

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  11/13/2025
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)
F 0578  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  (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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, observation and record review, the facility failed to ensure residents had the right to formulate an advanced directive for 3 (Resident #1, Resident #2 and Resident #3) of 8 residents reviewed for Advanced Directives. The facility failed to ensure that Resident #1, Resident #2 and Resident #3's OOH-DNR (Out of Hospital-Do Not Resuscitate) were completed correctly with both signatures of the resident/family and that it was signed by a physician making the forms invalid. This failure could affect all residents who have implemented an Advanced Directive and established their choice not to be resuscitated at the risk of receiving CPR (Cardiopulmonary Resuscitation) against their wishes. Findings included: Record review of Resident #1's face sheet dated [DATE] revealed he was admitted to the facility on [DATE] and was [AGE] years old. His diagnosis included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Side, (paralysis to one side of the body caused by a stroke), Type 2 Diabetes and Hypertension (high blood pressure). Resident #1's electronic face sheet reflected he was a Code Status: DNR. Record review of Resident #1's MDS (Minimum Data Set) dated [DATE] reflected he scored a 15 on his BIMS (Brief Interview of Mental Status) indicating no cognitive impairment. Resident #1's needed extensive assistance with bed mobility, transfers and limited assistance with eating and toileting. Record review of Resident #1's undated care plan revealed, Focus: he had an order for Do Not Resuscitate (DNR), Date initiated: [DATE], Revision on [DATE] Goal: Resident/Responsible party's decision for DNR will be honored through the next review date. Date Initiated: [DATE], Revised on: [DATE]. Interventions: All aspects of DNR will be explained to resident or responsible party, Date Initiated: [DATE] In absence of b/p, pulse, respiration, CPR will not be initiated, Date Initiated: [DATE] Notify MD of change of condition, Date Initiated: [DATE] Resident will be maintained at a level of comfort as ordered by physician, Date Initiated: [DATE] Social Services to consult with resident and RP regarding their decision to continue DNR, Date Initiated: [DATE] Record review of Resident #1's DNR dated [DATE] revealed it had been signed by the resident at the top of the form but did not have his second signature at the bottom of the form where all who signed must sign twice to make the document valid. In an interview on [DATE] at 3:10 pm. Resident # 1 stated he did not want CPR if his heart stopped and that he had a DNR in place already. Record review of the Code Status list that was generated from PCC provided by the facility revealed that Resident #1 was not listed on the document. Record review of Resident #2's face sheet dated [DATE] revealed she was admitted to the facility on [DATE] and was [AGE] years old. Her diagnosis included Unspecified Dementia, Unspecified Atrial Fibrillation (a condition in which the heart beats irregularly and often too fast), Hypertension (high blood pressure) and Muscle Wasting. Resident #2's electronic face sheet revealed she was a Code Status: DNR. Record review of Resident #2's Quarterly MDS dated [DATE] reflected that she scored a 3 on her BIMS indicating severe cognitive impairment. Resident # 2 needed supervision with toileting and dressing, moderate assistance with bathing and set up only for eating. Record review of Resident #2's undated care plan revealed, Focus: she had an order for Do Not Resuscitate (DNR), Date initiated: [DATE], Revision on [DATE] Goal: Resident/Responsible party's decision for DNR will be honored through the next review date. Date Initiated: [DATE], Revised on: [DATE]. Interventions: All aspects of DNR will be explained to resident or responsible party, Date Initiated: [DATE] In absence of b/p, pulse, respiration, CPR will not be initiated, Date Initiated: [DATE] Notify MD of change of condition, Date Initiated: [DATE] Resident will be maintained at a level of comfort as ordered by physician, Date Initiated: [DATE] Social Services to consult with resident and RP regarding their decision to continue DNR. Date Initiated: [DATE] Record review of Resident #2's DNR dated [DATE] revealed it had been signed only once by the resident's representative at the top of the form and is missing the second signature and the physician at the bottom of the form to make it a valid document. Record review of Resident #3's face sheet dated [DATE] revealed she was admitted to the facility on [DATE] and was [AGE] years old. Her diagnosis included Alzheimer's, Type 2 Diabetes and Hypertension (high blood pressure). Record review Resident #3's Quarterly MDS dated [DATE] reflected that she scored a 00 on her BIMS, indicating she was unable to participate. The staff interview was conducted and indicated she did not know the current season, location of her room, staff names/faces or that she was in a nursing home. Her cognitive skill for making daily decisions was severely impaired. Record review of Resident #3's undated care plan revealed, Focus: she had an order for Do Not Resuscitate (DNR), Date initiated: [DATE], Revision on [DATE] Goal: Resident/Responsible party's decision for DNR will be honored through the next review date. Date Initiated:</p>		