chronic condition characterized by high blood sugar [glucose] levels resulting from the body's inability to produce or properly use insulin) and malignant neoplasm (a cancerous tumor formed by rapid, uncontrolled cell growth that can invade nearby tissue and spread to other parts of the body via the blood or lymph systems). Additional diagnoses were added through Resident #1's stay, which included: metabolic encephalopathy (added 01/08/25-a reversible, non-traumatic brain dysfunction caused by systemic illness, organ failure or chemical imbalances), anemia (added 01/14/25-not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), chronic kidney disease-stage 4-severe (added 01/14/25-kidneys are moderately or severely damaged and are not properly filtering waste from the blood), pneumonia due to MRSA (added 1/14/25-a severe, often necrotizing lung infection caused by Methicillin-resistant Staphylococcus aureus, carrying a high mortality rate) and malnutrition (added 01/27/25-a serious condition resulting from an imbalance between the nutrients the body needs and what it receives). Record review of Resident #1's 5-day admission MDS, dated [DATE], reflected she had a BIMS score of 05, which indicated severe cognitive impairment. Resident #1 had range of motion impairment on the side of her lower extremity and used a wheelchair for ambulation. She required supervision or touching assistance when eating. Resident #1 had a mechanically altered and therapeutic diet and was administered three high-risk medications-an antidepressant, anticonvulsant and diuretic. She had occupational and physical therapies provided during the assessment period. Record<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676145 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2026 |
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| NAME OF PROVIDER OR SUPPLIER Prairie Estates | | STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Main St Frisco, TX 75034 | |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | review of Resident #1's speech therapy order, dated 12/20/24, reflected a need for skilled speech therapy for cognitive-linguistics deficits and dysphagia (difficulty swallowing) management five times a week for four weeks. Record review of Resident #1's SLP Cognitive and Nutrition Screening, dated 01/15/25, reflected Resident #1 had signs consistent with swallowing impairment, which included loss of liquids/solids from the mouth, holding food in the mouth or cheeks, and she required a mechanically altered diet. Record review of Resident #1's nephrology progress note, dated 01/23/25, reflected she was status-post hospitalization for right lower lung pneumonia and was treated with antibiotics and had an ordered textured diet. On 01/11/25, she was readmitted to the hospital due to altered mental status, was given intravenous fluids and sent back to the facility for skilled services on 01/14/25. Record review of Resident #1's physician orders, dated 01/31/25, reflected she had a LCS/NAS diet with ground texture and regular/thin consistency (start date 12/13/24). Record review of Resident #1's care plan reflected only two identified focus areas: pressure ulcer risk (initiated 12/17/2024) and antibiotic therapy (12/16/2024). The care plan did not address any concerns related to dysphagia, aspiration risk, supervision during meals or any respiratory issues and treatments related to pneumonia. An interview with the RNC and DON on 01/30/26 at 12:10 PM revealed the MDS nurse was responsible for the initial development of the care plan, but the issue with Resident #1 was she had never been at the facility continuously for 21-days to trigger the comprehensive care plan to be completed due to the resident being in and out of the hospital. The RNC and DON stated when a resident re-admitted from the hospital with any new conditions or concerns, an acute care plan had to be completed immediately. They stated both the charge nurses and ADONs could complete them. The RNC stated an acute care plan was a concern that needed attention immediately for the staff to know how to manage a situation. The RNC stated he expected the MDS nurses to complete any updates and revisions to residents' care plans, but around January/February 2025 when Resident #1 was at the facility, there was no MDS nurse. As a result, the facility went a month without one. The RNC stated there were some corporate staff who helped with the MDS and care planning but there remained a backlog. An interview with LVN A on 01/30/26 at 2:15 PM revealed she was the MDS nurse. LVN A stated the process post-hospital discharge was to review the specific resident in the morning meeting, review the hospital discharge orders, and then the MDS nurse was supposed to determine what needed to be added, modified or removed from the care plan. LVN A stated multiple disciplines attended morning meetings, which included the MDS nurses, ADONs, DON, administrator, social services, wound care nurses, dietary, nurses from the halls and CNAs. Each department was expected to report changes to their residents observed within the prior 24 hours. LVN A stated the process was intended to capture changes in condition, hospitalizations, diet changes, therapy referrals, and emerging risks. LVN A did not remember Resident #1's stay as it occurred about a year prior. LVN A stated repeat hospitalizations and continued decline of a resident should be addressed and trigger a care plan update. She said those updates to the care plan were expected to be identified through a review of hospital records, weekend 24-hour reports and daily clinical review. LVN A stated acute issues that arose during a resident's stay, such as pneumonia, swallowing risks, decline or hospice consideration should be incorporated into the care plan as they occur. She explained while wound care nurses were the exception and they completed care plans specific to wounds, other clinical concerns were typically addressed by the MDS nurses. LVN A also stated diet changes, downgrades and texture requirements were expected to be reflected in the care plan. She stated the MDS nurses typically updated diet-related care plans, but if a change occurred on the weekend or when the MDS nurse was not available, then the ADON could complete it. LVN A stated accurate and current care plans were critical for staff providing direct care because they<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | relied on the care plan to know what risks to monitor, which included diet changes, skin integrity issues and decline. She described care planning as vitally important to ensuring staff awareness and resident safety. LVN A stated there was a time when the facility experienced staffing shortages in the MDS department but since then processes were strengthened and morning meetings emphasized better communication in capturing resident changes. LVN A re-iterated while she could not speak to Resident #1's specific care plan, the facility's expectation was that repeated hospitalizations, pneumonia, diet changes, antibiotic use and decline should be reflected in the care plan to guide staff care and monitoring. Record review of the facility's policy titled, Comprehensive Person-Centered Care Plans, revised March 2022 reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. |