

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  02/04/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 (Residents #1, #2 and #3) of five residents reviewed for ADL assistance.</p> <p>The facility failed to provide Residents #1, #2 and #3 with consistent showers/bed bath and timely incontinent care.</p> <p>The failures could place the residents at risk of resident's needs, safety and psychosocial well-being not being met.</p> <p>Findings Include:</p> <p>Review of Resident #1's face sheet dated 02/04/25 reflected the resident was a [AGE] year old female and she was admitted on [DATE]. The resident was admitted with the following diagnoses, local infection of the skin and subcutaneous tissue, need for assistance with personal care, diarrhea, abnormalities of gait and mobility, hypothyroidism, morbid (severe) obesity due to excess calories, hyperlipidemia, hypertension, and muscle weakness.</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected the resident had a BIMS of 15, indicating no cognitive impairment. The resident required moderate to maximum assistance with activities of daily living. Resident #1 was incontinent of bowel and bladder.</p> <p>Review of Resident #1's care plan revised 06/14/24 reflected, Focus, (Resident #1) has an ADL Self Care Performance Deficit, Goal, The resident will maintain or improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date, Intervention, TOILET USE: The resident requires assistance max assist (specify: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet.</p> <p>Observation and interview on 02/04/25 at 10:18 am with Resident #1 revealed the resident was in bed, and she was well groomed. In an interview with the resident, she stated she had just been provided with incontinent care. She stated at times she had to wait for 2-3 hours, most of the time to be provided with incontinent care when she had her call light, the delay to be changed was with all shift. Resident #1 stated staffing had been an issue in the facility and management were aware and it seemed like they were not addressing the issue.</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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's face sheet dated 02/04/25 reflected the resident was a 96-year-old female, she was admitted on [DATE]. The resident was admitted with the following diagnoses, stroke, non-traumatic brain dysfunction, traumatic brain dysfunction, non-traumatic spinal cord dysfunction, traumatic spinal cord dysfunction, progressive neurological conditions, neurological conditions, amputation, hip and knee replacement, fractures and other multiple traumas.</p> <p>Review of #2's quarterly assessment MDS dated [DATE] reflected the resident had a BIMS of 12, indicating moderate cognitive impairment. The resident required maximum assistance with activities of daily living, and he was dependent on showers and toileting.</p> <p>Review of Resident #2's care plan revised 04/10/24 reflected, Focus, (Resident #2) has an ADL Self Care Performance Deficit. Goal, (Resident #2) will improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Intervention, . The resident requires max assistance (specify: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet.</p> <p>Review of shower sheets documentation for Resident #2 from December 2024 through 02/04/25 reflected no shower sheet was documented.</p> <p>Observation and interview on 02/04/25 at 11:25 am with Resident #2 revealed the resident was in her room in a wheelchair, and family members were at the bedside. Resident #1 was well groomed. In an interview with the resident revealed she had not been showered, she stated she was showered on Monday, Tuesday, and Friday but she did not get a shower on 02/03/25 which was on a Monday. Resident #2 stated she would like to be showered but she did not think the facility had enough staff to provide care.</p> <p>Review of Resident #3's face sheet dated 02/04/25 reflected she was [AGE] years old female, and the resident was admitted on [DATE]. The resident had the following diagnoses, traumatic subdural hemorrhage(a collection of blood between the brain and the inner lining of the skull (dura mater) that occurs after a head injury) without loss of consciousness, kidney disease stage 3, idiopathic progressive neuropathy(a condition characterized by progressive damage to the peripheral nerves, the nerves outside the brain and spinal cord) muscle wasting and atrophy, hypertensive chronic kidney disease, muscle weakness (generalized), abnormalities of gait and mobility.</p> <p>Review Resident #3's quarterly MDS assessment dated [DATE] reflected, Resident #3 had a BIMS of 15 indicating no cognitive impairment, and the resident required extensive assistance with activities of daily living.</p> <p>Review of Resident #3's care plan revised 04/02/24 reflected, Focus . (Resident #3) has bladder incontinence r/t physical debility, Goal, (Resident #3) will remain free from skin breakdown due to incontinence and brief use through the review date. Intervention, ACTIVITIES: notify nursing if incontinent during activities.</p> <p>Review of shower sheets documentation for Resident #3 from December 2024 through 02/04/25 reflected no shower sheet was documented.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 02/04/25 at 12:35 pm with Resident #3 revealed the resident was in bed. She was well groomed. In an interview with Resident #3 she stated care was delayed in the facility and at times she was not provided with bed baths as scheduled, which was three times per week, and when she got the bed baths she had to frequently ask. Resident #3 stated the facility did not have enough staff to provide care to the residents. Resident #3 stated the issue with staffing had been ongoing for a long period. Resident #3 stated she did not have wounds due to lack of care.</p> <p>In an interview on 02/04/25 at 12:47 pm with CNA A revealed she worked on the 6-2 shift but most times she will work 2-10 shift because there was not enough staff. CNA A was assigned to 15 to 22 residents on the shift, and none of the resident was independent. CNA A stated the issues with staffing had been ongoing for a while and even she had informed management that all the residents' assigned tasks were not completed because there was not enough staff. CNA A stated showers/bed baths were not completed per schedule because there was not enough staff to provide the care. CNA A stated she was supposed to document the shower sheets and in point click care of resident's ADLs but most of the time some of the tasks were not documented because they were not completed. If the residents were not provided to ADL care that would affect their self-esteem, they would have skin breakdown if they were not provided with incontinent care timely.</p> <p>In an interview on 02/04/25 at 1:15 pm with LVN B revealed most of the residents' activities of daily living like showers/bed baths were not completed because there was not enough staff to provide the care to the residents. LVN B stated management was aware of the staffing issues, and it seemed like they were not addressing the issue. LVN B stated she was responsible to make sure the ADLs were completed per shift, but the aides were not enough to complete the assigned tasks. LVN B stated at times when their was call-ins, the aides were assigned more assignments which was hard for them to complete and meet the resident's care timely. LVN B stated lack of ADL care would affect the residents' self-esteem, it could make the resident be isolated if they were not groomed well and not clean.</p> <p>In an interview on 02/04/25 at 2:18 pm the ADON stated staffing had been an issue for about two months and she had been trying to hire more staff, but it had not been successful. The ADON stated she had also identified shower issues because it had been reported by some of the residents during the morning rounds. Management discussed in December and the ADON put in place shower sheets that the aides were supposed to complete daily after showers, and she was to follow up and make sure the showers were completed. The ADON then stated she failed to follow up to make sure the showers were completed, and she was not able to provide Resident #1, #2, and #3's shower sheets, from December through 02/03/25. The ADON stated she was aware the facility did not have enough staff on hall shifts and the aides and nurses had reported that the facility did not have enough staff and they were not able to complete the daily tasks. The ADON stated lack of staffing in the facility will affect resident's quality of care and quality of life.</p> <p>In an interview on 02/04/25 at 3:40 pm with the Administrator he stated he had been made aware of the staffing issues. He had been in the facility for two months, and he would address the issue with showers and staffing. The Administrator stated lack of enough staff would affect the resident's quality of life.</p> <p>Review of resident advisory council minutes dated 01/08/25 reflected they were concerns of call light not answered timely, the residents were not receiving scheduled showers and beds were not made in a timely manner. Also reflected meals were not delivered to the resident's rooms timely, and not always there was enough staff assisting in the dinning room.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident advisory council minutes dated 12/04/24 reflected meals tray were not delivered timely to the resident rooms, there was not enough staff to assist in the dinning room,</p> <p>Review of the facility policy dated 2003, titled Bath, Tub/Shower reflected, . The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed The resident will experience improved comfort and cleanliness by bathing.</p> <p>Review of the facility policy dated 04/25/22 and titled Section, Nursing: Personal Care, Titled: Perineal Care, reflected, It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations.</p> <p>This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37193</p> <p>Based on observation, interviews, and record review the facility failed the have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 3 (Residents #1, #2, #3) of 5 residents reviewed for sufficient staffing.</p> <p>The facility failed to ensure the facility had sufficient staffing to meet the needs of Residents #1, #2, #3.</p> <p>This failure could place the residents at risk of resident's needs, safety and psychosocial well-being not being met.</p> <p>Findings Include:</p> <p>Review of Resident #1's face sheet dated 02/04/25 reflected the resident was [AGE] years old female and she was admitted on [DATE]. The resident was admitted with the following diagnoses, local infection of the skin and subcutaneous tissue, need for assistance with personal care, diarrhea, abnormalities of gait and mobility, hypothyroidism, morbid (severe) obesity due to excess calories, hyperlipidemia, hypertension, and muscle weakness.</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected the resident had a BIMS of 15, indicating no cognitive impairment. The resident required moderate to maximum assistance with activities of daily living. Resident #1 was incontinent of bowel and bladder.</p> <p>Review of Resident #1's care plan revised 06/14/24 reflected, Focus, (Resident #1) has an ADL Self Care Performance Deficit, Goal, The resident will maintain or improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date, Intervention, TOILET USE: The resident requires assistance max assist (specify: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet.</p> <p>Observation and interview on 02/04/25 at 10:18 am with Resident #1 revealed the resident was in bed, and she was well groomed. In an interview with the resident, she stated she had just been provided with incontinent care. She stated at times she had to wait for 2-3 hours, most of the time to be provided with incontinent care when she had her call light, the delay to be changed was with all shift. Resident #1 stated staffing had been an issue in the facility and management were aware and it seemed like they were not addressing the issue.</p> <p>Review of Resident #2's face sheet dated 02/04/25 reflected the resident was a 96-yearls old female, she was admitted on [DATE]. The resident was admitted with the following diagnoses, stroke, non-traumatic brain dysfunction, traumatic brain dysfunction, non-traumatic spinal cord dysfunction, traumatic spinal cord dysfunction, progressive neurological conditions, neurological conditions, amputation, hip and knee replacement, fractures and other multiple traumas.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of #2's quarterly assessment MDS dated [DATE] reflected the resident had a BIMS of 12, indicating moderate cognitive impairment. The resident required maximum assistance with activities of daily living, and he was dependent on showers and toileting.</p> <p>Review of Resident #2's care plan revised 04/10/24 reflected, Focus, (Resident #2) has an ADL Self Care Performance Deficit, . Goal, (Resident #2) will improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Intervention, . The resident requires max assistance (specify: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet) to use toilet.</p> <p>Review of shower sheets documentation for Resident #2 from December 2024 through 02/04/25 reflected no shower sheet was documented.</p> <p>Observation and interview on 02/04/25 at 11:25 am with Resident #2 revealed the resident was in her room in a wheelchair, and family members were at the bedside. Resident #1 was well groomed. In an interview with the resident revealed she had not been showered, she stated she was showered on Monday, Tuesday, and Friday but she did not get a shower on 02/03/25 which was on a Monday. Resident #2 stated she would like to be showered but she did not think the facility had enough staff to provide care.</p> <p>Review of Resident #3's face sheet dated 02/04/25 reflected she was [AGE] years old female, and the resident was admitted on [DATE]. The resident had the following diagnoses, traumatic subdural hemorrhage(a collection of blood between the brain and the inner lining of the skull (dura mater) that occurs after a head injury) without loss of consciousness, kidney disease stage 3, idiopathic progressive neuropathy(a condition characterized by progressive damage to the peripheral nerves, the nerves outside the brain and spinal cord) muscle wasting and atrophy, hypertensive chronic kidney disease, muscle weakness (generalized), abnormalities of gait and mobility.</p> <p>Review Resident #3's quarterly MDS assessment dated [DATE] reflected, Resident #3 had a BIMS of 15 indicating no cognitive impairment, and the resident required extensive assistance with activities of daily living.</p> <p>Review of Resident #3's care plan revised 04/02/24 reflected, Focus . (Resident #3) has bladder incontinence r/t physical debility, Goal, (Resident #3) will remain free from skin breakdown due to incontinence and brief use through the review date.Intervention, ACTIVITIES: notify nursing if incontinent during activities.</p> <p>Review of shower sheets documentation for Resident #3 from December 2024 through 02/04/25 reflected no shower sheet was documented.</p> <p>Observation and interview on 02/04/25 at 12:35 pm with Resident #3 revealed the resident was in bed. She was well groomed. In an interview with Resident #3 she stated care was delayed in the facility and at times she was not provided with bed baths as scheduled, which was three times per week, and when she got the bed baths she had to frequently ask. Resident #3 stated the facility did not have enough staff to provide care to the residents. Resident #3 stated the issue with staffing had been ongoing for a long period. Resident #3 stated she did not have wounds due to lack of care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/04/25 at 12:47 pm with CNA A revealed she worked on the 6-2 shift but most times she will work 2-10 shift because there was not enough staff. CNA A was assigned to 15 to 22 residents on the shift, and none of the resident was independent. CNA A stated the issues with staffing had been ongoing for a while and even she had informed management that all the residents' assigned tasks were not completed because there was not enough staff. CNA A stated showers/bed baths were not completed per schedule because there was not enough staff to provide the care. CNA A stated she was supposed to document the shower sheets and in point click care of resident's ADLs but most of the time some of the tasks were not documented because they were not completed. If the residents were not provided to ADL care that would affect their self-esteem, they would have skin breakdown if they were not provided with incontinent care timely.</p> <p>In an interview on 02/04/25 at 1:15 pm with LVN B revealed most of the residents' activities of daily living like showers/bed baths were not completed because there was not enough staff to provide the care to the residents. LVN B stated management was aware of the staffing issues, and it seemed like they were not addressing the issue. LVN B stated she was responsible to make sure the ADLs were completed per shift, but the aides were not enough to complete the assigned tasks. LVN B stated at times when their was call-ins, the aides were assigned more assignments which was hard for them to complete and meet the resident's care timely. LVN B stated lack of ADL care would affect the residents' self-esteem, it could make the resident be isolated if they were not groomed well and not clean.</p> <p>In an interview on 02/04/25 at 2:18 pm the ADON stated staffing had been an issue for about two months and she had been trying to hire more staff, but it had not been successful. The ADON stated she had also identified shower issues because it had been reported by some of the residents during the morning rounds. Management discussed in December and the ADON put in place shower sheets that the aides were supposed to complete daily after showers, and she was to follow up and make sure the showers were completed. The ADON then stated she failed to follow up to make sure the showers were completed, and she was not able to provide Resident #1, #2, and #3's shower sheets, from December through 02/03/25. The ADON stated she was aware the facility did not have enough staff on hall shifts and the aides and nurses had reported that the facility did not have enough staff and they were not able to complete the daily tasks. The ADON stated lack of staffing in the facility will affect resident's quality of care and quality of life.</p> <p>In an interview on 02/04/25 at 3:40 pm with the Administrator he stated he had been made aware of the staffing issues. He had been in the facility for two months, and he will address the issue with showers and staffing. The Administrator stated lack of enough staff will affect the resident's quality of life. The Administrator did not provide the sufficient nursing staff policy.</p> <p>Review of resident advisory council minutes dated 01/08/25 reflected they were concerns of call light not answered timely, the residents were not receiving scheduled showers and beds were not made in a timely manner. Also reflected meals were not delivered to the resident's rooms timely, and not always there was enough staff assisting in the dinning room.</p> <p>Review of resident advisory council minutes dated 12/04/24 reflected meals tray were not delivered timely to the resident rooms, there was not enough staff to assist in the dinning room,</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy dated 2003, titled Bath, Tub/Shower reflected, . The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed The resident will experience improved comfort and cleanliness by bathing.</p> <p>Review of the facility policy dated 04/25/22 and titled Section, Nursing: Personal Care, Titled: Perineal Care, reflected, It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations.</p> <p>This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition.</p>		