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 01/20/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for neglect reporting.The facility failed to report an allegation of neglect and abuse to the State Agency when an allegation was made on 11/28/2025 that Resident #1's brief had not been changed in 5 hours.This failure could place residents at risk for not having allegations of neglect reported which could lead to injuries or worsening of condition.Review of Resident #1's MDS assessment, dated 12/10/25, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. The resident had a BIMS score of 15 which indicated an intact cognitive status. His diagnoses included congestive heart failure (a chronic condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs and other body parts), Type II Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), hyperlipidemia (like cholesterol or triglycerides in the blood, which can raise the risk of heart disease and stroke), major depressive disorder (severe, persistent sadness and loss of interest that interferes with daily life), and hypertension (blood pressure is consistently too high, which can strain the heart and blood vessels). The resident mobilized with a manual wheelchair and required one person assist for transfers, turning, positioning, and dressing. The resident had frequent bowel incontinence and required staff assistance with toileting and incontinent care. Record review of a complaint report dated 11/28/2025 revealed law enforcement responded to the facility at 8:55 AM for elder abuse. The complaint stated that Resident #1 reported staff had not changed him in over 5 hours. An observation and interview on 1/20/26 at 10:18 AM with Resident #1 revealed he was sitting in his wheelchair, brushing his teeth and appeared well-groomed. He reported he had called the police because it took 5 hours before someone showed up to change his brief. He reported he was changed before breakfast and later used his call light for help changing his brief. He said someone came in his room to bring his meal, but they did not change him during that time. An interview on 1/20/26 at 1:45 PM with the DON revealed he was at the facility the day law enforcement responded to Resident #1's call and spoke to the officer directly regarding the allegations of abuse. The DON stated he then spoke to the administrator about the reported abuse and neglect. He stated the administrator was the abuse coordinator who would call and report any allegations to HHSC. The DON denied that Resident #1 was left for 5 hours without incontinent care. The DON reported the resident was changed before breakfast and again (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: 455861	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after breakfast was served. During an interview on 1/20/2026 at 12:15 PM with CNA A, she reported she worked both shifts on the day Resident #1 stated he went without assistance for 5 hours. She reported Resident #1 required care assistance for bowel movements and could not clean himself. She stated neither he nor any other resident she cared for ever had to wait 5 hours to be changed. During an interview on 1/20/2026 at 11:36 AM with LVN B, he stated that the resident was changed before his breakfast around 8am on the day the police were called. LVN B stated that residents are changed as needed throughout the day, but they are all checked before each meal. LVN B denied that resident was left unattended for 5 hours. An interview on 1/20/26 at 2:00 PM with the Administrator revealed she was not the administrator at the time of the incident. She reported she became the administrator of the facility on December 22, 2025. She reported that the incident would have been a reportable allegation, and she would have reported it to HHSC if she were the administrator at that time. She stated if allegations of such are not reported, it could put residents at risk of possible continued abuse and neglect which could affect their care and mental health. Review of the facility policy, Abuse, undated, reflected: E. Reporting1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 8/29/24.If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegationIf the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.