

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455861	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Landmark of Plano Rehabilitation and Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1621 Coit Rd 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs fo (Resident #3) reviewed for resident call system, in that.</p> <p>1.Resident #3s call lights was on the floor and not within reach on 08/24/2024.</p> <p>This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <p>Record review of Resident #3's electronic face sheet, printed on 08/26/24, revealed an [AGE] year-old male who was admitted to the facility initially 03/08/24 and readmitted on [DATE] with diagnoses that included but not limited to pressure ulcer of the sacral region, stage 4 and need for assistance with personal care.</p> <p>Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 14, indicating the resident was cognitively intact.</p> <p>Record review of Resident #3 s care plan, dated 07/23/2024, reflected, the resident was a risk for falls and the intervention reflected, anticipate resident needs, be sure the call light was in reach, and encourage the resident to use it for assistance .</p> <p>Interview and observation on 08/24/2024 at 1:00 PM with Resident #3 revealed Resident # 3 was eating and stated he wanted to request more food. Resident #3 stated he could not call for help and the call button was observed on the floor and out of reach of Resident #3. Resident #3 stated he was not sure how he would call for help due to his call button being on the floor. Resident #3 stated his call button had been out of reach in other days however he could not remember specifically when. Resident #3 stated he was not able to call for assistance without the call button The Surveyor gave Resident #3 the call button.</p> <p>Interview on 08/26/2024 at 2:20 PM with the DON revealed staff should have been checking to ensure call lights were working and within reach during rounds. The DON stated maintenance also checked call lights monthly to ensure they worked properly. The DON stated the risk of not ensuring call lights were working would be that residents would not be able to call for assistance when needed.</p> <p>(continued on next page)</p>

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A call light policy was requested from the Administrator and Director of Operations on 8/26/2024 at 2:06PM however was not provided prior to exit.		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview, and record review the facility failed to protect the confidentiality of personal health care information for one of three (Resident #1) residents reviewed for confidentiality of records.</p> <p>The facility failed to ensure LVN A locked and closed the laptop during the medication pass exposing Resident #1's personal information to include some of his medications.</p> <p>This failure could affect residents by placing them at risk for loss of privacy and dignity.</p> <p>The Findings included:</p> <p>Review of Resident #1's electronic face sheet printed 08/26/2024 revealed a [AGE] year- old male admitted to the facility initially on 04/02/2024 and re admitted on [DATE] with diagnoses that included but not limited too acute combined systolic and diastolic heart failure(both types of left-sided heart failure that affect the heart's ability to pump blood), type 2 diabetes mellitus unspecified complication(chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance and high blood pressure.</p> <p>Observation and interview on 08/24/2024 at 12:20 PM revealed the computer screen on LVN A's medication cart unlocked for approximately 1-2 minutes while LVN A was inside Resident #1's room . The medication cart was approximately 2 doors down from Resident #1's room and facing the hall which exposed Resident #1's personal information including medication to staff and residents who were on the hall. The computer displayed the medication that was being provided to Resident #1. LVN A was found in Resident #1's room and stated he was responding to a call light. LVN A stated he should have locked the computer when he walked off however he was trying to respond to the call light quickly.</p> <p>Interview on 08/26/2024 at 2:20PM with the Director of Nursing revealed during medication pass the computer screen should be locked or minimized when not in sight. The Director of Nursing stated the risk of leaving the computer unlocked would be patient information would be visible to residents or staff walking down the hall.</p> <p>Review of the facility policy Resident Rights undated revealed The resident has a right to secure and confidential personal and medical records.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one (Resident #1) of three residents reviewed for competent staff, in that:</p> <p>1. CNA C was not competent in gastrostomy feeding tube nutrition and care. CNA C adjusted Resident #1's feeding pump without alerting a nurse that there was liquid leaking.</p> <p>This failure placed residents with feeding tubes at risk for complications to include aspiration, nausea, vomiting and/or diarrhea, residents who required two staff for bed mobility at risk for discomfort/injury and for residents not to receive needed nursing assessments.</p> <p>Findings included:</p> <p>Review of Resident #1's electronic face sheet printed 08/26/2024 revealed a [AGE] year- old male admitted to the facility initially on 04/02/2024 and re admitted on [DATE] with diagnoses that included but not limited to acute combined systolic and diastolic heart failure(both types of left-sided heart failure that affect the heart's ability to pump blood), type 2 diabetes mellitus unspecified complication(chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance) , high blood pressure and infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter.</p> <p>Review of Resident #1's care plan dated last revised 04/12/24 revealed problems addressed included indwelling urinary catheter, feeding tube. Interventions included Clean insertion site daily as ordered, monitoring for signs and symptoms, infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to physician if symptoms arise. Monitor/document, report to physician as needed : Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness.</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated the resident was cognitively intact. Review of section K0520 Nutritional approach revealed Resident #1 had a feeding tube</p> <p>Observation on 08/26/2024 at 12:00 PM revealed CNA C responding to Resident#1 regarding his G tube leaking fluid. CNA C picked up the G Tube without washing her hands and without gloves to inspect the G Tube to determine the location of the leak. CNA C then pulled several gloves out of her pocket and placed them on Resident #1's bed while holding the G tube with the other hand. CNA C then put gloves on and put the gloves back in her pocket. CNA C closed the end of the G Tube to prevent leaking for Resident #1 and discarded the gloves on her hands, washed her hands and left the room. The Surveyor was in the resident's room for 30-45 minutes and no nurse assessed the resident.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/26/2024 at 2:00 PM with CNA C revealed she was aware that she should have washed her hands before touching Resident #1's G Tube however she was in a rush since it was leaking a fluid. CNA C stated she pulled all the gloves out of her pocket and put them on the bed because she was holding the G tube with one hand trying to prevent it from leaking. CNA C stated she did not use the gloves on another resident and threw them away once she left Resident #1's room. CNA C stated she was aware that she should not have assessed the G tube and should have gotten a nurse to assess the resident. CNA C stated the risk of not getting a nurse to assess the resident could be the resident could have complicated related to the G Tube.</p> <p>Interview on 08/26/2024 at 2:20 PM with the DON stated CNA C should have notified a nurse that the G tube was leaking and should not have attempted to assess the G tube. The DON stated CNA C was practicing outside of her scope of practice by assessing and adjusting the G tube without having a nurse assess. The DON stated the risk of the CNA C practicing outside of her scope of practice could be that the resident could have signs and symptoms related to the G tube that CNA C may not have been aware of.</p> <p>Review of the facility policy titled Gastrostomy Tube , revised February 13, 2007 Care did not address the competency needed to provide G tube care.</p> <p>Review of the CNA job description did not discuss G tube care.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #1) of 4 residents reviewed for accuracy of medical records.</p> <p>The facility failed to ensure the physician visit were documented for the correct resident. Resident #1's file contained physician visit notes for the wrong resident.</p> <p>These failures could place residents at risk for medication and /or treatment errors and omissions in care.</p> <p>Findings included:</p> <p>Review of Resident #1's electronic face sheet printed 08/26/2024 revealed a [AGE] year- old male admitted to the facility initially on 04/02/2024 and re admitted on [DATE] with diagnoses that included but not limited to acute combined systolic and diastolic heart failure(both types of left-sided heart failure that affect the heart's ability to pump blood), type 2 diabetes mellitus unspecified complication(chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance and high blood pressure.</p> <p>Review of Resident #2's electronic face sheet dated 08/26/2024 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included but not limited to displaced communicated fractur of left femur, hypothyroidism(abnormally low activity of the thyroid gland, resulting in slowing of growth and mental development in children and metabolic changes in adults), high blood pressure.</p> <p>Review of the electronic nursing notes for Resident #1 printed 08/26/2024 revealed the physician notes dated 08/12/2024, 08/09/2024, 08/08/2024, 08/07/2024 were for Resident #2 which included Resident #2's name, date of birth, vital signs and history, reason for visit, assessment, and plan.</p> <p>Interview on 08/26/2024 at 2:20 PM with the Director of nursing revealed she was not aware that the physician had documented the wrong visit notes in the resident's electronic file.</p> <p>Interview on 08/26/2024 at 3:00 PM with the Corporate Nurse revealed he was not aware of the physician documenting in the wrong file. The Corporate Nurse revealed the risk of documenting in the wrong file could be that staff could have provided incorrect care.</p> <p>Interview on 08/27/2024 at 12:00 PM with the Administrator revealed the physician was new to the system and just made a mistake with documenting. The Administrator stated the nursing staff did not catch the error because nurses did not look at physician notes and were not responsible for ensuring accuracy of the physician notes due to the physician being superior to nursing staff. The Administrator stated he did not feel there was a risk to residents due to the physician documenting in the wrong chart. The Administrator stated Resident #1 was last seen by the physician on 08/08/2024 and the records had been updated to reflect the correct information.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Documentation revised May 2015 revealed Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care(PCC). All documentation and clinical records are confidential and can be released only with signed permission of the resident or legal representative. Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview and record review, the facility failed to maintain an 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 one (Resident #1) of four residents reviewed for infection control.</p> <p>CNA C failed to use proper infection control prevention while tending to the G Tube for Resident #1</p> <p>This failure could place residents at-risk of cross contamination which could result in infections or illness.</p> <p>Findings included:</p> <p>Review of Resident #1's electronic face sheet printed 08/26/2024 revealed a [AGE] year- old male admitted to the facility initially on 04/02/2024 and re admitted on [DATE] with diagnoses that included but not limited too acute combined systolic and diastolic heart failure(both types of left-sided heart failure that affect the heart's ability to pump blood), type 2 diabetes mellitus unspecified complication(chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance and high blood pressure.</p> <p>Review of the training log for CNA C revealed infection control training was last completed 03/12/2024 titled Infection control: Essentials principles.</p> <p>Review of the faciliy in-service sign sheet revealed infection control in- service completed 04/01/2024 with all staff.</p> <p>Observation on 08/26/2024 at 12:00 PM revealed CNA C responding to Resident#1 regarding his G tube leaking fluid. CNA C picked up the G Tube without washing her hands and without gloves to inspect the G Tube to determine the location of the leak. CNA C then pulled several gloves out of her pocket and placed them on Resident #1's bed while holding the G tube with the other hand. CNA C then put gloves on and put the gloves back in her pocket. CNA C capped the G Tube for Resident #1 and discarded the gloves on her hands, washed her hands and left the room.</p> <p>In an interview on 08/26/2024 at 2:00 PM with CNA C revealed she was aware that she should have washed her hands before touching Resident #1's G Tube however she was in a rush since it was leaking a fluid. CNA C stated she pulled all the gloves out of her pocket and put them on the bed because [NAME] as holding the G tube with one hand trying to prevent it from leaking. CNA C stated she did not use the gloves on another resident and threw them away once she left Resident #1's room. CNA C stated the risk of not using proper infection control procedures would be that infection could be passed to different residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/26/2024 at 2:20 PM with the DON revealed she was not sure when staff last had infection control training since she was new to the building. The DON stated CNA C should not have touched the G tube without sanitizing or washing or hands and putting on gloves. The DON stated CNA C should have notified a nurse that the G tube was leaking. The DON stated the nurse should not have taken all gloves from her pocket and placed them on Resident #1's bed due to possibly spreading infection to other if she used those gloves on other residents. The DON stated the risk of not using proper infection control procedures could be that staff could pass infection to residents.</p> <p>Review of the facility policy titled Infection control plan : Overview dated 2019 revealed in part The intent of this policy is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will: Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</p> <p>Based on observation, interview, and record review, the facility failed to be adequately equipped to allow for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for one of three residents (Resident #3) reviewed for resident call system, in that.</p> <p>Resident# 3's call light was not working on 08/26/2024.</p> <p>These could place the residents at risk of not receiving the care and services to maintain their highest level of well-being.</p> <p>Findings included:</p> <p>Record review of Resident #3's electronic face sheet, printed on 08/26/24, revealed an [AGE] year-old male who was admitted to the facility initially 03/08/24 and readmitted on [DATE] with diagnoses that included but not limited to pressure ulcer of the sacral region, stage 4 and need for assistance with personal care.</p> <p>Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 14, indicating the resident was cognitively intact.</p> <p>Record review of Resident #3 s care plan, dated 07/23/2024, reflected, the resident was a risk for falls and the intervention reflected, anticipate resident needs, be sure the call light was in reach, and encourage the resident to use it for assistance .</p> <p>Interview and observation on 08/26/2024 at 11:45 AM with Resident #3 revealed he needed to call staff to let them know he was not able to find his wallet. Resident #3 attempted to use the call light however it did not light up indicating it was working. The Surveyor stepped into the hall to see if the light outside the door was lit indicating the call light was working and it was not. While in the hall the Surveyor flagged down the DON to inform her Resident #3 needed assistance and his call light was not working. The DON tested the call button and determined the call light was not working and stated she would let maintenance know.</p> <p>Interview on 08/26/2024 at 1:40 PM with the Maintenance Director revealed he checked call lights on different halls each month. He stated Resident #3's call light was last checked the beginning of August 2024. He stated staff informed him today that Resident #3's call light was not working, and it had been fixed. The Maintenance Director stated the risk of call lights not working would be that Residents would not be able to call for assistance.</p> <p>Interview on 08/26/2024 at 2:20 PM with the DON revealed staff should have been checking to ensure call lights were working and within reach during rounds. The DON stated maintenance also checked call lights monthly to ensure they worked properly. The DON stated the risk of not ensuring call lights were working would be that residents would not be able to call for assistance when needed.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A call light policy was requested from the Administrator on Director of Operations on 8/26/2024 at 2:06PM , however was not provided prior to exit</p>