STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455861	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Plano Rehabilitation and Nursing Cente	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for three (Resident #1, Resident #2 and Resident #4) of seven residents reviewed for treatment/services for pressure ulcers. 1. The facility failed to ensure Resident #2, who had a pressure ulcer on his coccyx, had a low air loss mattress pump with the correct settings for appropriate pressure redistribution on 06/18/25. 2. The facility failed to ensure Resident #3 and Resident #4 had a functioning low air loss mattress available to use to promote healing of their sacral wounds on 06/18/25. 3. The facility failed to ensure Resident #3 wound dressing was changed daily as per orders. These failures placed residents at risk of developing new or worsening pressure ulcers. Findings included: 1. Record review of Resident #2's Face Sheet dated 06/18/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's active diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life and can impact memory, thinking, language, judgment, and behavior), gangrene (a serious condition where body tissue dies due to a lack of blood supply or severe bacterial infection), non-pressure chronic ulcer of right foot (a persistent or recurring open sore on the foot that fails to heal within a typical timeframe), type 2 diabetes (a chronic disease where the body doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), malnutrition (a condition that arises from an imbalance or deficiency of essential nutrients in the body, leading to health problems) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood issues, no verbal or physical behaviors and no rejection of care issues. He had no range of motion impairments, was ambulatory and did not use any mobility devices. Resident #2 required substantial/maximum assistance for bed mobility, was frequently incontinent of urine and always incontinent of bowel. Resident #2 weighed 162 pounds and was at risk of developing pressure ulcers/injuries. He had one stage four pressure ulcer that was present upon admission. Resident #2 required a pressure reducing device for his bed, pressure ulcer/injury care and application of non-surgical dressings. Resident #2 also received hospice care during the assessment period and had a condition or chronic disease that could result in a life expectancy of less than 6 months. Record review of Resident #2's care plan dated 04/11/25 reflected, Focus: [Resident #2] has a pressure ulcer or potential for pressure ulcer development; Intervention: Ensure heels are floated with the use of pillows, Incontinent care after each episode and apply moisture barrier, Use lifting device, draw sheet, etc. to reduce friction, Requires a cushion to their wheel or Geri chair and needs assistance to turn/reposition at least every 2 hours. The care plan did not indicate what type of pressure ulcer or treatment orders he had. Record review of Resident #2's last wound care NP's visit dated 06/13/25 reflected he had a Stage 4 coccyx (commonly known as the tailbone, is the small bone located at the very bottom of the spine) wound with a measurement of 13.10 cm x 1.2 cm with a surface area of 144.10 cm, was undermining (a wound where the skin edges separate from the surrounding tissue, creating a pocket or cavity beneath the surface) from 6 o'clock to 5 o'clock- 2.4 cm and tunneling (a type of wound where a narrow channel or passageway extends from the surface of the wound into deeper layers of tissue) at 12 o'clock- 2.4 cm . There was 0% epithelial (forms the protective outer layer of the skin), 50% granulation (a normal part of the wound healing process, appearing as a bumpy, pink or red, moist tissue that fills in the wound bed), 50% slough (which is a layer of dead tissue that can accumulate on the wound surface), 0% eschar (a collection of dead tissue, often black, brown, or tan, that forms on the surface of a wound) with bone exposed, intact wound edges, and the wound was intact and fragile. There was moderate exudate (the fluid produced by a wound as part of the natural healing process) that was serosanguineous (a wound that is draining a fluid that contains both blood serum [a clear, yellowish fluid] and blood). The wound NP noted the pressure ulcer was not acquired in-house and was stable and had not worsened. The wound order included daily and PRN dressing change with a wound cleanser with moistened fluffed gauze and ABD, with bordered foam. Additionally, Resident #2 also had a wound on his right fifth toe, right fourth toe, right third toe and right second toe that were all noted by the wound care NP to be stable and required a wound care betadine cleanser and were to be left open to air. The wound care NP's note also reflected a summary of previous visits: - 04.11.25: Pt admitted to facility 04.08.25 under hospice services. Pressure injury to coccyx and wounds of undetermined etiology to right toes 1-5. Pt on air mattress .Continue pressure offloading and incontinence management. -05.28.25: .Pt tolerated debridement of coccyx wound. No s/s of infection noted . Air mattress in place. -06.06.25: Wounds stable. Tolerated debridement of coccyx wound without complications. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/13/2025: Coccyx pressure injury stage 4 stable. Wound debridement tolerated. Recommend continuing offloading and frequent repositioning while in bed. Record review of Resident #2's Physician's Order Summary reflected the following orders related to wound care: May have pressure relieving mattress every shift (start date 04/08/25); Sacrum: Cleanse with wound cleaner [name] moistened fluffed gauze, and cover with ABD and bordered foam every day and as needed for wound management (start date 06/07/25). Record review of Resident #2's June 2025 TAR/WAR (treatment/wound administration record) reflected an entry for checking his pressure relieving mattress every shift three times a day. Each shift was initialed by various charge nurses from 06/01/25-06/17/25. The nurse who initiated she checked his low air loss mattress on the morning (6AM) on 06/18/25 was charge nurse LVN D. Record review of Resident #2's weights recorded for the past three months reflected he weighed 162.2 pounds on 06/05/25, 160.4 pounds on 05/15/25 and 161.6 pounds on 04/08/25. Observation of Resident #2's low air loss mattress on 06/18/25 at 10:32 AM revealed the unit was set to a weight of 280 pounds and normal pressure. An interview with Resident #2 on 06/18/25 at 10:40 AM revealed he felt the mattress was uncomfortable and lumpy. He stated he weighed somewhere between 160 to 180 pounds, but nowhere near 280. An interview with LVN D on 06/18/25 at 10:41 AM revealed she observed Resident #2's low air loss mattress and said the charge nurses were usually responsible for setting the mattresses at the correct weight. She was not sure how much Resident #2 weighed but surmised he was not 280 pounds and would follow up on it. 2. Record review of Resident #3's MDS quarterly assessment dated [DATE] reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted [DATE] from an acute hospital stay. Resident #3's active diagnoses included diabetes (disease where the body either doesn't produce enough insulin or can't properly use the insulin it produces, causing high blood sugar levels), aphasia (a language disorder that affects the ability to communicate), stroke (occurs when blood flow to the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients), anoxic brain damage (occurs when the brain is deprived of oxygen, leading to cell death and potential neurological damage) and dysphagia (difficulty swallowing). Resident #3 had long and short-term memory problems with severely impaired cognitive skills for decision making. Resident #3 had no verbal or physical behaviors or rejection of care issues. He had range of motion impairment on one side of his upper and lower extremities and used a wheelchair for mobility. Resident #3 required substantial/maximum assistance for all ADLs as well as locomotion and bed mobility and was always incontinent of bowel and bladder. Resident #3 weighed 143 pounds at the time of the assessment and was noted not to be at risk for pressure ulcers and had no pressure ulcers. For Skin and Ulcer/Injury Treatments section of the MDS, it reflected, Pressure reducing device for bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 02/14/24 and last updated for wounds on 06/03/24 reflected, [Resident #3] has potential for pressure ulcer development; Interventions: .Do not massage over bony prominences and use mild cleansers for pericare/washing, Ensure heels are floated with the use of pillows, Follow facility policies/protocols for the prevention/treatment of skin breakdown; The resident needs assistance to turn/reposition at least every 2 hours., The resident requires a cushion to their wheel or gerichair, The resident requires the bed as flat as possible to reduce shear, Use lifting device, draw sheet, etc. to reduce friction. The care plan did not reflect a low air loss mattress as an intervention. Record review of a Weekly Skin assessment dated [DATE] by the wound care nurse WC LVN C reflected Resident #3 had redness to his sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis) noted under other skin findings present. Record review of the Wound Care NP's visit dated 06/06/25 reflected in a Skin and Wound Care Note that Resident #3 was being seen for a new skin and wound consult. The NP stated, 06.06.25: Pt being seen for new consult of breakdown to sacrum. On exam, fragility noted to sacrum with small superficial openings. No s/s of infection noted. Recommendations as noted in wound plan. Recommend continuing incontinence management and repositioning interventions. The primary etiology (cause) of the wound was noted to be incontinence associated dermatitis (skin inflammation, characterized by symptoms like itchiness, redness, and dryness) that was 4.5 cm x 5 cm x 0.1 cm and a surface area of 22.5 sq cm. The wound base was 100% epithelial , 0% granulation , 0% slough , 0% eschar with exposed dermis (middle layer of skin) tissue, attached wound edges and an intact and fragile periwound (the area of skin immediately surrounding a wound, extending outward from the wound's edge). There was no exudate (a fluid that leaks out of blood vessels into surrounding tissues, often due to inflammation or injury) and no wound pain. Treatment orders reflected, Wound # 3 Sacrum Incontinence Associated Dermatitis (IAD) Treatment Recommendations: 1. Cleanse with wound cleanser; 2. apply [name] paste to base of the wound; 3. secure with Leave open to air; 4. change Daily, and PRN. Preventative measures included, Continue with turning and repositioning schedule per protocol for pressure prevention. Use pillows for positioning to prevent pressure to bony prominences. Patient is at high risk for skin breakdown related to decreased mobility, inability to reposition self, incontinence of urine and stool. Record review of Resident #3's physician order summary reflected, May have pressure relieving mattress every shift (start dated 10/17/24); Sacrum: Cleanse with wound cleanser, apply collagen and cover with hydrocolloid every day shift every Mon, Wed, Fri and as needed for wound management (start date 06/18/25). Record review of Resident #3's June 2025 TAR/WAR (treatment/wound administration record) reflected an entry for checking his pressure relieving mattress every shift three times a day. Each shift was initialed by various charge nurses from 06/01/25-06/17/25. An observation of Resident #3 on 06/18/25 at 10:08 AM revealed he was in bed with no low air loss mattress in place. Resident #3 was not interviewable and had a triangular wedge under his legs, a contracted right hand and multiple pillow (approximately 3-4) around his body. His wound dressing with observed to be in place on his sacrum, covered and initiated/dated by the WC LVN C on 06/16/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LVN E on 06/18/25 at 10:08 AM occurred where she was asked about the low air loss mattress not being in place for Resident #3, to which she replied, We don't leave him in bed all day, we like to keep him in his wheelchair until after lunch. LVN E did affirm that Resident #3 had a wound on his sacrum. 3. Record review of Resident #4's Face Sheet dated 06/19/25 reflected she was a [AGE] year-old female who admitted to the facility on [DATE] and had active diagnosis of lupus erythematosus (a chronic autoimmune disease where the body's immune system mistakenly attacks healthy tissues and organs), adult failure to thrive (a decline in physical and cognitive function, accompanied by weight loss, decreased appetite, and reduced activity levels), vascular dementia (a condition where damage to blood vessels in the brain impairs blood flow, leading to cognitive decline), diabetes (a disease where the body either doesn't produce enough insulin or can't properly use the insulin it produces, causing high blood sugar levels), psoriasis (a chronic, immune-mediated skin disease that causes red, scaly patches on the skin) and dysphagia (difficulty swallowing). Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected she had long and short-term memory problems and severely impaired cognitive skills for decision making. Resident #4 did not have any behavioral symptoms or rejection of care issues. Resident #4 was totally dependent on staff for all ADLs, movement and bed mobility. She had no range of motion issues and used a wheelchair for ambulation. Resident #4 was always incontinent of bowel and bladder, weighed 127 pounds and was at risk of developing pressure ulcers/injuries. She did not have any identified wounds, ulcers or skin issues during the look back period but under the Skin and Ulcer/Injury Treatments, the box was checked that she had a pressure reducing device for her bed and applications of ointments and medications to areas other than feet. Resident #4 was also receiving hospice services and had a life expectancy of less than six months. Record review of Resident #4's care plan initiated 12/08/22 and last updated related to wounds on 01/23/24 reflected, Goal: [Resident #4] has a potential for skin breakdown r/t lupus (a chronic autoimmune disease where the body's immune system mistakenly attacks healthy tissue, causing inflammation and damage to various organs) and psoriasis (a chronic, immune-mediated skin condition that causes red, scaly patches on the skin); Interventions: .Provide pressure reducing mattress on bed, Weekly skin assessment to be completed. The care plan did not reflect she had a new skin alteration on her bottom. Record review of Resident #4's physician order summary reflected, Left buttock: Cleanse with wound cleanser pat dry, apply honey and calcium alginate. Cover, secure with border foam dressing. every day shift every Mon, Wed, Fri for wound management Hospice nurse will assess once a week (start date 06/18/25) . Right buttock: Cleanse with wound cleanser pat dry, apply xeroform and cover with border foam dressing every day shift every Mon, Wed, Fri for wound management (written 06/19/25 with a start date of 06/20/25). Resident #4 did not have an order for a pressure reducing mattress. An observation of Resident #4 on 06/18/25 at 10:25 AM revealed she was in bed, was not able to be interviewed as she was no responsive to questions. Resident #4 was observed to not have a low air loss mattress in place. She had a pillow minimally offloading her right butt cheek and another pillow under her thighs. The wound dressing was observed to be intact and on her left butt cheek and was dated 06/18/25 by WC LVN C. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LVN D on 06/18/25 at 10:25 AM revealed Resident #4 had a blister on her bottom that had popped and was currently receiving treatment for it. 4. An interview with ADON A on 06/18/25 at 3:16 PM revealed the purpose of an air loss mattress was for when a resident had compromised skin or to prevent skin breakdown from happening or getting worse, to promote healing and to make the resident feel comfortable. He stated the setting for the pump should go by the weight of the resident according to what the rental company staff for the mattress have told him, But I am not exactly sure, mostly when they [DME rental company] comes, they set it up for us. Then the nurses check it to make sure it is running with that parameter. ADON A stated the charge nurse was supposed to be checking the low air loss mattress and pump settings during a daily routine check. ADON A said in order to prevent pressure ulcers from getting worse, as a unit manager, he assesses residents with wounds and made sure there was a low air loss mattress in place for a new or reopened wound. ADON A stated using pillows versus a low air loss mattress would depend on the physician's order. He stated, Mostly from my experience, I don't know if a pillow is enough for a pressure ulcer, we need a low air loss mattress. I don't know if you can replace that with a pillow. But to prevent a wound, you can reposition, use pillows but once the wound starts forming, we need a low air loss mattress. An interview with ADON B on 06/19/25 at 10:45 AM revealed the purpose of a low air loss mattress was to prevent pressure ulcers or other wounds and the setting should go by the resident's weight. She said the setting should be monitored daily by the ADONs, treatment (wound care) nurse and the DON. An interview with WC LVN C on 06/19/25 at 11:15 AM revealed the purpose of a low air loss mattress was to prevent wounds and the setting should go by the weight of the resident. She did not know who was responsible for setting the pump to the correct setting. WC LVN C stated, I probably should check the setting on the mattress, I should know how it is being effective with the wound, but I don't do it with every wound. An interview with the ADM on 06/19/25 at 11:45 AM revealed after investigator intervention, Residents #3 and #4 were ordered and provided a low air loss mattress. He stated central supply was present during the stand-up meetings and when she was made aware of the need for a low air loss mattress, she ordered it and it would usually come within the same day or within 24-48 hours. He stated hospice delivered Resident #4's and Resident #3's came in on 06/19/25. The ADM stated he was not sure why there was a delay in getting them. An interview with LVN F on 06/19/25 at 12:58 PM revealed the purpose of a low air loss mattress was to help with pressure sores and positioning. LVN F stated she would know if the mattress was not set correctly because an alarm would go off and give an alert on the pump unit. She said when the dial was turned on, It goes to 250 and that is where it should be put, it is the amount of air going into the mattress. LVN F stated the low air loss mattresses were usually for residents who might be at risk for pressure ulcers as well as for those residents who could not reposition themselves in bed. She stated the setting for the pump to ensure accuracy was usually monitored by the charge nurses and CNAs. 5. Review of the facility's policy titled, Skin Integrity Management revised October 16, 2016, reflected, .14. Any individual assessed to be at high risk for developing pressure ulcers should be placed when lying in bed on a pressure-reducing device.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for two (Resident #2 and Resident #5) of seven residents reviewed for medications and pharmacy services. 1. The facility failed to administer Resident #2's blood pressure medication Carvedilol in accordance with physician orders, by not obtaining his blood pressure prior to administering the medication on nine occasions from 06/03/25 through 06/18/25. 2. The facility failed to administer Resident #5's blood pressure medication Midodrine in accordance with physician orders, by not obtaining his blood pressure prior to administering the medication on four occasions from 06/07/25 through 06/10/25. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status, including low blood pressure which could cause fainting or dizziness because the brain was not receiving enough blood. Findings included: 1. Record review of Resident #2's Face Sheet dated 06/18/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's active diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life and can impact memory, thinking, language, judgment, and behavior), hypertensive heart disease (heart conditions that develop as a result of long-term high blood pressure), diabetes (a chronic disease where the body doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), malnutrition (a condition that arises from an imbalance or deficiency of essential nutrients in the body, leading to health problems) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness) and atherosclerosis of native arteries of extremities of the right leg (the buildup of plaque in the arteries of the limbs, which can restrict blood flow to the legs and feet) and atrial fibrillation (a common heart condition where the heart's upper chambers (atria) beat irregularly and sometimes rapidly). Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood issues, no verbal or physical behaviors and no rejection of care issues. He had no range of motion impairments, was ambulatory and did not use any mobility devices. Resident #2 required substantial/maximum assistance for bed mobility, was frequently incontinent of urine and always incontinent of bowel. Resident #2 received hospice care during the assessment period and had a condition or chronic disease that could result in a life expectancy of less than 6 months. Record review of Resident #2's care plan dated 04/08/25 and last revised on 05/28/25 reflected no discussion of his blood pressure medication and related health condition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Order Summary Report reflected he was prescribed Carvedilol Oral Tablet 3.125 MG twice a day for high blood pressure related to hypertensive heart disease with heart failure, Hold for BP <110/60, P 60 (start date 04/08/25). Record review of Resident #2's June 2025 MAR did not reflect all blood pressure recordings twice a day prior to the administration of his Carvedilol on 06/03/25 (PM shift), 06/05/25 (AM and PM shift), 06/09/25 (AM and PM shift), 06/10/25 (PM shift), 06/13/25 (PM shift), 06/16/25 (AM shift) and 06/18/25 (AM shift). Record review of Resident #2's nursing progress notes and vitals recordings in the e-chart did not reflect all additional blood pressure readings for June 2025 when there was none documented on the MAR. 2. Record review of Resident #5's Face Sheet dated 06/18/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted on [DATE] after an acute hospital stay. Resident #5 had active diagnoses which included Parkinson's disease, diabetes, long term use of anticoagulants, dysphagia (difficulty swallowing), hyperlipidemia (a condition where there are abnormally high levels of lipids (fats) in the blood, including cholesterol and triglycerides) and seizures. Record review of Resident #5's annual MDS assessment dated [DATE] reflected his BIMS score was 12, which indicated moderate cognitive impairment. Resident #5 had no signs or symptoms of delirium, no negative mood problems, no behaviors and no rejection of care issues. He had range of motion issues on one side in his upper and lower extremities and was independently ambulatory. Record review of Resident #5's care plan initiated 05/27/22 and last revised on 12/27/24 reflected no discussion of his blood pressure medication and related health condition. Record review of Resident #5's Order Summary Report reflected he was prescribed Midodrine Oral Tablet 10 MG three times a day via the peg-tube for low blood pressure, hold if systolic BP greater than 120 (discontinued 06/12/25). Record review of Resident #5's June 2025 MAR did not reflect all blood pressure recordings three times a day prior to the administration of his Midodrine on 06/07/25 (PM and HS shift), 06/08/25 (HS shift), 06/10/25 (AM shift). Record review of Resident #5's nursing progress notes and vitals recordings in the e-chart did not reflect any additional blood pressure readings for June 2025 when there was none documented on the MAR. 3. An interview with ADON A on 06/18/25 at 3:16 PM revealed when a resident was prescribed Midodrine or Carvedilol, the charge nurse or med aide should document what the blood pressure was prior to administration. If the resident's blood pressure fell outside of the parameters noted on the order, then the med aide should report it to the nurse. ADON A stated Midodrine was given to residents who had low blood pressure to help elevate it. ADON A stated, If a doctor says hold if the blood pressure is this, and the patient has a blood pressure of 130 or 140 and you give the medication, it will shoot it up, that is why we hold. We check the vital and recheck because sometimes a resident might be upset or angry or annoyed when we go in and their blood pressure it up, we give then an hour and recheck. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with ADON B on 06/19/25 at 10:45 AM revealed it was important to document a resident's blood pressure prior to administering blood pressure medications, Because their blood pressure could be too low or too high and you could exacerbate the issue. We got to make sure of the vitals with blood pressure medications. They need to be writing it down. ADON B thought that the e-charting system would not let the med aide or nurse proceed in their administration documentation unless a blood pressure was entered. An interview with LVN F on 06/19/25 at 12:58 PM revealed it was important to take a resident's vitals prior to administering a blood pressure medication because it the parameters were not met, the medication had to be held. LVN F stated, For me, the medication aides check their own blood pressures but we let them know if there is something off, like 90/50, we do it [charge nurse] and follow up. LVN F stated the charge nurses were responsible for checking blood pressures daily on every resident along with the medication aides, A beds were done in the mornings and B beds were done in the afternoon/evening. LVN F stated, What happens when we put the orders in, if you don't pay attention to what the doctor is saying, there is a place on the MAR and if you don't put 'Add', it won't ask for any parameters. She stated the error could be that the person entering the order was not clicking on the parameters section when entering the order. 4. Review of the facility's policy titled, Medication Administration Procedures, revised 10/25/2017, reflected, . 13. When ordered or indicated, include specific item(s) to monitor (e.g., blood pressure, pulse, blood sugar, weight), frequency (e.g., weekly, daily), timing (e.g., before or after administering the medication), and parameters for notifying the prescriber.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455861	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Plano Rehabilitation and Nursing Cente	1621 Coit Rd Plano, TX 75075

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for three (Residents #2 , #3 and #7) of seven residents reviewed for resident records. 1. The facility failed to document if wound care was provided for Resident #2 in June 2025 on four occasions: 06/10/25, 06/14/25, 06/16/25 and 06/17/25. 2. The facility failed to document if wound care was provided for Resident #3 in June 2025 on three occasions: 06/10/25, 06/15/25 and 06/16/25. 3. The facility failed to document if wound care was provided for Resident #7 in May 2025 on four occasions: 05/05/25, 05/07/25, 05/21/25 and 05/26/25. These failures could place residents at risk of not receiving wound care, wounds worsening and a lack of oversight of their clinical records by the nursing staff and nursing management. Findings included: 1. Record review of Resident #2's Face Sheet dated 06/18/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's active diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life and can impact memory, thinking, language, judgment, and behavior), gangrene (a serious condition where body tissue dies due to a lack of blood supply or severe bacterial infection), non-pressure chronic ulcer of right foot (a persistent or recurring open sore on the foot that fails to heal within a typical timeframe), type 2 diabetes (a chronic disease where the body doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels), malnutrition (a condition that arises from an imbalance or deficiency of essential nutrients in the body, leading to health problems) and rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness). Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood issues, no verbal or physical behaviors and no rejection of care issues. He had no range of motion impairments, was ambulatory and did not use any mobility devices. Resident #2 required substantial/maximum assistance for bed mobility, was frequently incontinent of urine and always incontinent of bowel. Resident #2 weighed 162 pounds and was at risk of developing pressure ulcers/injuries. He had one stage four pressure ulcer that was present upon admission. Resident #2 required a pressure reducing device for his bed, pressure ulcer/injury care and application of non-surgical dressings. Resident #2 also received hospice care during the assessment period and had a condition or chronic disease that could result in a life expectancy of less than 6 months. (continued on next page)

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Landmark of Plano Rehabilitation and Nursing Cente	1621 Coit Rd Plano, TX 75075

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 04/11/25 reflected, Focus: [Resident #2] has a pressure ulcer or potential for pressure ulcer development; Intervention: Ensure heels are floated with the use of pillows, Incontinent care after each episode and apply moisture barrier, Use lifting device, draw sheet, etc. to reduce friction, Requires a cushion to their wheel or Geri chair and needs assistance to turn/reposition at least every 2 hours. The care plan did not indicate what type of pressure ulcer or treatment orders he had. Record review of Resident #2's last wound care NP's visit dated 06/13/25 reflected he had a Stage 4 coccyx (commonly known as the tailbone, is the small bone located at the very bottom of the spine) wound with a measurement of 13.10 cm x 1.2 cm with a surface area of 144.10 cm, was undermining (a wound where the skin edges separate from the surrounding tissue, creating a pocket or cavity beneath the surface) from 6 o'clock to 5 o'clock- 2.4 cm and tunneling (a type of wound where a narrow channel or passageway extends from the surface of the wound into deeper layers of tissue) at 12 o'clock- 2.4 cm . There was 0% epithelial (forms the protective outer layer of the skin), 50% granulation (a normal part of the wound healing process, appearing as a bumpy, pink or red, moist tissue that fills in the wound bed), 50% slough (which is a layer of dead tissue that can accumulate on the wound surface), 0% eschar (a collection of dead tissue, often black, brown, or tan, that forms on the surface of a wound) with bone exposed, intact wound edges, and the wound was intact and fragile. There was moderate exudate (the fluid produced by a wound as part of the natural healing process) that was serosanguineous (a wound that is draining a fluid that contains both blood serum [a clear, yellowish fluid] and blood). The wound NP noted the pressure ulcer was not acquired in-house and was stable and had not worsened. The wound order included daily and PRN dressing change with a wound cleanser with moistened fluffed gauze and ABD, with bordered foam. Additionally, Resident #2 also had a wound on his right fifth toe, right fourth toe, right third toe and right second toe that were all noted by the wound care NP to be stable and required a wound care betadine cleanser and were to be left open to air. Record review of Resident #2's Physician's Order Summary reflected the following orders related to wound care: Sacrum: Cleanse with wound cleaner [name] moistened fluffed gauze, and cover with ABD and bordered foam every day and as needed for wound management (start date 06/07/25). Record review of Resident #2's June 2025 TAR/WAR (treatment/wound administration record) reflected no documented treatment to his sacral wound on four occasions: 06/10/25, 06/14/25, 06/16/25 and 06/17/25. Record review of Resident #2's nursing progress notes for June 2025 reflected no additional wound treatment documented outside of what was already documented on the TAR. There was no documentation to indicate why the wound care was not performed on the numerous dates. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #3's MDS quarterly assessment dated [DATE] reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted [DATE] from an acute hospital stay. Resident #3's active diagnoses included diabetes, aphasia, stroke, anoxic brain damage and dysphagia. Resident #3 had long and short-term memory problems with severely impaired cognitive skills for decision making. Resident #3 had no verbal or physical behaviors or rejection of care issues. He had range of motion impairment on one side of his upper and lower extremities and used a wheelchair for mobility. Resident #3 required substantial/maximum assistance for all ADLs as well as locomotion and bed mobility and was always incontinent of bowel and bladder. Resident #3 weighed 143 pounds at the time of the assessment and was noted not to be at risk for pressure ulcers and had no pressure ulcers. For Skin and Ulcer/Injury Treatments section of the MDS, it reflected, Pressure reducing device for bed. Record review of Resident #2's care plan dated 02/14/24 and last updated for wounds on 06/03/24 reflected, [Resident #3] has potential for pressure ulcer development; Interventions: .Do not massage over bony prominences and use mild cleansers for pericare/washing, Ensure heels are floated with the use of pillows, Follow facility policies/protocols for the prevention/treatment of skin breakdown; The resident needs assistance to turn/reposition at least every 2 hours., The resident requires a cushion to their wheel or gerichair, The resident requires the bed as flat as possible to reduce shear, Use lifting device, draw sheet, etc. to reduce friction. The care plan did not reflect a low air loss mattress as an intervention. Record review of Resident #3's physician order summary reflected, Sacrum: Cleanse with wound cleanser, apply collagen and cover with hydrocolloid every day shift every Mon, Wed, Fri and as needed for wound management (start date 06/18/25). Record review of Resident #3's June 2025 TAR/WAR (treatment/wound administration record) reflected the following treatment was order from 06/01/25 through 06/16/25, Sacrum: Cleanse with wound cleanser and apply triad cream every day shift for wound management (discontinue date 06/16/25). The record did not indicate the nurse signed off for wound care treatment on 06/10/25, 06/15/25 and 06/16/25. An observation of Resident #3 on 06/18/25 at 10:08 AM revealed he was in bed with no low air loss mattress in place. Resident #3 was not interviewable and had a triangular wedge under his legs, a contracted right hand and multiple pillow (approximately 3-4) around his body. His wound dressing with observed to be in place on his sacrum, covered and initiated/dated by the WC LVN C on 06/16/25. 3. Record review of Resident #7's Face Sheet dated 06/18/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and re-admitted [DATE] after an acute hospital stay. Resident # 7's active diagnoses included cellulitis, local infection of the skin and subcutaneous tissue, non-pressure chronic ulcer of lower leg, secondary gout, pain, localized edema and lymphedema. Record review of Resident #7's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated no cognitive impairment. Resident #7 had no rejection of care issues, had range of motion impairment on both sides of his lower extremities and used a wheelchair for mobility. Resident #7 was at risk of developing pressure ulcers/injuries and had six venous and arterial ulcers present at the time of the assessment. He required a pressure reducing device for the bed, application of nonsurgical dressings and applications of ointments/medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's care plan initiated 12/15/23 and last revised 06/09/25 reflected, Focus: [Resident #7] has a pressure ulcer or potential for pressure ulcer development; Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. The care plan also indicated Resident #7 had a behavior problem of picking at his skin and refusing wound care. The care plan did not address the numerous venous/arterial ulcers Resident #3 had. Record review of Resident #7's Order Summary reflected: -Left Medial Leg: Wash with hibiclens rinse, and pat dry thoroughly. Apply collagen, xeroform, then apply A&D ointment to areas of dryness secure with rolled gauze and ace wrap every day shift every Mon, Wed, Fri for wound management (discontinued 05/19/25) -Left Posterior Leg: Wash with hibiclens rinse,and pat dry thoroughly. Apply collagen, xeroform, then apply A&D ointment to areas of dryness secure with rolled gauze and ace wrap every day shift every Mon, Wed, Fri for wound management (discontinued 06/06/25) -Left second toe: Cleanse with wound cleaner apply betadine secure with dry dressing every day shift every Mon, Wed, Fri for wound management (discontinued 06/06/25) -Left Superior Lateral leg:Wash with hibiclens rinse,and pat dry thoroughly. Apply collagen, xeroform, then apply A&D ointment to areas of dryness secure with rolled gauze and ace wrap. every day shift every Mon, Wed, Fri for wound management (discontinued 06/06/25) -Right Dorsal Leg: Wash with Hibiclens, rinse and pat dry thoroughly. Apply collagen, xeroform. And apply A&D ointment to areas of dryness, secure with rolled gauze and ace wrap. every day shift every Mon, Wed, Fri for wound management (discontinued 06/06/25) -Right Medial Leg: Wash with hibiclens rinse, and pat dry thoroughly. Apply collagen, xeroform, then apply A&D ointment to areas of dryness secure with rolled gauze and ace wrap every day shift every Mon, Wed, Fri for wound management (discontinued 06/06/25). Record review of Resident #7's WAR/TAR for May 2025 did not indicate the nurse signed off for wound care treatment on 05/05/25, 05/07/25, 05/21/25 and 05/26/25. Record review of Resident #7's nursing progress notes for May 2025 reflected no additional wound treatment documented outside of what was already documented on the TAR. There was no documentation to indicate why the wound care was not performed on the numerous dates. An interview was attempted and unsuccessful with Resident #7 while in the hospital on [DATE] at 1:08 PM and rang busy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. An interview with ADON B on 06/19/25 at 10:45 AM revealed after treatment was done for a wound, there was a WAR (wound administration record) to complete and the nurse should not forget to document the treatment was provided because the e-charting system for that treatment administration will stay red on the screen until resolved. ADON B stated nursing management could see who was missing medications and treatment administrations and if that happened, the nursing management would go and talk to the nurse in question. She stated, in order for the red administration notification to go away in the e-charting system, the nurse would have to document and put a progress note in the resident's chart to state why the treatment was not completed. An interview with WC LVN C on 06/19/25 at 11:15 AM revealed she was responsible for documenting on the WAR when she changed a resident's wound dressing. She stated when there were blanks on the WAR, it could be because she was not at the facility working and the charge nurses were responsible for completing the wound care and WARs. An interview with LVN F on 06/19/25 at 12:58 PM revealed she only did wound care if the wound care nurse was not present at the facility. She stated wound care treatment was documented on the WAR and if the wound care nurse or charge nurse did not click and enter that it was done, the treatment administration time would remain showing red on the e-chart and it meant you probably didn't do it or forgot to click it off. An interview with the C-RN on 06/19/25 at 1:49 PM revealed the facility management had completed a one-on-one in-service with WC LVN C and ensured that she did do the wound care but did not check it off as completed on the WAR. He stated they did a one-on-one training to ensure she understood the point of doing treatment was to ensure the treatment was documented and if not clicked off at the point of care, then you get to the end of the day, you may forget. 5. Review of the facility's policy titled, Skin Integrity Management revised 10/05/2016, reflected, General Guidelines: 1. If wound is noted, perform an assessment and initiate a treatment plan as soon as possible. Document in resident's chart, area of change, who you notified and treatment applied; .3. Wound care should be performed as ordered by the physician.