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	11/24/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 (Residents #1 and #2) of 5 residents reviewed for ADL care. The facility failed to provide Residents #1 and #2 with showers based on their weekly shower/bathing schedule. This failure could place residents at risk of not receiving the care they require to maintain their highest practical well-being, and could result in low self-esteem, anxiety, embarrassment, and a decline in their quality of life.Findings included: Record review of Resident #1's MDS assessment, dated 08/26/25, reflected he was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE]. His BIMs score was 15 indicating his cognitive status was not impaired. His diagnoses included hypertension, acute kidney failure, need assistance with personal care and muscle weakness. The resident was dependent on staff for showering/bathing and required maximal assistance. Record review of Resident #1's care plan revised 06/25/24 reflected: The resident had an ADL self-care performance deficit related to impaired gait, impaired coordination. Facility interventions included resident required assistance with showering every other day and as necessary. Observation and interview on 10/01/25 at 10:52 a.m., of Resident #1 revealed he was in the wheelchair near his room. He stated he was heading to dialysis. Resident #1 stated he had issues with showers. He stated the facility did not offer showers consistently per the schedule, and at times he had requested a shower, but he was not provided with the shower. At times he would request the staff to come at a later time, but they did not. Resident #1 stated not being provided with a shower had been an ongoing issue. He stated the last time he was offered a shower had been more than one week. Resident #1 stated he would have loved to receive a shower per the scheduled days. He was supposed to receive showers on the days he did not go to dialysis. Record review of Resident #2's quarterly MDS assessment, dated 09/09/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 14 indicating his cognitive status was not impaired. His diagnoses included hypertension, muscle weakness and abnormalities of gait and mobility. The resident was dependent on staff for showering/bathing and required total assistance. Record review of Resident #2's care plan revised 06/17/25 reflected: The resident had an ADL self-care performance deficit. The facility goal was for the resident to maintain or improve the current level of function.Observation and interview on 10/01/25 at 11:15 a.m., Resident #2 was in bed. Resident #2 stated he had been in the facility for a few months, and he had not been provided with showers/bed baths consistently. He stated he preferred a bed bath because he had right side weakness. He stated the last time he received a bed bath was last week, and when he asked the staff told him that he refused. He stated at times he refused the shower but not all the time as the staff was indicating. He stated he would like to be cleaned and offered the bed baths. Review of the showers sheets for the month of September, 2025 revealed there was missing shower sheets for Resident #1 and #2. In an interview on 10/01/25 at 12:32 p.m., CNA A revealed she was taking care of Resident #2. The resident required total assistance with activities of daily living and with showers. CNA A stated she had not given either of the residents shower/bed bath because the facility had shower staff who came in the evenings to provide only showers. CNA A stated if she gave a resident a shower she would document in the shower sheet that was at every nurse station, and then the charge nurse will sign the shower sheet. CNA A stated the resident was to be offered showers to prevent skin breakdown and foul smell. In an interview on 10/01/25 at 1:50 p.m., LVN B revealed she was the one responsible for making sure the residents was being offered showers/bed baths and shower sheets were completed on the days the residents was scheduled to be showered. LVN B stated she failed to follow up if the residents received showers/bed baths for the missing shower sheets, and she stated she did not have the record for the missing shower sheet. LVN B stated the residents were to be offered showers on their scheduled days, and if not, the aides were to report to the charge nurses. LVN B stated the residents were to be offered showers/bed baths to prevent skin breakdown. In an interview on 10/01/25 at 2:13 p.m., with the DON revealed LVN B was responsible for making sure showers were completed, and she was supposed to follow up if there were no records of any resident missing a shower record. The DON stated they had been reviewing showers every morning during the morning meetings, and LVN B had been indicating showers were offered and she had records. The DON stated he was not aware that Residents #1 and #2 were not being provided with showers/bed baths. In an interview on 10/01/25 at 2:50 p.m., with CNA C she stated she