STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676395	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Plano	3325 West Plano Parkway Plano, TX 75075

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #1) of 4 residents reviewed for pressure ulcers. CNA A and CNA B failed to reposition Resident #1 as required by her orders and care plan on 10/15/25. This failure could place residents with pressure wounds at risk of the wound worsening, leading to increased pain, infection, delayed healing, serious complications including sepsis, reduced mobility, and a lower quality of life.Record Review of Resident 1's admission MDS assessment, dated 09/19/25, revealed she was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cognitive communication deficit, severe protein calories malnutrition, pressure ulcer to the sacrum region, stage IV, needed assistance with personal care. The resident used a Foley catheter. Resident #1's BIMS score was 4 indicating severe cognitive impairment. Resident #1 was understood and was able to understand. The resident was dependent on staff to roll her from left to right. Record Review of Resident #1's Care Plans, dated 09/15/25, reflected,1. Has potential for pressure ulcer development r/t generalized weakness, decreased mobility, history of pressure ulcers, incontinence, poor to variable PO intake. Facility interventions included: Has been refusing repositioning even with education of the importance of repositioning. - educated granddaughter and resident of the risk of further skin breakdown and deterioration of current wound and resident's right to refuse care. Position frequently - resident likes to curl up in bed.2. Resident has current skin concerns: Has stage IV pressure wound of the sacrum. Facility interventions included: Turn and reposition as tolerated. Encourage to turn and reposition, provide assistance as necessary. Record Review of Resident #1's Order Summary Report, dated 09/15/25, reflected: May use mobility bars to aide in easy turning & repositioning while in bed every shift. Review of Resident #1's Wound Evaluation and Management Summary reflected: 10/15/25 Stage IV Pressure Ulcer Sacrum - 5 CM x 4.6 CM x 1.9 CM Wound Progress: Improved evidenced by decreased surface area. An observation and interview on 10/15/25 at 11:54 AM with Resident #1 revealed the resident was in bed. She had an air mattress and head of bed was elevated. Resident #1 had a wound vac that was functioning, and she was lying on her right side. Interview with Resident #1 answered simple questions with a yes and seemed disinterested to speak. When asked if she was repositioned, she did not answer. An interview on 10/15/25 at 1:38 PM with LVN D revealed she was the treatment nurse. LVN D stated she completed all the wound treatments in the facility. She stated on 10/15/25 she completed Resident #1's wound care while the wound care doctor was assessing the wounds in the facility. She stated the resident used a wound vac, and wound care was completed on Monday, Wednesday and Friday. LVN D stated the resident's wound had improved compared to the wound assessment that had been completed the previous week. Resident #1's was admitted with the pressure ulcer at stage IV. LVN D stated staff were expected to reposition the residents with wounds and who were in bed, to prevent the wounds from getting worse or having a skin breakdown. An interview on 10/15/25 at 3:45 PM with CNA A revealed staffing was sufficient for the morning shift on 10/15/25 . CNA A stated he was assigned to provide care to Resident #1, but he was asked to switch the resident with CNA B because Resident #1 preferred a female aide. CNA A stated he had not repositioned Resident #1 during the morning shift until around 2:30 PM when he assisted CNA B in repositioning and providing incontinent care. CNA A said he always tried to keep his residents repositioned and the DON expected that all residents were repositioned , at least every two hours. CNA A said Resident #1 required two staff to assist with repositioning. CNA A stated the residents were supposed to be repositioned to prevent skin breakdown or from the wounds getting worse. An interview on 10/15/25 at 4:05 PM with CNA B revealed she was assigned for the morning shift on 10/15/25. CNA B stated she was not assigned to Resident #1, she was only asked by the ADON to give her a shower. CNA B stated at around 9:30 AM she went in the room and informed Resident #1 she was going to give her a shower, but the resident declined to take a shower. CNA B stated while she was in the room the therapist personnel came in the room to assist with getting the resident out of bed, but the resident declined to get out of bed. CNA B stated she left the resident's room, and she did not go back until around 2:30 PM when she went to assist CNA A with repositioning the resident and providing incontinent care. CNA B stated residents who were bed bound were to be repositioned every 2 hours to prevent skin breakdown. An interview on 10/15/25 at 4:24