STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676002	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Edgemere	8502 Edgemere Dallas, TX 75225

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objectives and time frames to meet the resident's medical, nursing, and psychosocial needs identified in the comprehensive assessment for 1 (Resident #2) of 4 residents reviewed for care plan review and revision.The facility failed to review and revise Resident #2's care plan after he fell on [DATE] and 06/22/2025. This failure could affect all residents and contribute to residents not receiving the care and services they needed to prevent falls. The findings included: Record review of Resident #2's Face Sheet, dated 10/09/2025, reflected the resident was a [AGE] year-old male who admitted on [DATE]. Resident #2 had diagnoses which included dementia (decline in cognitive function that interferes with daily life) and a history of falls. Record review of Resident #2's Quarterly MDS (tool used to measure health status) Assessment, dated 07/13/2025, reflected severely impaired cognition with a BIMS (tool used to assess cognition) score of 03. Section J (Health Conditions) indicated Resident #2 had two or more falls since admission/reentry which did not result in any injury. Record review of Resident #2's Comprehensive Care Plan, dated 07/16/2025, reflected the resident was at risk for falls related to a history of falls and gait/balance problems. The Comprehensive Care Plan indicated Resident #2 had a fall on 06/17/2025 and 06/22/2025 with no injury. An intervention to prevent a future fall was not added to the care plan after the resident fell on [DATE] and 06/22/2025. Record review of Resident #2's Incident Report, dated 06/17/2025, reflected Incident DescriptionNursing Description: Resident attempting to go to restroom without assistanceResident Description: was attempting to go to restroom and lost balance and fell onto the floorWas this incident witnessed: NImmediate Action TakenDescription: Head to toe assessment completed by nurse and treatment nurse, no c/o pain at this time. Assisted back to chair. No injuries noted. Reeducated resident to use call light to call for assist. Neuro checks started, will monitor resident over the next 72 hours for any changes. MD notified, no new orders given at this time. POA, hospice and DON notified.Record review of Resident #2's Neurological/Vital Sign Checks reflected staff monitoring and documentation after the resident fell on [DATE]. Record review of Resident #2's Incident Report, dated 06/22/2025, reflected Incident DescriptionNursing Description: Staff notified this writer that resident was on the floor on his left side of the bedResident Description: Resident Unable to give DescriptionWas this incident witnessed: NImmediate Action TakenDescription: Head to toes assessments done . able to move all extremities, 2-3 person assisted back to bed. and call light in reach, no new injuries. Will continue as plan of careRecord review of Resident #2's Neurological/Vital Sign Checks reflected staff monitoring and documentation after the resident fell on [DATE]. During an interview on 10/09/2025 at 4:46 PM, the MDS Coordinator stated she was responsible for completing the residents' comprehensive care plans. She stated the DON and ADON were responsible for acute care plans such as falls. The MDS Coordinator opened Resident #2's chart and stated she did not see a new intervention added after he fell on [DATE] and 06/22/2025. She stated residents' care plans were important, so everyone was aware of their needs.During an interview on 10/09/2025 at 5:20 PM, the DON stated she and the ADON added and updated acute care plans, including when a resident fell. She stated the MDS Coordinator completed the comprehensive care plans. The DON looked at Resident #2's chart and stated the intervention added on 06/22/2025 was to continue interventions on the at-risk plan. She stated a new intervention was not added. The DON stated a new intervention should have been added to Resident #2's fall risk care plan after each fall. She stated it was important to ensure the facility had appropriate interventions in place, and all staff were alert of interventions, to prevent falls and injury.During a telephone interview on 10/15/25 at 2:33 PM, the ADON stated Resident #2's care plan should have been updated each time he fell. She stated it was important to ensure care plans were updated and the interventions implemented were appropriate and working for the resident. Record review of the facility's policy Baseline Care Plan, undated, reflected Interventions shall be initiated that address the resident's current needs including. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.Record review of the facility's policy Care Plan Revisions Upon Status Change, undated, reflected The comprehensive care plan will be reviewed, and revised as necessary, when a resident experience a status change. The care plan will be updated with the new or modified interventions.