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	07/18/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe, clean, comfortable, and homelike environment for one (Resident #1) of six residents reviewed for decent living environment. 1. The facility failed to ensure Resident #1 had access to her bathroom. This failure could place residents at risk for diminished quality of life due to a lake of a well-kept environment. Findings included: Record review of Resident #1's face sheet, dated 07/18/25, reflected a [AGE] year-old female, with an initial admit date of 03/28/25, and a readmit date of 05/16/25. Resident #1 had diagnoses of Frontotemporal Neurocognitive Disorder (brain disease that leads to significant changes in behavior, language abilities, and personality), Dementia (Decline in memory, thinking, and social abilities), Muscle Weakness, Bipolar Disorder (Extreme Mood Swings), Depression (disorder causing feelings of sadness, anger, or loss), Manic Disorder (causes periods of extreme changes in mood or emotions and energy level), Impulse Disorder (Inability to resist strong urges), and Cognitive Communication Deficit (Communication difficulty). Record review of Resident #1's Quarterly MDS Assessment, dated 05/01/25, reflected Resident #1 had a BIMS score of 03, which indicated Resident #1 was severely impaired. In an observation and interview on 07/18/25 at 5:18 PM, Resident #1's bathroom in her room was locked. The Maintenance Director stated the bathroom was locked, because Resident #1 put all items down the toilet like clothes and briefs. He stated her toilet caused other toilets in memory care to back up in the memory care unit. In an interview on 07/18/25 at 6:50 PM, the DON stated Resident #1's bathroom was locked, because she had a behavior of throwing things down the toilet. She stated the door was locked to prevent flooding in the memory care unit. The DON stated the staff took her to the community restroom in the memory care unit if Resident #1 needed to use the bathroom. The DON stated the memory care unit community bathroom was locked, but the staff were able to unlock the community bathroom door. The DON stated she felt there was no risk since it was for Resident #1's safety and it prevented plumbing issues. In an interview on 07/18/25 at 8:10 PM, the Corporate Nurse stated the Administrator was suspended and no longer in the building. He stated Resident #1's bathroom was unlocked and would be cleaned for use. He stated he did know about the risks, but stated Resident #1 should have had access to an unlocked bathroom. Record review of the facility's undated policy, titled, Resident Rights, reflected the following: Resident Rights A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative. Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-- A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported no later than 2 hours if the events that caused the allegation did involve abuse or serious bodily injury to HHS, for 1 of 1 resident (Resident #1) reviewed for abuse, neglect, exploitation, or mistreatment. The facility failed to report to HHS within two hours, when a staff member reported CNA A spoke rudely and pushed Resident #1 down the memory care hallway on 07/05/25. This failure could place residents at risk of abuse or mistreatment. Findings included: Record review of Resident #1's face sheet, dated 07/18/25, reflected a [AGE] year-old female, with an initial admit date of 03/28/25, and a readmit date of 05/16/25. Resident #1 had diagnoses of Frontotemporal Neurocognitive Disorder (brain disease that leads to significant changes in behavior, language abilities, and personality), Dementia (Decline in memory, thinking, and social abilities), Muscle Weakness, Bipolar Disorder (Extreme Mood Swings), Depression (disorder causing feelings of sadness, anger, or loss), Manic Disorder (causes periods of extreme changes in mood or emotions and energy level), Impulse Disorder (Inability to resist strong urges), and Cognitive Communication Deficit (Communication difficulty). Record review of Resident #1's Quarterly MDS Assessment, dated 05/01/25, reflected Resident #1 had a BIMS score of 03, which indicated Resident #1 was severely impaired. In an interview on 07/18/25 at 11:45 AM, the Administrator stated he was informed by a Charge Nurse who worked in memory care, that CNA A allegedly abused a resident on 07/05/25. He stated he was told that CNA A spoke rudely to the resident. He stated he suspended CNA A, who allegedly abused Resident #1, and he stated he started an investigation. The Administrator stated he did not find any evidence of abuse. He stated Resident #1 was assessed and did not have any bruises, marks, or injuries, and he stated Resident #1 did not have an outcry of abuse. The Administrator stated he did not report the allegation to HHS, because it was not an abuse issue but a customer service issue. The Administrator stated CNA A was in-serviced on customer service. The Administrator stated he felt there was no risk of not reporting the allegations, because it was a customer service issue. In a telephone interview on 07/18/25 at 1:23 PM, CNA A stated she worked the 2:00 PM to 10:00 PM shift on 07/05/25. She stated she could hear someone beat on the door while she sat at the nurse's station. CNA A stated she had worked for years at the facility and was very familiar with Resident #1, so when she saw it was Resident #1 who made the noise, she went to calm her. She stated the staff knew to take Resident #1 to the back of memory care, to the sunroom area, where she was not around other residents, and had the opportunity to calm down. CNA A stated Resident #1 stated she wanted a snack and to use the bathroom. CNA stated Resident #1 was calm after she received a snack and had a trip to the bathroom. CNA A stated she never yelled, grabbed, pushed, pulled, or harmed Resident #1. CNA A stated she walked arm in arm with Resident #1 like she did often. CNA A stated she was trained on how to redirect residents in memory care, as well as on abuse and neglect. She stated three types of abuse were verbal, physical, and sexual. She stated she had never abused a resident, never witnessed any abuse at the facility, and would tell the abuse coordinator if she witnessed any type of abuse. In a telephone interview on 07/18/25 at 1:35 PM, the CNA Trainee stated she and the Charge Nurse went to the vending machine, and when they returned CNA B told them she did not like how that girl treated Resident #1. The CNA Trainee stated CNA B told them CNA A was very stern with Resident #1. The CNA Trainee stated CNA B told them CNA A forced Resident #1 down the hallway toward the sunroom. The CNA Trainee stated Resident #1 would yell loudly at times and had psychiatric issues. The CNA Trainee stated Resident #1 had to be redirected often. The CNA Trainee stated she did not witness the incident. She stated it happened while she and the Charge Nurse left to go to the vending machine. In a telephone interview on 07/18/25 at 1:45 PM, the Charge Nurse stated she was not in memory care to witness the incident. She stated was gone to the vending machine with the CNA Trainee. The Charge Nurse stated when they returned to the memory care unit CNA B told them she did not like how CNA A talked to Resident #1. The Charge Nurse stated at the time of the complaint, CNA A was in the bathroom with Resident #1. The Charge Nurse stated once they were finished, she asked CNA A to leave for the day. She stated CNA A was suspended, but she was not sure how long it was before she returned to work. She stated CNA B called and told the Administrator about the incident. In an interview on 07/18/25 at 5:18 PM, Resident #1 stated she could not think of any staff who were rude to her, and she stated she felt safe in the facility. Resident #1 stated she could not remember any staff member by name. She stated she could not remember