

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  05/28/2025
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure residents right to retain their personal clothing for one of one resident, (Resident #4) reviewed for resident's rights.</p> <p>The facility failed to allow Resident #4 to exercise the right to retain and use personal possessions, including clothing.</p> <p>This failure placed residents at risk of for anxiety, frustration, and decreased quality of life who retain their personal clothing in their room.</p> <p>The Findings:</p> <p>Record review of Resident #4's admission Record dated 5/28/25 reflected a [AGE] year-old female admitted to the facility on [DATE].</p> <p>Record review of Resident #4's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 2 indicating severely impaired cognition. Her diagnoses included unspecified dementia, and anxiety disorder.</p> <p>Record review of Resident #4's Care Plan Report reflected impaired cognitive function/dementia or impaired thought processes- Dementia.</p> <p>Record review of Resident #4's progress notes dated 2/11/25 at 18:54 AM revealed RN F, pronounced Resident#4 dead at 18:34 at the facility.</p> <p>Interview on 5/28/25 at 12:48pm the family member revealed three weeks of clothing including pajamas were brought to the facility at admission. Revealed all clothes had Resident #4's name on clothing which disappeared by January. While visiting one day family found Resident #4 dressed in a hospital gown. On 1/27/25 Resident #4 had an appointment but had no clothing to wear to the appointment. Family revealed before going to the appointment they had to purchase clothing. Family revealed the newly purchased clothing cost \$150.00. The family revealed they did not have a receipt for the clothing. The Family member revealed Resident #4's name and room number was put on the new clothing. The Family member revealed by the time Resident #4 passed she only had 1-2 pair of pajamas. Family did not write grievances.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/28/25 at 3:12pm with RN G, revealed no family complained about missing clothes. Does inventory of clothing in electronic health records not sure where in electronic health records but does it upon admission. No Inventory Record of Resident # 4's clothing. Staff revealed they need help with inventory for clothing added or removed and have asked mgt for label maker.</p> <p>Interview on 5/28/25 at 3:38pm CNA H, revealed never knew of Resident #4 had missing clothing. Residents kept their clothing in their rooms. kept in Resident #4's room. CNAH revealed no knowledge of clothes going missing or that Resident #4 had a large amount of clothes.</p> <p>Interview on 5/28/25 at 4:10pm CNA I, worked here almost 3yrs. CNA I revealed at admission the resident clothes were put in a trash bag and given to laundry to label each item. CNA, I revealed it took days to get clothes back. If aide had a permanent marker and time, CNA I would label the clothes. CNAI revealed if the clothing came labeled, they put the clothing in the resident's room. CNA I revealed ADON C was supposed to do the inventory sheet.</p> <p>Interview on 5/28/25 at 4:18pm with ADON C who revealed knowledge of Resident #4 for missing clothes but revealed no knowledge of Resident #4 having multiple bags of clothes . ADON C reveled if clothing was missing, they looked in the laundry area. ADON C revealed the aides took laundry to the laundry area with an unknown period for when the laundry was returned to the resident. ADON C revealed when resident admitted then the inventory was done by medical records and had family and staff signed the inventory form, and it uploaded into the electronic health records. ADON C revealed the facility did not have a system for documenting removed clothing during the stay, such as if family swapped out seasonal clothes.</p> <p>Interview on 5/28/25 at 7:15pm with the Administrator revealed nursing usually did resident inventory at admission and if family brought additional things throughout the stay. The Administrator revealed residents kept their clothing in their rooms. The Administrator revealed at discharge the staff went through clothing and items that went home with the resident. The Administrator revealed after the passing of Resident #4 the family revealed they wanted to donate all remaining items including the television, clothing, and any other items the resident had in left in the room. The Administrator revealed Resident #4's family came back at some point to request a refund for Resident #4's missing clothing. The Administrator revealed he informed Resident #4's family would need to provide a receipt for him to consider a refund. The Administrator revealed the facility did not have a missing items policy.</p> <p>Review of records revealed facility policy titled: Abuse/Neglect Nursing Policy and Procedure Manual 2003 Rev: 5/9/2017 TG 03-1.0 The policy reveals: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</p> <p>9. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</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>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**</b> Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 6 residents (Residents #1, #2, and #3) reviewed for ADL care.</p> <p>The facility failed to ensure Residents #1, #2, and #3 were provided their showers as scheduled for the month of May 2025.</p> <p>This failure could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission Record dated 5/28/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE].</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 indicating no impaired cognition. Her diagnoses included hypertension (high blood pressure); type 2 diabetes, stroke, amputation, and progressive neurological conditions. Review of the shower/bathe reflected the resident required substantial/maximal assistance.</p> <p>Record review of Resident #1's Care Plan Report reflected the following entries:</p> <p>Focus: [Resident #1] has an ADL Self Care Performance Deficit, dated initiated on 3/12/24. Interventions: Bathing: requires staff x1 for assistance .</p> <p>Record review of Resident #1's shower sheet records for the month of May 2025 reflected an entry of shower or bed bath on 5/7, 5/9, 5/10, 5/12, 5/14, 5/16, 5/19 and 5/23.</p> <p>Observation and interview on 5/28/25 at 10:40 AM revealed Resident #1 was in her room, resting in bed. She appeared well-dressed and groomed. Resident #1 stated she did not always get her showers as scheduled because the staff did not always get to her. She stated she was supposed to receive a shower every Tuesday, Thursday, and Saturday. She stated, she was to get a shower on 5/27/25 but she was not offered. She stated she was going for radiation that she completed on Friday (5/23/25) and would have loved to be showered on the days she went to radiation but that did not happen.</p> <p>Resident #1 stated the showers were not consistent, and there were days she missed to be showered and no explanation was provided.</p> <p>Record review of Resident #2's admission Record dated 5/28/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE].</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>Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 indicating no impaired cognition. Her diagnoses included hypertension (high blood pressure), hemiplegia or hemiparesis (one sided muscle weakness), Parkinson's disease (movement disorder of the nervous system) and muscle weakness. Review of the shower/bathe reflected the resident was dependent.</p> <p>Record review of Resident #2's Care Plan Report reflected the following entries:</p> <p>Focus: [Resident #2] requires assistance with ADLs r/t CVA, Hemiplegia, pain,</p> <p>Parkinson's and obesity dated initiated on 8/24/22. Interventions: Assist resident as needed to assure they are clean, dry, and odor free, Complete nail care with showers twice weekly and as needed for jagged, broken, and or dirty nails . Resident will receive shower and/or complete bed bath twice weekly.</p> <p>Record review of Resident #2's shower sheet records for the month of May 2025 reflected an entry of shower or bed bath on 5/14, 5/20 and 5/26.</p> <p>Observation and interview on 5/28/25 at 10:48 AM with Resident #2 revealed she was in her room in bed watching television. The resident seemed to be well groomed. The resident stated she received a shower but after several days. She did not receive the shower three times per week. She stated she was not aware why she was not offered a shower every other day. She stated she would like to receive the shower every other day, to be clean.</p> <p>Record review of Resident #3's admission Record dated 5/28/25 reflected a [AGE] year-old male originally admitted to the facility on [DATE].</p> <p>Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 12 indicating moderate impaired cognition. His diagnoses included hypertension (high blood pressure), muscle weakness, acute kidney failure, seizures and type 2 diabetes. Review of the shower/bathe reflected the resident required substantial/maximal assistance.</p> <p>Record review of Resident #3's Care Plan Report reflected the following entries:</p> <p>Focus: [Resident #3] has an ADL Self Care Performance Deficit dated initiated on 7/4/24. Interventions: Bathing: requires staff x1 for assistance. Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care.</p> <p>Record review of Resident #3's shower sheet records for the month of May 2025 reflected an entry of shower or bed bath on 5/20, 5/22, 5/24, 5/27.</p> <p>Observation and interview on 5/28/25 at 10:55 AM revealed Resident #3 was in his room in bed. He appeared well groomed. The resident stated he had been in the facility for about one year. He stated at times he had not been offered a shower for two weeks, and they were not consistent. The resident stated he would like to have the showers per the schedule.</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>During an interview on 5/28/25 at 1:43 PM with CNA A revealed she had worked in the facility for three months. CNA A stated she was assigned to Resident #1, #2 and #3. She stated she provided showers to Resident #1 and Residents #2 and #3 were scheduled in the afternoon. CNA A stated at times the resident were not provided with showers because there were no towels to use. She stated on 5/27/25 she did not offer any scheduled showers because there were no towels to use, the towels were brought to the hall at 1 pm when she was completing her final rounds on her shift. She stated management were aware that the facility did not have enough towels for the staff to be able to provider showers. She stated lack of showers could cause foul odor.</p> <p>During an interview on 5/28/25 at 2:25 PM with RN B revealed she had worked in the facility for about three months. She stated she was the charge nurse for Residents #1, #2 and #3. RN B stated the aides had reported not being able to provide showers to the residents because there were no towels to use. She stated it had been an ongoing issue since she started working in the facility. She stated the ADON, and management were aware. She stated the residents had a right to be offered a shower and shower prevented skin odor and skin breakdown.</p> <p>During an interview on 5/28/25 at 3:40 PM with ADON C revealed she oversees resident care in the 200 hall where the residents resided. She stated she was responsible on making sure the residents received showers per the schedule. She stated she was trying but she was not able to complete most of the tasks because there was no DON in the facility. ADON C stated she was trying to find a system that will help to track the showers. She stated she was aware the facility lack of towels and she had reported to the Administrator, and nothing had been done. he also, stated she expected the aides to complete the shower sheets if they completed the showers, and lack of shower sheet in the shower binder was an indication that the shower was not offered. She stated the residents were to be provided showers to prevent skin infection, skin odor and self-esteem.</p> <p>In an interview on 5/28/25 at 6:48 PM with the Administrator he stated he was not aware the residents were not being provided showers because there were no towels. He stated his expectations was for the residents to be showered to maintain residents skin integrity and the resident being clean. He stated the ADON was responsible on making sure the showers were completed.</p> <p>Review of the grievances for the months of April and May of 2025 reflected one grievance filed for each month regarding not being provided.</p> <p>Record review of undated facility policy titled, Bath, Tub/Shower reflected, Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation.</p> <p>Goals</p> <ol style="list-style-type: none"> <li>1. The resident will experience improved comfort and cleanliness by bathing.</li> <li>2. The resident will maintain intact skin integrity.</li> <li>3. The resident will be free from soil, odor, dryness, and pruritus following bathing.</li> </ol>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 6 residents reviewed for quality of care.</p> <p>The facility failed to ensure Resident #1 received treatment immediately after she complained of having symptoms of a urinary tract infection.</p> <p>This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, harm and/or the need for hospitalization and prolonged treatment.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission Record dated 5/28/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE].</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 15 indicating no impaired cognition. Her diagnoses included hypertension (high blood pressure); type 2 diabetes, stroke, amputation, and progressive neurological conditions.</p> <p>Record review of Resident #1's Care Plan Report dated 5/28/25 reflected no indication of the resident with urinary tract infection.</p> <p>Review of Resident #1's Physician Order as of 5/28/25 reflected there were no orders for urinalysis, antibiotics, or medications to treat a urinary tract infection.</p> <p>Review of the facility 24-report for 5/28/25 reflected there was no information documented about Resident #1.</p> <p>Review of Resident #1's progress notes from 5/23/25 through 5/28/25 reflected no progress notes regarding Resident #1's complaint of a urinary tract infection.</p> <p>Observation and interview on 5/28/25 at 10:40 AM revealed Resident #1 was in her room, resting in bed. She appeared well-dressed and groomed. Resident #1 stated she was having signs and symptoms of urinary tract infection, voiding frequently and burning when voiding. The resident stated she informed the charge nurse in the morning of Friday, but she did not remember the name of the charge nurse. She stated she was still having the signs and symptoms of urinary tract infection, and nothing had been done yet.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 5/28/25 at 2:30 PM with RN B she stated she was the charge nurse for Resident #1 for the 2-10 shift. She stated the resident had not reported having any signs or symptoms of infection. She also stated LVN E did not inform her of the resident's change of condition or obtaining the urine specimen. She stated if the resident had a change of condition the resident's primary care provider was to be notified and follow the doctor's orders. If laboratory test was required, the staff was expected to fill the laboratory request online and document in the 24-hours report and progress notes. RN B stated urinalysis was to be completed timely to prevent the symptoms from getting worse.</p> <p>In an interview on 5/28/25 at 2:34 PM with LVN D she stated while completing the resident's wound assessment with the wound doctor on 5/27/25, the resident stated she was having signs and symptoms of urinary tract infection. The resident stated she had already notified the nurse assigned to her, so she did not follow up with the charge nurse on the hall.</p> <p>In an interview on 5/28/25 at 3:40 PM with ADON C she stated she was not aware of the resident having a change of condition. She stated the resident had not reported having signs and symptoms of infection to her. She stated early today (5/28/25) a laboratory personnel had come to the facility and asked for Resident #1 urine specimen, ADON C checked in the specimen fridge and there was no urine specimen for Resident #1. ADON C stated she failed to do a follow up and find out why the urine specimen was required for the resident. ADON C stated if there was a change of condition the charge nurse was expected to assess the resident and notify the resident's primary care provider and follow the orders. The charge nurse was expected to document the orders in the physician orders and document in the progress notes and in the 24-hour report, and if a laboratory test was required the charge nurse was to fill out the laboratory request online. When ADON C reviewed the laboratory request she saw a urinalysis laboratory request that was completed on 5/26/25 but was unable to tell who completed the request because the system does not a section to fill the nurse who filled the request. ADON C stated laboratory tests was to be completed timely to prevent the symptoms getting worse, and if the resident was having signs and symptoms of infection to prevent the resident being septic.</p> <p>In an interview on 5/28/25 at 6:27 PM with LVN E she initially stated the resident reported to her on Friday (5/23/25) she was having signs and symptoms of urinary tract an infection. LVN E contacted the resident's primary care provider and was given an order for urinalysis for the resident. LVN E then stated it was not on Friday when the resident informed her it was on Tuesday (5/27/28). LVN E stated she did not document in the progress notes or in the 24 hours reports and did not write the order. LVN E stated she was supposed to follow the primary care providers orders and obtain the specimen and if she was not able to, she was supposed to inform the oncoming charge nurse. The nurse was not able to give a reason why she did not document or write the order. LVN E stated not completing the orders could worsen the resident's symptoms and could be septic if the resident had an infection. LVN E also stated she was expected to document in the 24 hours report and progress notes and inform the ADON of the resident's change of condition.</p> <p>Contacted the resident's primary care provider on 5/28/25 at 6:38pm and was unable to reach the primary care provider.</p> <p>Review of the facility policy revised 3/11/13 and dated Notifying the Physician of Change in Status reflected, . 1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.</p>