STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455864	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plano	3800 W Park Blvd 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #329) of 5 residents reviewed for accidents and hazards. The facility failed to ensure Resident #329 was missing from the facility for approximately 1.5 hours without any staff being aware until notified by the apartment complex staff. Resident crossed a parking lot and service road to get to the apartment complex. Review of [NAME] maps ([NAME] Maps to Apartment Complex, [NAME], TX 75075) revealed the apartment complex was about 500 feet from the facility. The noncompliance was identified as Past Noncompliance (PNC) Immediate Jeopardy on 04/24/25. The noncompliance began on 03/18/25 and ended on 03/31/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of elopements, falls, injuries, hospitalization and/or death. Findings included: Record Review of Resident #329's Discharge MDS, dated [DATE], reflected he was an [AGE] year-old male admitted to the facility on [DATE] and discharged on 03/19/25 to another facility. He had the diagnoses of metabolic encephalopathy (brain dysfunction caused by a metabolic disorder), chronic kidney disease, and he had a memory problem with inattention behaviors that came and went. Record review of Resident #329's admission assessment dated [DATE] reflected he was able to make himself understood and was orientated to person, place, and time. Record review of Resident #329's Elopement Risk Evaluation, dated 03/07/25 reflected resident was not at risk of elopement. He did not have a history of elopement, did not wander, and did not verbally express that he wanted to leave the facility. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #329's care plan reflected he was at risk for elopement and had an actual elopement, dated 03/18/25. Interventions included add resident to elopement book, frequent one on one monitoring until discharge to a secure unit, provide for safe wandering and activities to divert from exit seeking. He was at risk for falls and required assistance with activities of daily living and interventions included to assist with mobility and activity of daily living care. Record review of Resident #329's nurse progress note, dated 03/18/25 at 6 PM by LVN M revealed Resident #329 had eloped and was brought back to the facility by staff and was assessed with no injuries or signs of discomfort. Resident #329 was moved rooms, placed on one-on-one supervision, 15-minute checks, and the Administrator, unit manager, physician, and family were notified. Further review revealed a progress note dated 03/19/25 at 10 PM by LVN M revealed Resident #329 had remained on one-on-one supervision until he was discharged to another facility. Record review of the Provider Investigation Report (PIR), dated 03/25/25, reflected an incident report, dated 03/18/25 by LVN G. Resident #329 had left the facility around 2:30 PM and was returned by the Maintenance Director at 4 PM. Staff were in-serviced on resident elopements and abuse and neglect dated 03/18/25 and included the Receptionist and LVN M. Resident #329 was assessed and showed no distress and had no injuries. He was moved to a room within eyesight of nurses' station, placed on one-on-one monitoring until discharged on 03/19/25 at 6:20 PM. The facility notified the physician and resident representative. Further review of PIR reflected an employee education form, dated 03/26/25, for the Receptionist with training that included the elopement policy, patient identification binder, reviewing the updated daily census, online training on elopements and reviewing and putting pictures of new residents who are at risk in the patient binder. Record review of Resident #329's elopement assessment, dated 03/18/25, completed by LVN M, reflected Resident #329 had left the building around 3 pm and was brought back to the facility by staff. Resident #329 had no injuries, distress, or discomfort noted with stable vital signs, and he was unable to describe what had happened. Notifications were made the physician, responsible party, and Administrator on 03/18/25. Record review of in-service, dated 03/18/25, by RN G, titled Missing Residents/Actual Development Event, reflected that all staff on all shifts had been in-serviced including LVN M and the Receptionist. Record review of the police incident report dated, 03/18/25 at 3:40 PM, reflected Law Enforcement Officer responded to a welfare concern regarding an elderly man who had entered an apartment complex for low-income seniors and was asking for assistance. The Law Enforcement Officer arrived and spoke to Resident #329, whose clothes appeared well maintained and clean and Resident #329 did not make sense when talking and stated that he had taken a bus from another city and was trying to get to another city. The apartment complex had reached out to the facility and was able to determine that he was a resident at the facility and when the Maintenance Director came to pick up Resident #329 he told the Law Enforcement Officer that he was not sure how the resident left the facility and all doors were locked and had passcodes to open the door. The Law Enforcement Officer reported the incident to Adult Protective Services. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Logbook Report, dated generated on 04/09/25, of elopement drills for the past 12 months reflected the task name of: Emergency Preparedness Drills: Conduct Elopement drill (Missing Resident Drill) reflected the following due dates: 06/30/24, 09/30/24, 12/31/24, 03/31/25. Record review of the facility's Logbook Documentation for task: Conduct Elopement drill (Missing Resident Drill) for the past 6 months reflected: Start dated 06/26/24 at 1 PM, ended at 1:15 PM (6 AM- 2 PM Shift) and marked done on time by the Maintenance Director on 06/26/25. Start dated 09/17/24 at 9:30 AM, ended at 10:30 AM (6 AM- 2 PM Shift) and marked done on time by the Maintenance Director on 10/07/24. Start dated 12/31/24 at 11 AM, ended at 12 PM (6 AM-2 PM Shift) and marked done on time by the Maintenance Director on 12/31/24. Start dated 03/18/25 at 3:55 PM, ended at 4:10 PM (2 PM-10 PM Shift) and marked done on time by the Maintenance Director on 03/31/25. Interview on 04/07/25 at 12:34 PM with Law Enforcement Officer revealed on 03/18/25 in the afternoon he was called to an apartment complex around the corner from the facility because Resident #329 had wandered from the facility to a nearby apartment complex. He stated that the apartment complex called the facility to ask if Resident #329 was their resident after about 30 minutes and it was uncertain what time the resident had eloped from the facility. He stated that the resident did not seem to have any psychosocial harm or physical injuries, he was confused, and a staff member came and took Resident #329 back to the facility. Interview on 04/09/25 at 9:26 AM with the Receptionist revealed she did not realize Resident #329 was a resident at the facility when she unlocked the front door when another visitor was leaving the facility. She stated he exited behind the visitor around 2:30 PM. She stated she realized Resident #329 was a resident when he returned with the Maintenance Director. She stated she had been in-serviced on elopements, participated in elopement drills, and now updated the elopement book each day. Observation of elopement book with the Receptionist revealed it was updated to include face sheets with pictures of residents at risk of elopement. In an interview on 04/09/25 at 2:59 PM CNA N said she used to work with Resident #329 and was not working the day he eloped. She stated that Resident #329 walked around the facility but did not exit seek or show any signs of wandering before the elopement. She stated if she had seen any signs of exit seeking, she would have notified the nurse. She stated that she kept a list of residents at risk of elopement in her pocket and the facility conducted elopement drills. She stated that she had been in-serviced on elopements after the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/10/25 at 8:59 AM LVN M said he noticed during his shift rounds around 3 PM that Resident #329 was not in his room and thought Resident #329 was in therapy and did not check. He stated he learned the resident had left the facility when he was brought back by the Maintenance Director. He stated that he assessed Resident #329 when he returned, and he had no injuries and did not appear upset. He stated that he had participated in past elopement drills and had been in-serviced on elopements after the incident. He stated that staff were updated on any residents who were elopement risks during morning meetings and shift change, and there was an elopement book at the nurses' station with residents who were at risk of elopement. He stated in the future he would find where the resident was and ensure they were in therapy rather than assume. He stated it was important to prevent elopements because a resident could be harmed if they left the facility without supervision. In an interview on 04/10/25 at 10:07 AM RN G said elopement drills were conducted by her and the Maintenance Director every 3 months. She stated that she was working when the resident came back to the facility, and he did not seem upset and had no injuries. She stated she conducted the elopement and abuse and neglect in-services with staff and notified the physician and the family. She stated Resident #329's room was moved in between both nurses' stations and he was on one-on-one supervision until he discharged to another facility. In an interview on 04/10/25 at 2:50 PM the Administrator said Resident #329 did not display any exit seeking or wandering behavior before the incident and was placed on one to one supervision until he was discharged to a facility with a secure unit. He stated that the Receptionist did not realize Resident #329 was a resident at the facility when he had exited along with a visitor of the facility. He stated that staff were immediately in-serviced on elopements and included the Receptionist who was also provided additional education. He stated that Resident #329 had no injuries and did not seem upset. He stated it was important to ensure residents did not elope from the facility to ensure residents are kept safe. In an interview on 04/10/25 at 3:27 PM the Maintenance Director said he was the employee that picked up Resident #329 from the apartment complex next-door to the facility that was separated from the facility with a grass median. He stated that the resident did not appear upset or injured. He stated that he and RN G conducted the elopement drills every 3 months and that there are elopement books at the receptionist and nurse's stations that identify the residents at risk of elopement. He stated that they conducted an elopement drill after the resident had eloped and staff were in-serviced on elopements and abuse and neglect. He stated that it was important to ensure residents did not elope because they could get lost, get hit by a car, or be seriously injured or die. In interviews covering all three shifts (6 AM- 2PM, 2 PM-10 PM, and 10 PM- 6 AM), the following staff said they had been in-serviced (03/18/25 -03/19/25) after the elopement on 03/18/25 on preventing and responding to elopements, participated in past elopement drills, knew the alert code for an eloped resident, were aware of where to find the elopement book at the nurses' station and carried a list of residents who were at risk of elopement: 04/08/25 from 1:20 PM to 1:46 PM with LVN C, CNA Q, and MA R 04/09/25 from 1 PM- 5 PM with 2 LVNs (LVN E & T), 7 CNAs (CNA S, D, Q, N, V, W, X), 2 Unit Managers (Unit Manager U & AA) 04/10/25 from 9:55 AM- 11:10 AM with the Restorative Aide I, the Treatment Nurse, and RN G (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of inservices sign in sheets dated 03/18/25 and 03/19/25 revealed staff were inserviced on elopement on 03/18/25 and 03/19/25. Record review of the facility's elopement policy, titled Area of Focus: Elopement, dated reviewed 11/19/24, reflected . Elopement occurs when a resident leaves the premises or a safe area without authorization . and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle . Residents will be assessed for unsafe wandering and elopement indicators upon admission, readmission, change in condition, quarterly and with any unsafe wandering or elopement event utilizing the Elopement Risk Evaluation UDA (Universal Design for Assessment) in PCC (Point Click Care) (an electronic medical health record program) . Elopement drills will be conducted at least quarterly . Record review of the facility's policy for elopement prevention, titled Unsafe Wandering and Elopement Prevention, revised 03/04/25, reflected The facility will ensure that residents are assessed to determine risk for elopement in accordance with current standards of practice and implement interventions as appropriate to mitigate the risks identified . Record review of the facility's policy for an actual elopement, titled Missing Residents/Actual Elopement Event, dated reviewed 04/03/25 reflected .It is the responsibility of all associated to report any resident who is suspected of being missing to the nurse manager immediately . 11. When the resident is found, the charge nurse or designee will assess the resident's physical, mental, emotional, and cognitive state and notify the physician and responsible party. The resident will be monitored as deemed necessary by the interdisciplinary team . 12. An incident (event) report will be completed by the charge nurse or designee to include witness statements .13. The Executive Director or designee will report the event to all appropriate agencies as well as the regional and divisional team . The Administrator and DON were notified of PNC IJ on 04/24/25 at 3:32 PM and PNC IJ template was provided to the facility at this time. In an interview on 04/24/25 at 11:27 AM the Maintenance Director said on 03/18/25 the Administrator texted him to inform him about Resident #329 had eloped and he needed to go pick him up. He stated he went at 3:55 PM on 03/18/25 with a wheelchair and the Housekeeping Supervisor assisted him to go pick up Resident #329. He stated Resident #329 was wearing a t-shirt and sweatpants but could not recall if he had shoes on. He stated Resident #329 was confused stating he had come from another city. He stated he considered this incident an elopement drill but did not do an elopement drill like he usually did where the staff had to find a resident who was missing and implement code yellow which was missing resident. He stated he just discussed with staff to ensure they are aware of where their residents are. He stated he did check all the doors ensuring they were alarming and working properly. He had no issues with any of the doors on 03/18/25. He stated he did not complete his usual elopement drill which was done quarterly until later in December 2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/24/25 at 11:50 AM the Housekeeping Supervisor said she went with Maintenance Director to go get Resident #329 who had been found at a neighboring apartment complex. She stated the apartment complex was separated by a grass median in front of the facility, so they walked there to get him taking the wheelchair with them and they pushed him in the wheelchair back to the facility. She stated Resident #329 had on a t-shirt, sweatpants and shoes. She stated Resident #329 was confused but did not have any visible injuries. She stated it took about 15 minutes for them to get Resident #329 and bring him back in the wheelchair. She stated they brought him back to the facility about a few minutes after 4 pm. She stated she was in-serviced on missing residents and elopement protocol. She was knowledgeable of facility's policy and what to do if a resident reported missing. In an interview on 04/24/25 at 12:02 PM RN G said she was notified Resident #329 had eloped out of the facility by the Administrator. She stated she went to the floor a few minutes past 4 pm. She stated she and charge nurse went to assess Resident #329. She stated Resident #329 had no signs of heat exhaustion. Resident #329 was confused and could not remember leaving the facility. She stated vital signs were within normal limits and there were no injuries. She stated she assisted the charge nurse and ensured Resident #329 was safe. She stated she notified the physician and responsible party for Resident #329. She stated the physician ordered for the facility to start initiating a discharge to a facility with a secure unit since Resident #329 had eloped and facility had no current secure unit for resident safety. She initiated the in-service for elopement and abuse and neglect on 03/18/25 on the 2 pm to 10 pm shift and continued education with all shifts until 03/19/25 to get the last shift on the 6 am to 2 pm shift. She stated Resident #329 was placed on 1:1 until he was discharged to another facility with secure unit for resident safety. Observations on 04/24/25 from 12:52 PM to 1:05 PM with the Maintenance Director revealed all exit doors were working properly. Observations revealed all exit doors alarmed when pressed on and if held 15 seconds would continue to alarm. The front door alarmed when pressed on and if held for 15 seconds would alarm until the code was put in. In a follow-up interview on 04/24/25 at 12:58 PM the Maintenance Director said there was grass between the facility and the building Resident #329 was at. He stated he pushed the wheelchair across the grass. He stated he went to the front of the building. He stated Resident #329 had no visible injuries and was very confused. He did not know that he was a resident at the facility. The Maintenance Director stated Resident #329 was cooperative and they took him back in the wheelchair. He stated they used a side street to take Resident #329 back in the wheelchair. He stated they returned with Resident #329 at 4:10 PM. The noncompliance was identified as Past Noncompliance (PNC) Immediate Jeopardy (IJ). The noncompliance began on 03/18/25 and ended on 03/31/25. The facility had corrected the noncompliance before the Incident investigation began on 04/08/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for one of nine (Resident #64) residents reviewed for pharmacy services. The facility failed to ensure facility staff re-ordered medications in a timely manner for Resident #64 which resulted in a missed dose of levothyroxine 50 mcg (used to treat low thyroid) on 04/09/25. The facility failed to keep medications secure when LVN H borrowed a medication from another resident to administer to Resident # 64. This failure could place residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings include: Record review of Resident #64's face sheet, dated 04/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #64's 5-day MDS Assessment, dated 02/08/25, reflected he had BIMS score of 13, which indicated he was cognitively intact. The 5-day assessment reflected the resident had diagnoses which included malnutrition and seizure disorder. Record review of Resident #64's Physician order Summary Report, dated 04/10/25, reflected Levothyroxine Sodium Oral Tablet 50 mcg 1 time a day for low thyroid, with a start date of 03/28/25. Record review of Resident #64's MAR for April 2025 reflected on 04/09/25 the 06:00 a.m. administration for Levothyroxine 50 mcg was coded as 7 (which indicated see progress note) by LVN H. There were no other missed doses for April 2025. Record review of Resident #64's progress notes did not reflect any documentation by LVH H for 04/09/25. During a medication observation and interview on 04/09/25 at 06:25 a.m. revealed LVN H at the medication cart in front of Resident #64'sroom. LVN H pulled up the Medication Profile for Resident #64. She looked in the medication cart to obtain the residents Levothyroxine and stated there was none on the cart. She stated she would have to retrieve the medication from the E-Kit. LVN H pushed the Medication cart to the next room. LVN H was never observed going to the medication room to retrieve the Levothyroxine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/09/25 at 10:00 a.m. with Unit Manager F, revealed the facility had a computer coded pharmacy dispensing unit (E-Kit) for on demand supply of routine medications. Unit Manager F stated they must contact the pharmacy to retrieve information on what was pulled from the system and who pulled it. Unit Manager F contacted their contracted pharmacy and verified no Levothyroxine for Resident #64 was pulled today (04/09/25). In a telephone interview with LVN H on 04/09/25 at 10:05 a.m., LVN H stated she borrowed a Levothyroxine 50 mcg tablet from another resident's medication supply and administered it to Resident #64 before she left. She stated she was running late and had an appointment she needed to get to and just did not go to the other hall where the E-Kit was located to retrieve the necessary medications. She stated she was not sure why the medications had not been re-ordered timely. In an interview with LVN E, charge nurse for the 6 a.m. to 2 p.m. shift, on 04/09/25 at 10:15 a.m. she stated, LVN H had not mentioned anything to her when they counted the medication cart at change of shift about Resident #64's Levothyroxine needing to be ordered. She stated each nurse was responsible to re-order the resident's medication when they had a 7-day supply left. She stated the re-ordering was done through the electronic record and it was as simple as pushing the re-order button in the system. She stated if the medication did not come in on the next day shipment from the pharmacy, they had to call the pharmacy and follow up. She stated Levothyroxine was almost always given by the night shift charge nurse since it was usually ordered to be taken before meals. She stated the night shift charge nurse would be responsible for re-ordering those medications for which they gave routinely. She stated in the event a medication did not get re-ordered or was delayed they always had access to the E-Kit. In an interview with the facility's contracted pharmacy, on 04/10/24 at 8:45 a.m., revealed the facility sent a re-order request to the pharmacy on 04/09/25 for Resident #64's Levothyroxine 50 mcg. The pharmacy representative stated the procedure for any re-order for medications was to submit the request when the resident had 5-7-day supply on hand. In an interview with the DON on 04/10/25 at 09:25 a.m., the DON stated it was never acceptable to borrow a medication from another resident and the staff member would be counseled. He stated there was no excuse for this since they had an E-Kit that had most of the common medications the residents took. He stated the re-ordering process was a very simple process and the staff all knew they were to re-order when a resident had a 7-day supply on hand. He stated whoever administered the medication and saw the 7-day mark was responsible for re-ordering the medication. He stated the staff were responsible for following up with the pharmacy in the event the medication was not delivered. He stated there was no excuse for this. Record review of the facility's policy, Reordering, Changing, and Discontinuing Medication Orders, dated July 2024, reflected Facilities are encouraged to reorder medications electronically or by fax whenever possible . Facility staff should re-order medications using an electronic list of residents and medications due or by use of barcode technology .Facility staff should review the transmitted re-orders for status and potential issues and pharmacy response