| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455861 | A. Building<br>B. Wing | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Landmark of Plano Rehabilitation and Nursing Cente | 1621 Coit Rd<br>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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>37028<br><br>Based on interviews and record review, the facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property, and exploitation for one (Resident #1) of three residents reviewed for abuse.<br><br>The facility failed to ensure CNA A did not abuse Resident #1 on 03/14/25 by taking a private photo of her. This was determined to be past non-compliance.<br><br>The noncompliance was identified as PNC. The noncompliance began on 03/14/25 and ended on 03/16/25. The facility had corrected the noncompliance before the survey began.<br><br>This failure placed residents at risk of being abused by having their photo taken.<br><br>Findings included:<br><br>Review of Resident #1's Quarterly MDS Assessment, dated 01/05/25, reflected the resident had a BIMS score of 15 and was cognitively intact. The Resident had diagnoses which included hip fracture and diarrhea. The resident was always incontinent of bowel and bladder. The resident required maximum assistance with toileting.<br><br>Review of Resident #1's Comprehensive Care Plan, dated 05/16/24, reflected the resident had bowel incontinence. Facility interventions included to check the resident every two hours and assist with toileting as needed.<br><br>(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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview on 03/18/25 at 10:55 am with Resident #1 revealed on 03/14/25, evening shift CNA A entered her room and was cursing. The resident said she turned her light on at 1:30 PM to be changed because she had a blow-out. CNA A entered the room and the resident said CNA A was mad because she had to perform incontinence care for the resident. The resident said CNA A told her that the day shift CNA should have changed Resident #1. The resident said CNA A took a phone out of her pocket, told the resident to turn her face to the side, and took a picture of the resident's private area. The resident said CNA A told her that she was going to send the picture to the DON because day shift should have changed the resident. Resident #1 said it really bothered her that CNA A would take such a private and embarrassing photo of her. Resident #1 said she was crying and called her family member on 03/15/25 about the incident. The resident said the did not tell anyone at the facility about the incident. The police were called on 03/15/25. Resident #1 said the DON came and spoke to her and said the incident was being addressed and CNA A was suspended. Resident #1 said the Administrator spoke to her and made sure the photo was deleted.<br><br>An interview on 03/18/25 at 1:00 PM with the DON revealed she had been employed at the facility for a month. The DON said on 03/15/25 she received a call that the police were at the facility because CNA A took a photo of Resident #1. The DON said she never received a picture from CNA A and she never saw the photo. The DON said she spoke to the resident and told her the facility was investigating the incident. The DON said CNA A deleted the photo and did not share it with anyone. The DON said she had been monitoring the resident to ensure the resident did not have any on-going issues.<br><br>An interview on 03/18/25 at 3:00 PM with the Administrator revealed CNA A admitted to him that she took the photo of the resident and deleted it. The Administrator said the facility was still investigating and CNA A was suspended and being terminated pending the investigation findings.<br><br>An interview was attempted with CNA A on 03/18/25 at 12:20 PM. CNA A did not return the call of the Surveyor.<br><br>Record reviews of facility in-services for abuse, personal cell phone usage, and HIPPA were completed. Some of the in-services were not dated and some were dated 03/16/25. The facility also completed safe surveys with residents.<br><br>Interviews with facility staff and residents on 03/18/25 from 9:15 AM to 3:00 PM revealed staff knew not to take pictures of residents and the residents said no one had taken their picture.<br><br>Review of the facility policy, Abuse, revised 05/09/17, reflected:<br><br>The resident has the right to be free from abuse, neglect, misappropriation of resident property,<br><br>and exploitation . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>37028<br><br>Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1 and Resident #2) of four residents, reviewed for infection control.<br><br>1. The facility failed to ensure CNA B changed gloves and performed hand hygiene during incontinence care for Resident #1.<br><br>2. The facility failed to ensure CNA C performed hand hygiene during incontinence care for Resident #2.<br><br>These failures placed residents at risk for healthcare associated cross contamination and infections.<br><br>Findings included:<br><br>1. Review of Resident #1's Quarterly MDS Assessment, dated 01/05/25, reflected the resident had a BIMs score of 15 and was cognitively intact. The Resident had diagnoses which included hip fracture and diarrhea. The resident was always incontinent of bowel and bladder. The resident required maximum assistance with toileting.<br><br>Review of Resident #1's Comprehensive Care Plan, dated 05/16/24, reflected the resident had bowel incontinence. Facility interventions included to check the resident every two hours and assist with toileting as needed.<br><br>An observation on 03/18/25 at 11:10 AM revealed CNA B was preparing to do perform incontinence care for Resident #1. CNA B cleaned the peri-area and buttocks, applied cream, and put on a clean brief. CNA B did not change his gloves or perform hand hygiene after cleaning the resident and before putting on the clean brief.<br><br>An interview on 03/18/25 at 12:45 PM with CNA B revealed he did not have to change gloves and perform hand hygiene after cleaning a resident. CNA B said he only had to perform hand hygiene and wear gloves before and after care. He said he did not see any reason to change his gloves during care.<br><br>2. Review of Resident #2's Quarterly MDS Assessment, dated 01/24/25, reflected the resident had a BIMs score of 00 and was severely cognitively impaired. The resident had diagnoses which included diabetes, stroke, and non-Alzheimer's dementia. The resident was always incontinent of bowel and bladder. The resident was completely dependent on staff for toileting.<br><br>Review of Resident #2's Comprehensive Care Plan, dated 12/06/22, reflected the resident required assistance with activities of daily living. Facility interventions included to assist resident as needed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation and interview on 03/18/25 at 12:25 pm revealed CNA C was preparing to do incontinence care for Resident #2. CNA C cleaned the resident's peri-area and buttocks. CNA C changed gloves but did not perform hand hygiene. CNA C applied cream to the resident's buttocks and put on a clean brief. CNA C said she did not need to perform hand hygiene when changing gloves unless there was bowel movement on her gloves.<br><br>An interview on 03/18/25 at 1:00 PM with the DON revealed staff were supposed to change gloves and perform hand hygiene during incontinence care to reduce the risk of infection.<br><br>Review of the facility policy, Handwashing, dated 2012, reflected:<br><br>We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing . |