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	01/16/2025

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

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51181 Based on interviews and record review the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) level 1 residents with mental illness were provided with a PASRR level 2 evaluation for 1 of 4 residents (Resident #91), reviewed for resident assessment. Resident #91's PASRR level 1 screening form did not reflect mental illness and the resident did not have a PASRR level II evaluation when Resident #91 had a diagnosis of schizophrenia. This could place residents at risk of not receiving necessary specialized services to meet their individual needs. Findings included: Record review of Resident #91's Quarterly MDS dated [DATE] revealed she was a [AGE] year-old female who was admitted on [DATE]. Her diagnoses included unspecified schizophrenia (a condition where a patient's symptoms do not meet the full diagnostic criteria for schizophrenia or another more specific psychotic disorder), major depressive disorder (a mental health condition that involves persistent feelings of sadness, hopelessness, and a loss of interest in activities), psychotic disturbance (a mental state where a person experiences a significant disruption in their perception of reality, often characterized by hallucinations [seeing or hearing things that aren't there] and delusions [strongly held false beliefs], leading to difficulty functioning in daily life), mood disturbance (a mental health condition that involves persistent feelings of sadness, irritability, or extreme highs and lows that are out of sync with a person's actual circumstances), and anxiety (a common mental health condition characterized by feelings of unease, worry, fear, and apprehension). Resident #91 MDS revealed a BIMS score of 4, indicating she had severe cognitive impairment. Record review of Rresident #91"s Care Plan, dated 1/15/2025 indicated Resident #91 was taking psychotropic medication(s) as evidenced by: Depression, schizoaffective disorder, anxiety, paranoia, aggression, cognitive impairment. Resident #91 was prescribed Haldol and Prozac. Record review of Resident #91's PASRR level 1 screening, dated 08/26/2024, reflected the resident did not have a serious mental illness and serious mental illness was checked as no. Record review of Resident #91'"s Electronic Health Record revealed no PASRR level 2 evaluation was completed. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #91's Electronic Clinical Notes revealed Resident #91 was admitted to the facility on [DATE] with diagnosis of cognitive deficit, dementia, and schizophrenia. An interview on 1/16/25 with the Administrator revealed she did not know why Resident #91 had a negative PASRR Level 1 screening. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services she could qualify for. An interview on 1/16/2025 with the MDS nurse revealed Resident #91 was negative for PASSR II. MDS nurse reported the original PASSR level I was completed June 10, 2022, when resident #91 first came to the facility. MDS nurse stated when the information was entered, Resident #91 did not have any mental or intellectual disability. MDS nurse stated with a diagnosis of dementia, she will not be eligible for PASRR Level II. MDS nurse stated the system was showing schizophrenia as her primary diagnosis, but she will change it to dementia in their system . MDS nurse reported she did not have a copy of Resident #91's PASSR level I completed 08/26/24. Surveyor explained it was obtained by surveyor in Resident's electronic health record. Review of the facility policy, CANTEX CONTINUING CARE NETWORK PATIENT CARE MANAGEMENT SYSTEM 12 Assessments dated November 2017 state: Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, it must indicate its rationale in the Patient's/Resident's medical record. In addition, the facility must provide or obtain the required services from an outside resource from a Medicare and/or Medicaid provider to provide any rehabilitative services such as physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, required in the Patient's comprehensive plan of care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for two (Resident #118 and Resident #141) of 7 residents reviewed for baseline care plans. The facility failed to complete baseline care plans for Resident #118 and Resident #141 within 48 hours of their admission. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services. Findings included: Review of Resident #118's Face Sheet, dated 01/16/25, reflected she was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses including displaced trimalleolar fracture of the right lower leg (a break in the lower leg sections that form the ankle joint and help one move their foot and ankle). Review of Resident #118's Progress Notes, dated 12/05/24, reflected Resident #118 was admitted to the hospital for surgery following a visit with an orthopedic physician. Review of Resident #118's Progress Notes, dated 12/14/24, reflected Resident #118 was readmitted to the facility following her hospitalization . Review of Resident #118's the electronic medical record on 01/16/25 revealed her baseline care plan had been completed on 12/16/24, following her re-admission to the facility. A baseline care plan had not been completed prior to this time, following her initial admission to the facility on [DATE]. Review of Resident #141's Face Sheet, dated 01/16/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses including displaced fracture of greater trochanter of right femur (a break in the upper part of the thigh bone) and chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and damage to the airways, leading to difficulty breathing). Review of Resident #141's electronic medical record on 01/16/25 revealed her baseline care plan had been completed on 12/31/24. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN B on 01/16/25 at 11:06AM, he stated he was responsible for monitoring the completion of Baseline Care Plans. He stated he was not sure of the timeframe in which Baseline Care Plans had to be completed. He said the facility utilized an electronic medical charting system, which provided staff with notifications when various assessments (including Baseline Care Plans) were due. RN B stated there was no risk posed when Baseline Care Plans were not completed in the required timeframe, as staff communicated amongst themselves to ensure residents still received proper care. During an interview with the Director of Nursing on 01/16/25 at 11:19AM, she stated Baseline Care Plans needed to be completed within 48 hours of a resident's admission to the facility. She said the facility utilized an electronic medical charting system, which provided staff with notifications when various assessments (including Baseline Care Plans) were due. She stated there may have been an error within the system, which caused staff not to receive a notification when Resident #118 and Resident #141's Baseline Care Plans were due. The Director of Nursing stated there was no risk posed when Baseline Care Plans were not completed in the required timeframe, as staff were still able to ensure residents received proper care. Review of the facility's Patient Care Management System 12 Policy and Procedure, dated 11/2017, reflected, .A Baseline, Person-centered Plan of Care for each patient that includes the instructions needed to provide effective and person-centered care of the patient that meet professional standards of quality care. The baseline care plan must be initiated within 48 hours of admission (including readmission) .

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections to the extent possible for one (Resident #75) of four residents reviewed for indwelling urinary catheters. The facility failed to provide physician ordered catheter care to Resident #75 and failed to notify Resident #75's NP when she experience pain and discomfort from her urinary catheter. These failures led to Resident # 75 experiencing increased pain and discomfort from her catheter and placed Resident # 75 at risk for urethral tears, dislodging of the catheter, and urinary tract infections. Findings included: Review of Resident #75's quarterly MDS Resident assessment dated [DATE] revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her active diagnoses included, coronary artery disease (heart disease), hypertension (high blood pressure), neurogenic bladder(lack of bladder control due to brain, spinal cord, or nerve problems), renal insufficiency(kidneys are functioning poorly and need treatment or further diagnosis), diabetes(condition that affects blood sugar levels), hyperlipidemia (high cholesterol), Non-Alzheimer's Dementia, anxiety disorder, depression, and bladder disorder. The resident had an indwelling catheter . Her BIMS score was 15 which indicated she was cognitively intact. Review of Resident #75's Physician Orders reflected: Oxycodone HCL Capsule 5 mg-give two tablets by mouth every six hours as needed for moderate to severe pain (start date 01/03/25); Oxycodone HCL Capsule 5 mg-give 5 mg by mouth every six hours as needed for pain (start date 01/16/25); Phenazopyridine HCL tablet 200 mg-give one tablet by mouth every 12 hours as needed for prophylaxis (measures used to prevent disease) (11/08/24). Foley catheter 22fr with 30cc bulb (refers to catheter size) every night shift starting on the 15th and ending on the 15th every month (start date 11/15/24); Foley catheter every night shift starting on the 15th and ending on the 15th every month (order date 10/21/24 - start date 11/15/24) (per DON the order referred to catheter change); and Foley catheter every night shift starting on the 1st and ending on the 1st every month (order date 10/21/24 - start date 12/04/24) (per DON the order referred to catheter change). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of Medication Administration Record dated 01/01/25 - 01/31/25 reflected Resident #75 was sleeping and catheter was not changed on the 1st and 15th of January. There was no documentation noting Resident #75's catheter was changed on 01/09/25 . Resident #75 was administered the following medications: Phenazopyridine HCL tablet 200 mg (give 1 tablet by mouth every 12 hours as needed for prophylaxis) on 01/15/25 at 10:20 am; Oxycodone HCL capsule 5 mg (give 2 tablets by mouth every 6 hours as needed for moderate to severe pain) on 01/15/25 at 9:47 pm; Oxycodone HCL capsule 5 mg (give 2 tablets by mouth every 6 hours as needed for moderate to severe pain) on 01/16/25 at 11:45 am; Oxycodone HCL capsule 5 mg (give 2 tablets by mouth every 6 hours as needed for moderate to severe pain) on 01/16/25 at 9:47 pm; and Phenazopyridine HCL tablet 200 mg (give 1 tablet by mouth every 12 hours as needed for prophylaxis (measures used to prevent disease)) on 01/16/25 at 9:47 pm. Review of Resident #75's progress note dated 01/09/25 reflected her catheter was changed. Review of Resident #75's Comprehensive Care Plan, undated, reflected she had an indwelling catheter. Her goal was to remain free from catheter-related trauma. Her interventions were to position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks with each interaction every shift, maintain enhanced barrier precautions, monitor/document for pain/discomfort due to catheter, and monitor/record/report to MD for signs and symptoms of UTI (pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns). An observation and interview with Resident #75 on 01/14/25 at 1:00 PM revealed she had an indwelling catheter. Resident # 75's catheter bag was clipped to her bed. Her catheter tubing appeared to have sediment and her urine appeared to be yellow and cloudy in color. Her catheter bag was dated 01/09/25. She stated staff were providing catheter care. She stated her catheter was previously changed. She stated her catheter was changed around the first week of January 2025. She stated her catheter tube frequently clogs due to sediment buildup. She stated she was diagnosed with a UTI in 12/2024 and received intravenous antibiotics. She stated she experienced pain when she previously had a UTI. She stated she was not currently experiencing pain . An observation and interview with Resident #75 on 01/16/25 at 2:15 PM revealed there was sediment in her catheter tubing and her urine was orange. She stated she was experiencing pain and discomfort from her catheter. Resident #75 stated her nurse (LVN C) was aware of her catheter pain and change in urine color. She stated she had been experiencing catheter pain and discomfort for two days. She stated her pain level was a 5. She stated LVN C gave her pain medication . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	An interview with LVN C on 01/16/25 at 3:12 PM revealed Resident #75 had a foley catheter. She stated all catheters in the building were to be changed monthly. She stated Resident #75's catheter was changed more frequently due to leaks and sediments. She stated the resident had a UTI in the past. She stated pain, fever, and cloudiness of urine were signs of a UTI. She stated Resident #75's urine appeared to be a little cloudy on 01/14/25 and the NP was notified. She stated the NP requested Resident #75 be monitored for a change in condition. She stated Resident #75 complained of catheter pain on 01/15/25 and 01/16/25. She stated Resident #75s catheter was changed on 01/15/25. She stated she did not document Resident #75's catheter change because she did not know how to navigate the new EMR system. She stated she should have documented Resident #75's catheter change. She stated Resident #75 was administrated oxycodone and phenazopyridine on 01/15/25 and 01/16/25. She stated Resident #75 experienced a change in condition and the NP was not notified until 01/16/25. LVN C stated she did not notify the NP until 01/16/25 because Resident #75 refused to move due to pain from the catheter. She stated she should have notified the NP on 01/15/25 due to a change in the resident's condition. She stated Resident #75 was at risk of an infection and retention . An interview with the DON on 01/16/25 at 4:56 PM revealed Resident #75 had a foley catheter. She stated Resident #75 had monthly and PRN orders for catheter changes. She stated LVN C informed her that Resident #75 received a catheter change on 01/13/25 . She stated the nurses check catheters during daily rounds. She stated she did not have any issues with nurses regarding catheter care. She stated Resident #75 had a history of UTIs, sediment back up, and was being seen by a urologist. She stated Resident #75 had a UTI within the last thirty days and received intravenous antibiotics. She stated cloudiness in urine was normal after being changed. She stated LVN C not notifying the NP until the second day of Resident #75's catheter pain was appropriate. The DON stated the nurses knew catheter discomfort was expected due to Resident #75's diagnoses. She stated there was no risk to Resident #75 because the catheter was changed on 01/13/25. She stated LVN C did not document the catheter change in Resident #75's EMR. An interview with the NP on 01/16/25 at 5:53 PM revealed Resident #75 had a catheter and frequently requested catheter changes. She stated Resident #75 had chronic UTIs and frequently experienced discomfort. She stated LVN C notified her on 01/16/2025 regarding Resident #75's sediment. She stated she visited Resident #75 the week of 01/06/25. She stated her expectation was for LVN C to notify her on 01/15/25 regarding Resident #75's pain. She stated the facility was good at notifying her regarding change of condition but did not know why she was not contacted about Resident #75's change . An interview with Infection NP on 01/16/25 at 6:23 PM revealed she was notified on 01/16/25 regarding Resident #75 needing a catheter change due to sediment. She stated she was notified Resident #75 was experiencing pain but was given medication to resolve problem. She stated Resident #75 had chronic dysuria (pain, discomfort, or burning during urination). She stated her expectation was for the facility not to notify her if Resident #75's pain was resolved. She stated the facility was supposed to notify her if Resident #75's pain persisted after phenazopyridine or fever. She stated Resident #75's sediment in catheter tubing was not new. She stated she was unaware Resident #75's was experiencing pain, cloudy urine, and sediment for the past two days. She stated she was concerned and would contact the facility to order labs (CBC and UA) immediately. Review of the facility policy titled, Catheter Care, updated March 2019, revealed Purpose: To prevent infection and to reduce irritation. Documentation: date, time, procedure, condition of the perineum and catheter insertion site; how well patient tolerated procedure; color, amount, consistency, and odor of urine; notification of the physician of any condition change; signature and title.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview and record review, the facility failed to ensure that a resident fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings, for 1 (Resident #120) of 2 residents that were reviewed for feeding tubes. The facility failed to ensure LNV A verified G-tube (Gastrostomy tube a surgically placed tube directly into the stomach to deliver food and medicine) placement. LVN A failed to aspirate (the act of withdrawing fluid from the stomach to check G-tube placement and measure stomach content) prior to administering water flushes and medications. LVN A failed to administer G-tube water flushes by gravity (the use of gravity to move the water flushes and medications through the G-tube into the resident). This failure could place residents at risk for adverse reactions, inadequate therapy, and a decreased quality of care. Findings included: Record review of Resident #120's face sheet dated 01/16/25 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #120 had diagnoses which included: type 2 diabetes, hypertension, disease of stomach and duodenum, obstructive and reflux uropathy . Record review of Resident #120's quarterly MDS assessment dated [DATE] revealed her BIMS score was 0 indicating severe cognitive impairment. The MDS revealed Resident #120's used a feeding tube and received total calories through the feeding tube. Record review of Resident #120's care plan last review dated 11/18/24 revealed: Focus, [Resident #120] requires G-tube feeding r/t Dysphagia . Goal, Will remain free of side effects. or complications related to tube feeding through review date. Intervention, Check for tube placement and gastric contents/residual volume per facility protocol and record. Is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Record review of Resident #120's Physician Order Summary dated 10/24/24 revealed enteral - check tube placement every shift check tube for proper placement by auscultation of injected air or visual inspection of aspirated stomach contents prior to instilling medication, and/or initiating a feeding. During an observation on 01/16/24 at 12:47 PM of medication administration for Resident #120, LVN A checked the resident's vital signs. LVN A washed her hands. Then LVN A crushed Resident #120's Labetalol 200 mg 1 tablet and ISOSORB DIN 20 mg 1 tablet (both blood pressure medications). LVN A added 5 ml water to the medication cups. LVN A measured medication cups with 30 ml water to flush the G-tube before medication administration. Resident #120 was non-verbal. LVN A withdrew the 30ml of water with the syringe and slowly pushed the water using the syringe plunger into the G-tube. LVN A then administered the medications via gravity flushing in between with 10cc of water. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/16/24 at 01:30 PM, with LVN A she stated she checked the residual in the morning during medication administration. LVN A stated she was supposed to check for residual before medication administration, but she forgot. LVN A stated she was supposed to check for residual to make sure the resident did not have a lot in the stomach which could have led to aspiration. LVN A stated per the orders she was supposed to check for stomach content to confirm placement before medication administration . In an interview on 01/16/25 at 04:09 PM with DON she stated during medication administration if the nurse stopped the feeding to administer medication, then she did not need to check for residual. The DON stated she did not remember what the policy said regarding g-tube medication administration. After the DON reviewed the policy on G-tube medication administration, she stated the staff was to follow the facility policy on g-tube medication administration . She did not indicate on negative effects for not checking the g-tube residual. Review of the facility updated March 2019, titled Medication Administration through the Feeding Tube reflected, . disconnect the feeding from the set or open the Y port on the feeding tube. Check feeding tube for placement (refer to procedure for confirming placement). Check gastric content for residual feeding. Flushing feeding tube with at least 30 cc of water.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42283 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchens reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's kitchen. These failures could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 01/14/25 beginning at 9:07 AM revealed: - 1 open bin of raw chicken open and exposed to air; and - 1 open bag of ham. Observation of a prep table located in the open area of the facility's kitchen on 01/14/25 beginning at 9:18 AM revealed: -1 box of bananas dated 01/06/25 with black spots and a bug; and - 1 box of bananas dated 01/08/25 with fuzzy white spots. An interview with the Dietary Supervisor on 01/16/25 at 4:47 PM revealed she completed walk throughs of the kitchen daily and before she left. She stated she checked produce in between food truck delivery days (Tuesdays and Thursdays). She stated she was responsible for ensuring dietary staff were storing food properly. She stated the chicken and ham were supposed to be sealed. She stated the bananas were supposed to be discarded. She stated improper food storage could cause harm to residents such as food borne illnesses . Record review of the facility policy titled Food Storage, undated, revealed Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. Review of the Food and Drug Administration Food Code, dated 2017, reflected, .3-305.11 Food Storage. (A) . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51181 Based on interviews and record review, the facility failed to maintain clinical records that were complete and/or accurate for one (Residents #91) of four residents reviewed for clinical records. --Resident #91 received psychotropic medications without documented diagnoses for which the medication was prescribed. These failures placed residents at risk of not having accurate clinical records completed to indicate if a medication or treatment was administered, resulting in potential medical errors and a decline in health. Findings include: Resident #91 Record review of Resident #91's Quarterly MDS dated [DATE] revealed she was a [AGE] year-old female who was admitted on [DATE]. Her diagnoses included unspecified schizophrenia (a condition where a patient's symptoms do not meet the full diagnostic criteria for schizophrenia or another more specific psychotic disorder), major depressive disorder (a mental health condition that involves persistent feelings of sadness, hopelessness, and a loss of interest in activities), psychotic disturbance (a mental state where a person experiences a significant disruption in their perception of reality, often characterized by hallucinations [seeing or hearing things that aren't there] and delusions [strongly held false beliefs], leading to difficulty functioning in daily life), mood disturbance (a mental health condition that involves persistent feelings of sadness, irritability, or extreme highs and lows that are out of sync with a person's actual circumstances), and anxiety (a common mental health condition characterized by feelings of unease, worry, fear, and apprehension). Resident #91 MDS revealed a BIMS score of 4, indicating she had severe cognitive impairment. Record review of Resident #91's physician's active orders revealed she was prescribed Fluoxetine 40mg for Antidepressant, Gabapentin 100mg for Neuralgia, Haloperidol tab 2mg for Agitation, Haloperidol Decanoate Solution 100mg for Agitation, Memantine Tab HCL 10mg for Dementia, Rivastigmine Cap 3mg for Alzheimer's disease, HumaLog Injection Solution for Diabetes, Metformin for Diabetes. Record review of Resident #91's Clinical Treatment Plan Review completed 10/29/2024 indicates resident's psychotropic medications were monitored by clinical assessment, staff observations and feedback, and Patient's Self-Report. The report indicates GDR failed for resident. Record review of resident #91's Care Plan indicated Resident was taking psychotropic medication(s) as evidenced by: Depression, schizoaffective disorder, anxiety, paranoia, aggression, cognitive impairment. Resident took: Haldol and Prozac. (continued on next page)

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	01/16/2025

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an nterview with the DON on 01/16/2025 at 4:11 p.m. the DON reported that Resident #91 needs both prescriptions of Haldol. DON stated that with her diagnosis and behaviors, if not given the injection of Haldol, Reisdent #91's behaviors will escalate. The DON reported gradual dose reductions (GDR) had been attempted and failed. The DON reported Resident #91 would become very hostile. The DON reported Resident #91 was stable with where she was with her medications. She does not recommend her medications to reduced or increased. Surveyor notified the DON that resident's diagnosis for the Haldol is listed as agitation. The DON stated that agitation was not the correct diagnosis. During an observation and interview of Resident #91 on 1/16/2025 at 12:03 p.m. Resident #91 stated she did not want to speak to surveyor and then said she would. She denied having any mental health diagnoses. Resident #91 stated she did therapy for walking. She denied participating in talking therapy. Resident stated she was done talking and ended the interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 51419 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 10 residents (Resident #75) observed for infection control. The facility failed to ensure LVN C used PPE while assessing the foley catheter on Resident #75 who was on enhanced barrier precautions. This failure could place residents at risk for cross contamination and risk of further infection. Findings included: Record review of Resident #75's Admission MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE]. Resident#75 had a BIMS score of 15 which indicated she was cognitively intact. Diagnoses included encounter for surgical aftercare following surgery on the genitourinary system, calculus of kidney, urinary tract infection, site not specified, bladder disorder, unspecified, neuromuscular dysfunction of bladder, unspecified, type 2 diabetes mellitus, unspecified kidney failure . Record Review of Resident #75's physician orders dated 12/09/24 indicated the resident required enhanced barrier precautions. In an observation on 01/16/25 at 1:23pm, observed LVN C assess foley catheter drainage on Resident #75. LVN C entered room and did not don PPE. An Enhanced Barrier Precaution sign was posted outside of Resident # 75's door and a kit of gloves and gowns were outside the room. LVN C washed her hands put on gloves, assessed for placement of foley catheter and assessed sedimentation by touching the foley catheter tubing with gloves. LVN C then repositioned the catheter bag and hooked the foley catheter bag to a non-moveable part of the resident's bed. In an interview on 01/16/25 at 1:30 pm with LVN C revealed that she was aware the resident was on enhanced barrier precaution. LVN C verbalized that she had been in-serviced on enhanced barrier precaution and stated that she should have donned full PPE. LVN C stated that she was required to maintain enhanced barrier precautions to prevent the spread of infection. An interview on 01/16/25 at 4:27 pm with the DON revealed that all staff had been in-serviced on the use of enhanced barrier precautions and they were expected to use PPE on residents who were on enhanced barrier precautions. The DON stated that the risk of not using PPE on residents who were on enhanced barrier precautions would predispose residents to infections . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of enhanced barrier policy, reflected, Residents Requiring EBP .Indwelling Medical Devices (regardless of MDRO) central lines, urinary catheters, feeding tubes, tracheostomies .Duration . discontinuation of indwelling devices .Required PPE (gown/gloves) during High-Contact Resident care . Dressing, Bathing/showering, Transferring, Providing Hygiene, Changing linens, Toileting/Changing Brief, Device Care/Use, Wounds/Skin care & treatment .Implementation .Staff awareness .Update Care profile . Update POC .EBP Signage .PPE set up-Gloves, Gown, Hand Sanitizer . 42283