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	05/16/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interviews, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one resident (Resident #194) of five residents reviewed for care plans. The facility failed to create a care plan addressing Resident #194's hearing deficit. This failure could affect residents by placing them at risk for not receiving care and services to meet their needs. Findings included: Review of Resident #194's admission record, 05/15/24, revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Review of Resident #194's MDS assessment, dated 05/02/24, reflected she had a BIMS score of 14, indicating no cognitive impairment. Further review revealed she had active diagnoses of pneumonia, cerebrovascular accident (a stroke), unspecified hearing loss, bilateral (two sides). Review of Resident #194's undated care plan reflected it did not address her hearing deficit. Observation and interview on 05/14/24 at 12:05 PM with Resident #194 revealed she could not hear the surveyor asking questions and motioned towards her phone for the surveyor to speak into. Resident #194's phone had an app that took verbal words and put them in written form so that Resident #194 could read and respond verbally. Resident #194 said this was her preferred way to communicate with staff and others. Resident #194 said there had not been any issues using the app with staff or others. Interview on 05/14/24 at 12:00 PM with LVN Z revealed Resident #194 was deaf and used her phone to translate words that people say to text for her to read and understand. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 3:13 PM with the DON revealed the MDS Coordinator was not at the facility this week during the survey period. The DON said Resident #194 had hearing deficits in both her ears and her preferred way to communicate was to use her phone and people talk to it and she reads the text and responds. The DON said this should have been reflected on Resident #194's care plan. The DON said the facility has an IDT approach to care plans so she was not sure who would be responsible for ensuring the care plan included Resident #194's hearing deficit. The DON said the purpose of the care plan was so that all staff know and were on the same page on how to care for a resident while at the facility. The DON said the entire IDT team was responsible for care plans. Review of the facility's policy, revised 12/23, and titled Comprehensive Person-Centered Care Planning reflected: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 1 (Resident #27) of 1 resident reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #27 after return from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Review of Resident #27's face sheet dated 05/16/24 reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE]. Review of Resident #27's admission MDS assessment dated [DATE], revealed Resident #27 had diagnoses of metabolic encephalopathy (problem in the brain), monoclonal gammopathy (abnormal proteins (antibodies) are found in the blood), calcium of kidney, acute gastritis without bleeding and chronic pancreatitis. Resident #27 had a BIMS score of 15, indicating no cognitive impairment. The MDS section O related to special treatments, procedures, and programs reflected Resident #27 received dialysis. Review of Resident #27's care plan, undated, revealed Focus: [Resident 27] requires Hemodialysis r/t ESRD. On T-TH-SAT at [Dialysis Center name] dialysis center. Chair times may vary. Goal: Will have no s/sx of complications from dialysis through the review date. Interventions: Check arteriovenous fistula every day for bruit and thrill. Do not draw blood or take B/P in arm with graft. Encourage resident to go for the scheduled dialysis appointments. Monitor intake and output. Monitor labs and report to doctor as needed. Monitor/document for peripheral edema. Monitor/document report to MD s/sx of depression. Obtain order for mental health consult if needed. Monitor/document/report to MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Monitor/document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Nutritionist to consult. Obtain vital signs and weight. Report significant changes in pulse, respirations, and BP immediately. Review of Resident 27's physician's order, dated 05/03/24, reflected Hemodialysis Monday, Wednesday, and Friday at dialysis center. Chair times @10:15am may vary. Review of Resident #27's EHR reflected no nursing documentation regarding Resident #27's dialysis, monitoring of the resident's post-dialysis vital signs. Review of Resident #27's renal dialysis communication forms dated 05/03/24, 05/0-6/24 and 05/10/24 reflected dialysis communication forms with no information on the resident's assessment and observation post dialysis section completed. For the month of May 2024 four communications forms were provided and only 1 form dated 05/08/24 that had post dialysis vitals completed. Facility was unable to provide dialysis communications forms for the days of 05/13/24 and 05/15/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/24 at 9:16 AM revealed Resident #27 was lying in bed. Resident #27 refused to answer any questions. Interview on 05/16/24 at 1:11 PM with LVN D revealed he was the nurse assigned to Resident #27. LVN D stated Resident #27 was a dialysis patient and the resident's dialysis days were Monday, Wednesday, and Fridays; chair time 10:15 AM and returned at 3:30PM. He stated Resident #27 would return from dialysis during his shift 6AM-6PM. He stated it was his responsibility to complete post dialysis vitals. LVN D stated he documents the vitals in the Resident #27's progress notes, and dialysis communication forms. LVN D reviewed Resident #27's dialysis communication forms and stated he was unaware Resident #27's post dialysis vitals were not being documented. LVN D stated he could assure Resident #27's vitals were taken. LVN D stated the potential risk of not monitoring and documenting the vital signs could lead to the patient having fluid retentions. Interview on 05/16/24 at 2:30 PM with the ADON revealed her expectations were for the nurses to complete the pre and post dialysis communication forms. Once the forms were completed the nurses should provide the forms to medical records to upload into the resident's charts. She stated nurses were expected to check vitals, monitor, and document. She stated she was unaware the dialysis communication forms were not completed. She stated the ADONs were responsible to ensure the forms were being completed. She stated the risk of not monitoring or documenting would lead to blood pressure being low and vital signs going up. Interview on 05/16/24 at 3:10 PM with the DON revealed her expectations were for her nurses to complete the dialysis communication forms pre and post dialysis vitals. Once the forms were completed the nurses should provide the forms to medical records. The DON stated she was not aware residents post dialysis vitals were not being completed. She stated the risk would be room for concerns if the patient was not stable. Review of the facility's current Dialysis (Renal), Pre- and Post-Care policy, review dated 01/2022, reflected the following: It is the policy of this facility to: Assist resident in maintaining homeostasis pre- and post-renal dialysis; Assess and maintain patency of renal dialysis access; Assess resident daily for function related to renal dialysis; Participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of three medication carts (West Hall) and 6 of 6 (Resident #1, #2, #3, #16, #27, #32, #37, and #143) reviewed for pharmacy services. 1. LVN D failed to document the administration of narcotic medications in a timely manner for Residents #1, #2, and #27. 2. The facility failed to ensure the [NAME] Hall nurses medication cart contained accurate narcotic logs for Residents #3, #32, and #143. 3. The facility failed to ensure Residents #1, #16 and #27 lidocaine patches and #37's intravenous bottle and tubing were labeled with the date, time, and the initials. These failures could place residents at risk for medication error, drug diversion and delay in medication administration. Findings included: 1. Review of Resident# 1's entry MDS assessment, dated 05/06/24, revealed the resident was [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included elevated blood pressure, and fracture of t11-t12 vertebra. Resident #1's BIMS score was not completed as resident was newly admitted . Review of Resident #1's physician's orders dated 5/6/24 and 5/13/24 revealed Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth one time a day for Pain, and Salonpas Pain, and Relieving External Patch 4% (Lidocaine) Apply to back topically one time a day for Pain and remove per schedule. Review of Resident #2's face sheet, dated 05/16/24, revealed the resident was a [AGE] year-old female admitted on [DATE]. Resident #2's diagnosis included displaced intertrochanteric fracture of left femur. Review of Resident #2's entry MDS assessment , was not completed resident was newly admitted . Resident #2 had severe cognitive impairment with a BIMS score of 03. Review of Resident #2's physician orders dated 5/14/24 revealed Hydrocodone-Acetaminophen Oral Tablet 10-325MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours for Pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's entry MDS assessment, dated 05/06/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. The resident had diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and other fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing. Residen t#27 had intact cognition with a BIMS score of 15. Review of Resident #27's physician orders dated 5/01/24 and 05/11/24, revealed Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain, and Lidocaine External Patch (Lidocaine) Apply to affected areas topically every 12 hours for Pain. Observation on 05/15/24 at 07:29 AM, revealed LVN D performing morning medication pass on Resident #27. LVN D prepared the pill and he administered Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen)1 tablet and Lidocaine patch 5% on the back to Resident #27. He did not document the administration of narcotic medications in a correct and timely manner on the NAR. He left the room and continued to administer morning medications to other residents. He also did not label the patch with date and initial after administering. Observation on 05/15/24 at 07:43 AM, revealed LVN D performing morning medication pass on Resident #1. LVN D prepared the pill, and he administered tramadol oral Tablet 50 MG 1 tablet and Lidocaine patch 5% on the back to Resident #1. He did not document the administration of narcotic medications in a correct and timely manner on the NAR. He left the room and continued to pass medications to other resident Observation on 05/15/24 at 08:00 AM, revealed LVN D performing morning medication pass on Resident #2. LVN D prepared the pill and he administered Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) 1 tablet to Resident #2. He did not document the administration of narcotic medications in a correct and timely manner on the NAR. Interview with LVN D on 05/15/24 at 08:30 AM, revealed he was supposed to log off the narcotic after administering before going to the next resident, but he does not do that he usually log narcotics after administering medications to all residents on the hall. LVN D stated the best practice was to log off immediately after administering the medication and as per facility policy. He stated failure to log after administration could lead to overdose, missing a dose and narcotic diversion. LVN D stated he had done training on narcotic administration records. Observation on 05/15/24 at 12:44 PM, of [NAME] Hall nurses' medication cart and the narcotic administration record, with LVN F, revealed the following information: 2. Resident #3's narcotic administration record sheet for oxycodone 5 mg revealed a total of 30 pills remaining while the blister pack count was 28 pills. Resident #32's narcotic administration record sheet for Armodafinil 150 mg was last signed off on 05/14/24 for a one-tablet dose given at 8:30 AM, for a total of 25 pills remaining while the blister pack count was 24 pills. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #143's narcotic administration record sheet for Tramadol 50 mg was last signed off on 05/13/24 for a one-tablet dose given at 8:36 AM, for a total of 55 pills remaining while the blister pack count was 53 pills. Interview with LVN F on 05/15/24 at 01:03 PM, revealed she administered oxycodone 5 mg 1 tablet to Resident #3 as needed for pain, Armodafinil 150 mg 1 tablet to Resident #32 and Tramadol 50mgs as needed to Resident #143 and she had not signed off on the NAR. She stated she gave the residents the medication, but she forgot to document on the medication administration record and sign off on the narcotic administration log. She stated she knew she was to sign-out on the narcotic count sheet after administration and on the medication administration record, but she did not. She stated failure to do that would cause the narcotic count to show less on the next count and it could lead to a narcotics diversion, overdose and resident missing a dose. She stated she had done in-service on medication administration. Interview on 05/15/24 at 1:37PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. The DON stated failure to document could lead to discrepancy and drug diversion. She stated it was her responsibility and the ADON's to audit the medication carts, but she was new to the facility. She stated she had started training of staffs and she could not tell if the facility had done training prior. Interview on 05/16/24 at 2:33 PM, the ADON revealed she was responsible for spot checks for the carts, but nurses were responsible of checking the narcotics during shift changes and report discrepancies. She stated her expectation was when staff administer narcotics they should document on MAR and also log off on NAR. She could not tell the last day she had checked the carts. Review of facility trainings revealed in services on Medication management on 02/08/24 and medication administration on 02/07/24. Review of the facility's current Controlled Medication-storage and reconciliation policy, dated July 2017, reflected the following: 6.When a controlled mediation is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record. .Date and time of administration .Amount administered. .Signature of the nurse administering the dose, completed after the medication is actually administered. 3. Review of Resident# 1's entry MDS assessment, dated 05/06/24, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included elevated blood pressure, and fracture of t11-t12 vertebra. Resident #1's BIMS score was not completed as resident was newly admitted . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1 physician's orders dated 5/6/24 and 5/13/24 revealed Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth one time a day for Pain, and Salonpas external Patch 4 % (Lidocaine). Apply to back topically one time a day for Pain and remove per schedule. Review of Resident #27's entry MDS assessment, dated 05/06/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. The resident had diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and other fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing. Resident#27 had intact cognition with a BIMS score of 15. Review of Resident #27's physician orders dated 5/01/24 and 05/11/24, revealed Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain, and Lidocaine external patch. Apply to affected areas topically every 12 hours for Pain. Review of Resident #37's face sheet, dated 05/16/24, revealed the resident was a [AGE] year-old male with an initial admitted [DATE] and re-admitted [DATE]. Resident #37's diagnoses which included sepsis, unspecified organism (a life-threatening medical emergency caused by body's overwhelming response to an infection) and bacteremia (the presence of bacteria in blood). Review of Resident #37's physician's orders dated 04/17/24 reflected: (Zosyn Intravenous Solution Reconstituted 3.375 (3-0.375) grams (Piperacillin Sodium-Tazobactam Sodium use 3.375 gram intravenously every 8 hours) and (change intravenous tubing with new intravenous bag every day shift)". Observation and interview on 05/14/24 at 10:53 AM revealed Resident #37 in his room, laying on his bed. He was observed to have a picc line dated 5/12/24. The intravenous medication bottle was hanging on the pole. The IV bag and the tubing's were observed not labelled with date, time and initials. Observation and interview on 05/14/24 at 3:14 PM revealed Resident #37 in his room, on his wheelchair. He was observed on intravenous medication being administered. The IV bag and the tubing's were observed not labelled with date, time and initials. Interview on 05/14/24 at 3:20 PM with LVN A revealed she had not hung Resident #37's bag when it was due in the morning, another nurse was on duty, but she could not tell who was the nurse. LVN A stated she was the one that had hung the one that was administering. LVN A said the I.V bag was supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated she was aware she was supposed to label the bag and the tubing's, but she forgot. She stated failure to label the bag and the tubing could lead to overdose, omission of a dose and infection control. She stated the bag was changed as scheduled and the tubing's could be changed every 24 hours as per the orders. LVN A stated she had done training on IV administration. Observation on 05/15/24 at 07:29 AM, revealed LVN D performing morning medication pass on Resident #27. LVN D prepared Lidocaine patch 5% and sanitized, put gloves and applied it on the back of Resident #27. He did not label the patch with date and initial after administering. Observation on 05/15/24 at 07:43 AM, revealed LVN D performing morning medication pass on Resident #1. LVN D prepared Lidocaine patch 5% and sanitized, put gloves and applied on the back of Resident #1. He did not label the patch with date and initial after administering. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN D on 05/15/24 at 08:29 AM, revealed he was supposed to label the patch with date and initial to show the date it was applied on Residents #27 and #1. He stated failure to label could cause overdose and skin irritation. He stated he was aware to label but he forgot. Interview on 05/16/24 at 01:44 PM with the DON revealed her expectation was that the staff should date initial iv bags, tubing's and lidocaine patch when administering intravenous medications to prevent infection and while applying the patch prevent overdose and skin irritation. Review of Resident #16's face sheet dated 05/16/24 reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Review of Resident #16's quarterly MDS assessment dated [DATE], revealed Resident #16 had a diagnoses of Parkinson's dis w/o dyskinesia, cirrhosis of liver, low back pain, and cardiomegaly. Resident #16 had a BIMS score of 15, indicating no cognitive impairment. The MDS section J related to Pain Management reflected Resident #16 received scheduled pain medication regimen. Review of Resident #16's care plan, undated, revealed Focus: Has acute/chronic pain r/t muscle spasms, generalized pain, bilateral knee pain, low back pain. Goal: Will voice a level of comfort of through the review date. Interventions: Able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain). Anticipate need for pain relief and respond immediately to any complaint of pain. Follow pain scale to medicate as ordered. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Pain assessment every shift. Reposition for comfort Review of Resident 16's physician's order, dated 05/01/24, reflected Lidopac External Kit 5 % (Lidocaine-Transparent Dressing) Apply to affected area topically every 12 hours related to pain, unspecified. Interview and observation on 05/14/24 at 3:36 PM with Resident #16 revealed he was doing well. Observed Resident #16 sitting on his wheelchair. Resident #16 had lidocaine patches on both knees. Lidocaine patches were not dated. Resident #16 stated years ago he had knee surgery and he had constant pain. Resident #16 stated staff put on the patches daily and were removed at night. Observation on 05/15/24 at 2:46 PM revealed Resident #16 in his room. Resident #16 was sleeping. Resident #16 had lidocaine patches on both knees. Lidocaine patches were not dated. Interview on 05/16/24 at 1:11 PM with LVN D revealed he was the nurse assigned to Resident #16. LVN D stated Resident #16 had an order for Lidocaine patches for 12 hours. LVN D stated Lidocaine patches should be dated. He stated the reason the patches were not dated was because Resident #16 removes them, and they had to administer new ones. LVN D stated lidocaine patches should be dated so that the nurses know when the patches were put on. He stated the risk of not labeling the patches could lead to over medicating the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/16/24 at 2:33 PM with the ADON revealed her expectations were for nurses to place the lidocaine patches in the morning, sign and date, and remove at night. The ADON stated nurses should follow the physician order and lidocaine patches should only be administered for 12 hours. She stated it was the ADONs responsibility to oversee that the nurses were dating the patches; however, she had not done so because she assumed the nurses were doing it. She stated the potential risk would be not knowing how long the residents have had the patches for. Interview on 05/16/24 at 3:19 PM with the DON revealed her expectations were patches to be initialed and dated by the nurse who administered. She stated the potential risk would be staff not knowing how long the resident have had the patches on for.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments and were labeled in accordance with currently accepted professional principles for 2 (Residents #143 and #146) of 10 residents reviewed for pharmacy services and one (West Hall cart) of two medication carts reviewed for storage of medications. 1.The facility failed to ensure Residents #143 and #146's Fluticasone Propionate (Nasal spray), Potassium tablet, Brimonidine eye drop solution 02.2% and Restasis (cyclosporins opth 0.05% eye drops were not stored at the resident's bedside table and not secured in the medication cart or medication room. 2.The facility failed to ensure the nurse medication cart for the [NAME] Side Hall was locked when unattended on 05/16/24. These failures could place residents at risk of overdosing, infection and missing a dose. Findings included: 1. Review of Resident #143's face sheet, dated 05/16/24, revealed the resident was an [AGE] year-old female with an admitted [DATE]. Resident #143's diagnoses which included nondisplaced intertrochanteric fracture of left femur (fracture in the proximal femur, between the lesser trochanter and greater trochanter), pain and primary open-angle glaucoma (a syndrome of optic nerve damage associated with an open anterior chamber angle and an elevated or sometimes average intraocular pressure. Record review of Resident #143's entry MDS, dated [DATE], revealed no BIMS score as she was newly admitted . Review of Resident #143's care plan dated 01/10/24, reflected: focus: At risk for impaired visual function rule out glaucoma. Goal: Will show no decline in visual function through the review date. Intervention: Is able to see large print in a well-lit room and remind resident to wear glasses when up. Resident #143's care plan did not reflect anything regarding being able to self-administer any medications. Review of Resident #143's physician order, dated 05/02/24, revealed she had an order for Brimonidine Tartrate Ophthalmic Solution 0.2 %(Brimonidine Tartrate) Instill 1 drop in both eyes three times a day related to primary open angle and Restasis Ophthalmic Emulsion 0.05 % (Cyclosporine(Ophthalmology) instill 1 drop in both eyes two times a day related to primary open-angle glaucoma. Review of Resident#143's Medication administration record dated 05/02/24, revealed she was receiving Restasis Ophthalmic Emulsion 0.05 % (Cyclosporine (Ophth) 1 drop in both eyes two times a day at 8:00AM and 8:00PM and Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) 1 drop in both eyes three times a day. (continued on next page)

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	05/16/2024

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #146's face sheet, dated 05/16/24, revealed the resident was a [AGE] year-old female with an admitted [DATE]. Review of Resident #146's Quarterly MDS assessment, dated 05/04/24, reflected the resident was a [AGE] year-old female with an admitted [DATE]. Resident #146's diagnoses which included allergic rhinitis (inflammation, redness, and swelling) of the inside of the nose),acute on chronic diastolic (congestive) heart failure (left heart ventricle is stiff, it doesn't relax properly between heartbeats) and chronic kidney disease (the kidneys have become damaged over time and have a hard time doing all their important jobs). Resident #146 had intact cognition with a BIMS score of 14. Review of Resident #146's care plan dated 5/16/24, reflected: Problem: Has altered respiratory status/difficulty breathing rule out pulmonary fibrosis and interstitial pulmonary disease, sleep apnea, asthma. Goal: Resident Will have no signs and symptoms of poor oxygen absorption through the review date. Intervention: Monitor for signs and symptoms of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Monitor for SOB when lying flat. If with episodes, assist to position so that head of bed is elevated. Resident #146's care plan did not reflect anything regarding being able to self-administer any medications. Review of Resident #146's physician order dated 05/01/24 revealed Resident #146 had orders for Fluticasone Propionate Nasal Suspension 50 MCG(Fluticasone Propionate (Nasal) 2 sprays in each nostril one time a day for allergic rhinitis, at 8:00 AM and Potassium Chloride ER Oral Tablet (Extended Release) 20 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day for potassium at 8:00AM. Review of Resident#146's Medication administration record dated 05/01/24, revealed she was receiving Fluticasone Propionate Nasal Suspension 50 MCG(Fluticasone Propionate (Nasal) 2 sprays in each nostril one time a day for allergic rhinitis, at 8:00 AM another order dated 05/06/24 revealed Potassium Chloride ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride)Give 1 tablet by mouth one time a day for potassium at 8:00AM. Observation and interview on 05/14/24 at 11:54 AM revealed Resident #146 in her room, seated on her wheelchair. There was a box of Fluticasone Propionate 50 mcg spray and a cup with 2 white tablets on resident's bedside table. Resident #146 stated the nurse left the inhalers on her table in the morning. Resident#146 stated she was the one that put the 2 white pills in the cup. She stated the nurse handed her the pills in a cup, and she took all others apart from the 2 which she was not sure of. She stated the nurses provide the pills and left the room and she did not notify her that she had not taken the pills because she did not want to upset her . Observation and interview on 05/14/24 at 12:06 PM with LVN B revealed 2 white pill and a bottle of nasal spray on the Resident #146's bedside table. LVN B stated the resident should not have any medication in her room. LVN B stated she administered medications to Resident #146's that morning, and she did not wait for her to take all the pills, she went to check on another resident. She stated she was aware she was not supposed to leave the room before Resident #146 had taken all the pills. LVN B stated medication should not be left unsupervised or left in the room. She stated the risk of leaving meds was that it could lead to another resident taking it. LVN B stated she had been trained on medication administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/14/24 at 2:10 PM revealed Resident #143 in her room, laying on her bed. There were 2 bottles, 1 with Brimonidine solution 02.2% eye drop and another with Restasis (cyclosporins opth 0.05% eye drops on resident's bedside table. Resident #143 stated she had been using the eye drops since admission. She stated she came with them from home. Interview on 05/14/24 at 3:15 PM with LVN A revealed she was the nurse assigned to Resident #143. LVN A stated she was in Resident #143's room earlier and did not see any medications in the room. She stated all medications needed to be secured to ensure the resident's safety. LVN A stated she administered Resident #143 eye drop from her cart. She stated Resident #143 had not been assessed for self-administration for the eye drops. LVA stated if Resident #143 was not care planned or did not have an order to self-administer eye drops, the risk for leaving medications in the room could lead to resident over medicating or another resident taking them. She stated she had done training medication storage. Interview on 05/16/24 at 01:47 PM with the DON revealed her expectation was that the staff should be checking for medications in the rooms and if found they call the doctor for orders .She stated in case of self-administration of medication residents had to be reviewed by the doctor and an assessment done and medications locked in a walk box in their rooms. She stated Residents #143 and #146 had not been assessed for self-administration. The DON stated the risk of leaving medication in rooms was that it could lead to another resident taking the medication or the resident not taking the medication as ordered. She stated the facility had done in-services with the staff on medication administration. 2. Observation on 05/16/24 at 3:26 PM revealed medication cart for the [NAME] Side Hall parked next to room [ROOM NUMBER] unlocked. Medication cart was unattended and unlocked. Interview on 05/16/24 at 3:35 PM with LVN C revealed the medication cart was assigned to her. LVN C stated when medication cart were not being used, they should be locked. LVN C stated she forgot to lock the medication cart because she was called to a resident room in another hall. LVN C stated she had a bad habit of forgetting to lock the medication cart and she was working on that bad habit. LVN C stated the risk of leaving unlocked medication cart could lead to someone getting into the medications she had in the medication cart. Interview on 05/16/24 at 3:51 PM the DON revealed her expectations when medication carts were not being used was for her nurses to lock the medication cart when they step away or when not being used. She stated the risk of leaving medication cart unlocked would be someone accessing the medications inside the cart. Review of the facility's in-services revealed the facility offered training titled no meds at bedside dated 3/28/24. Review of the facility's IV Administration of drugs policy, revised May 2007, reflected: .IV solutions must be labeled in accordance with established procedures governing all labelling IV solution medication found at the bedside that are not authorized for self-administration are turned over to the nurse in charge (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Medication Access and Storage policy, revised date 05/2007, reflected: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Review of the facility's Labeling of Medications and Biologicals policy, revised May 2007, reflected: 4.Over the Counter (OTC) medications stored at bedside for self-administration are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information is not covered. 44140

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview and record review, the facility failed to maintain infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 8 residents (Resident #1, #2, and #27) reviewed for infection control. LVN D failed to perform hand hygiene, disinfect the blood pressure cuff between residents while monitoring blood pressure to Resident #1, #2, and #27 and disinfecting the insulin pens tips while administering insulin to Residents #2. This failure could place residents at-risk of cross contamination which could result in infections or illness. Findings included: Review of Resident #1's entry MDS assessment, dated 05/06/24, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included elevated blood pressure, and fracture of T11-T12 vertebra. Resident #1's BIMS score was not completed as resident was newly admitted . Review of Resident #2's face sheet, dated 05/16/24, revealed the resident was a [AGE] year-old female admitted on [DATE]. Resident #2's diagnoses included displaced intertrochanteric fracture of left femur. Review of Resident #2's entry MDS assessment, was not completed as resident was newly admitted . Resident #2 had severe cognitive impairment with a BIMS score of 03. Review of Resident #27's entry MDS assessment, dated 05/06/24, reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE]. The resident had diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and other fracture of third lumbar vertebra, subsequent encounter for fracture with routine healing. Resident#27 had intact cognition with a BIMS score of 15. Observation on 05/15/24 at 07:29 AM revealed LVN D, performing morning medication pass. LVN D checked Resident #27's blood pressure. LVN D did not disinfect the blood pressure cuff after using it on Resident #27. LVN D put the blood pressure cuff on top of the medication cart after use. Observation on 05/15/24 at 07:43 AM revealed LVN D performing morning medication pass. LVN D checked Resident #1's blood pressure with cuff that he had used on Resident#27. LVN D did not disinfect the blood pressure cuff after using it on Resident #1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/24 at 08:00 AM revealed LVN D performing morning medication pass. LVN D checked Resident #2's blood pressure with cuff that he had used on Resident#1. LVN D did not disinfect the blood pressure cuff after using it on Resident #2. He was also observed preparing insulin Tresiba FlexTouch Subcutaneous Solution Pen-injector 200 UNIT/ML 48 units. He failed to cleanse the pen tip with alcohol wipes before connecting the needle. Interview on 05/15/24 at 08:18 AM, LVN D revealed he does not disinfect the blood pressure cuff between the resident, but he disinfects before he starts the shift and before going to another hall. LVN D stated he was aware he was supposed to disinfect the blood pressure cuff between the residents, but he forgot as he was focused on passing the medication to all residents. LVN D stated he was aware he was supposed to disinfect the blood pressure cuff to prevent contamination and spread of infection. LVN D stated he had done training on infection control. Interview on 05/15/24 at 08:24 AM, LVN D revealed, he was supposed to wipe the insulin pen tip with alcohol pad before attaching the needle to prevent contamination and infection. He stated he forgot to wipe because he was busy. LVN D stated he had done training on infection control and care of insulin vials and pens. Interview on 05/15/24 at 1:39 PM, the DON revealed her expectation was that staff should disinfect items shared by residents between each resident to prevent contamination and spread of infection. She stated she was responsible of monitoring the staff. The DON stated she had not done training with staff because she was new to the facility. Interview on 05/15/24 at 1:41 PM, the DON revealed her expectation was that staff should disinfect the pen and vials with alcohol pads before attaching the needle to prevent contamination and infection prevention. Record review of facility trainings revealed training on hand washing and infection control dated 4/12/24, LVN D was in attendance. Record review of facility's infection prevention and control program policy, dated October 2022 reflected: The facility will provide areas, equipment, and supplies to implement its infection control program with goal of: C. Effective cleaning and disinfecting equipment as needed, to include bathing areas between each resident use. Review of a pamphlet issued by the facility titled instruction of insulin use revealed: 1D.Wipe the rubber seal with an alcohol swab.