

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 08/26/2025
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident call light system was maintained within reach for 4 of 6 residents (Resident #14, Resident #3, Resident #21, and Resident #69) reviewed for call light system access. The facility failed to ensure Resident #14 had access to their call light by allowing it to remain on the floor at the foot of the bed, out of the resident's reach. The facility failed to ensure Resident #3 had access to their call light by allowing it to remain draped over a light fixture about the resident's bed, out of the resident's reach. The facility failed to ensure Resident #21 had access to their call light by allowing the cord to become unattached from the clip, resulting in the call light to dangle from the wall, out of the resident's reach. The facility failed to ensure Resident #69 had access to their call light by allowing it to remain on the floor in a shoe, out of the resident's reach. This failure could place residents at risk for delayed assistance and an inability to request help when needed. Record review of Resident #14's annual MDS dated [DATE], reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had severely impaired cognitive function. Diagnoses included: Parkinson's Disease (a neurodegenerative disorder that affects the dopamine-producing neurons in the brain, it causes slowed movements, tremors, balance problems, and changes in mood and behavior), Dementia (severe decrease in memory and intellectual functioning), hypertension (high blood pressure), and muscle weakness (less strength or control in muscles). She required substantial/maximal assistance for daily care tasks like toileting hygiene, bathing, dressing, and grooming. She also required similar support for mobility tasks like toilet transfer, rolling from side to side, chair/bed-to chair transfer. She was dependent on staff to assist with walking, taking steps, picking up objects and utilized a wheelchair for mobility. Record review of Resident #14's Comprehensive Care plan dated 05/15/2025 reflected a fall focus: [Resident] is at risk for falls. Goal: [Resident] will not sustain serious injury through the review date. Interventions included: Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. Review of Resident #14's Comprehensive Care Plan also revealed a communication focus. [Resident] has a communication problem. Goal: Resident will be able to make basic needs known by (specify) [sic] on a daily basis through the review date. Interventions included: Ensure/provide a safe environment: Call light in reach. During an interview and observation on 08/24/2025 at 9:44 AM, Resident #14 was observed in bed. The call light was on the floor at the end of the bed, out of the reach of the resident. Due to cognitive impairment, she was unable to provide reliable information during the interview. During an observation on 08/24/2025 at 10:15 AM, Resident #14 was observed in bed. The call light remained in the same location, on the floor and not accessible. During an interview with LVN A on 08/24/2025 at 10:56 AM, in response to the Resident's call light placement, LVN A reported Resident #14 did not use her call light and they would check on her every 30 minutes to an hour. Record review of Resident #3's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Diagnoses included heart failure, Type 2 Diabetes (a condition where the body does not use insulin properly, causing high blood sugar levels (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455861	Facility ID: 455861 If continuation sheet Page 1 of 22

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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. **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 5 (Resident's #54, #43, #66, #75, and #72) of 6 residents reviewed for ADL care. 1. The facility failed to provide Resident #54 with timely incontinence care on 08/24/25. 2. The facility failed to provide Residents #43, #66, #75, and #72 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. 1. Record review of Resident #54's quarterly MDS assessment, dated 05/15/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was a 03 indicating his cognitive status was severely impaired. His diagnoses included hypertension, dementia, muscle weakness and need for assistance with personal care. The resident was dependent on staff for toileting. The resident was always incontinent of bowel and bladder. The resident was depended on staff for toileting, and he was always incontinent of bowel and bladder. Record review of Resident #54's care plan initiated 02/10/25 reflected: The resident had an ADL self-care performance deficit. Facility interventions included resident required assistance with toileting with 2 persons assistance with toilet use. 02/10/25 The resident had bowel/bladder incontinence, the facility goal was for the resident not have any complications related to incontinence. Facility interventions included apply barrier cream with every incontinence, check resident every two hours and assist with toileting and provide pericare with every incontinent episode. An observation on 08/24/25 at 03:10 pm, revealed Resident #54 was in bed. The resident seemed confused from his conversation. The resident had a foul smell. On wound assessment with RN B of the sacrum area (Posterior part of the pelvis, below the lumbar vertebrae and above the coccyx), revealed the resident's brief was wet and the linen he was sleeping on was also wet. The RN B stated she was not aware what time the resident was provided with incontinent care. RN B stated the resident was to be kept dry and provided incontinent care timely to avoid skin breakdown or infection. In an interview on 08/25/25 at 01:55 pm with CNA D, she stated she was assigned to Resident #54 on the 2pm-10pm shift on the day the resident was noted to be lying on soiled linens. CNA D stated she had not completed the rounds on the resident at the time he was found to be heavily soiled. CNA D stated she was expected to complete rounds every 2 hours and as needed to make sure the resident was clean and dry. She stated the expectations were for the resident to be dry to prevent skin breakdown, to maintain the resident's dignity and prevent foul smell. In an interview on 08/26/25 at 12:50 pm with ADON E revealed the staff were expected to make sure the residents were changed timely and kept dry. He stated leaving the resident in soiled linens and brief could lead to skin breakdown and infections. He stated he completed random checks to make sure the residents had been cleaned and not left in soiled linens. In an interview on 08/26/25 at 02:15 pm with the DON, he stated he expected the staff to complete activities of daily living care timely. The residents were to be kept dry and well-groomed and free (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from soiled linens and brief to prevent skin breakdown. Record review of a policy dated 04/25/22 and titled Nursing: Personal Care reflected, An incontinent resident of urine and/or bowl should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible. It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations. Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. Purpose This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. 2. Record review of Resident #43's annual MDS dated [DATE], reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery (a medical condition where a blood vessel in the brain becomes blocked or narrowed, leading to a loss of blood flow to the brain), hypothyroidism (underactive thyroid gland that did not make enough hormone), lack of coordination, and hypertension (high blood pressure). For showering/bathing and toileting hygiene the resident required substantial/maximal assistance, with the staff completing more than half the effort and full assistance with walking. For tub/shower transfer, toilet transfer, sit to stand, and chair/bed-to-chair transfers, the resident was required substantial/maximal assistance, with the staff completing more than half the effort. Record review of Resident #43's Comprehensive Care Plan dated 07/14/2025, reflected an ADL self-care performance deficit: [Resident] has an ADL Self Care Performance Deficit. Goal: [Resident] will maintain or improve current level of function in (Specify: bed mobility, transfers, eating, dressing, toilet use and personal hygiene; ADL Score) through the review date. Interventions: Assist with personal hygiene as required: hair, shaving, oral care as needed. Bathing: requires staff x1 for assistance. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bed mobility: requires staff x1 for assistance. Discuss with resident/family/POA care any concerns related to loss of independence, decline in function. Dressing: staff x1 for assistance. Bathing: Check nail length and trim and clean on bath day and as necessary. Record review of facility shower documentation dated August 2025 reflected Resident #43's shower/bath days were Tuesdays, Thursdays, and Saturdays. The shower/bathing documents reflected she was bathed/showered on the following days: 08/02/2025 (Saturday), 08/05/2025 (Tuesday), 08/07/2025 (Thursday), 08/12/2025 (Tuesday), and 08/14/2025 (Thursday). Record review of Resident #43's progress notes dated 08/22/2025 (Friday) reflected that the resident initially refused a shower/bath but was eventually bathed. During an observation and interview on 08/24/2025 at 9:45 AM with Resident #43, she was observed in her room lying in bed. She appeared to be well-groomed. She reported she had not had a shower in over a week. She reported her last shower was the week before last on Thursday, August 14, 2025. She stated she was then given a shower on the 22nd of August which was a Friday. She reported she was not bathed on 08/21/2025 because there were not enough towels. Resident #43 stated she was not given reasons as to why those days were missed. She reported she would prefer to have her showers as scheduled. Record review of Resident #66's annual MDS dated [DATE], reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had moderate cognitive impairment, as indicated by a BIMS score of 9. The score suggested the resident experienced some difficulty with memory and orientation but was still able to engage in conversation and participate in decision-making with support. Diagnosis included chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe), hypothyroidism (underactive thyroid gland that did not make enough hormone), muscle wasting and atrophy (when a part of the body, like a muscle or tissue, shrinks or wastes away from lack of use or disease), major depressive disorder (severe, persistent sadness and loss of interest that interferes with daily life), generalized anxiety disorder (ongoing excessive worry and nervousness that interferes with daily life), Type 2 diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications). The resident required some assistance with toileting, showing/bathing, and dressing (both upper and lower body), and was completely dependent on staff for putting on and taking off footwear and overall personal hygiene. The resident required extensive assistance to roll left and right, transition from sitting to lying and from lying to sitting on the side of the bed, and to move from sitting to standing. She was completely dependent on staff for chair-to chair toilet, tub/shower transfers, and walking any distance. Record review of Resident #66's Comprehensive Care Plan dated 05/28/2025, reflected an ADL self-care performance deficit: [Resident] has an ADL self-care performance deficit. Goal: (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Resident #66 on 08/25/2025 at 11:00 AM, the resident was observed sitting in his wheelchair. He appeared to be well-groomed. Resident #66 reported he was not getting showers as scheduled. He reported he was being told on days that he did not get one that the facility was out of towels. The resident did not recall when his last shower was. Record review of facility shower documentation dated August 2025 reflected Resident #75's shower/bath days were Tuesdays, Thursdays, and Saturdays. The shower/bathing documents reflected he was bathed/showered on the following days: 08/2/2025 (Saturday), 08/07/2025 (Thursday), 08/12/2025 (Thursday), 08/21/2025 (Thursday.) Record review of Resident #72's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had moderate cognitive impairment, as indicated by a BIMS score of 11. The score suggested the resident experienced some difficulty with memory and orientation but was still able to engage in conversation and participate in decision-making with support. Diagnoses included unspecified dementia (memory loss and thinking problems caused by another medical condition, like Parkinson's or Huntington's (a rare, inherited neurodegenerative disorder that affects the brain, causing progressive physical, cognitive, and psychiatric symptoms), rather than Alzheimer's itself), muscle weakness, atherosclerotic heart disease (buildup of fatty deposits (plaque) inside the coronary arteries), depression (persistent sadness and loss of interest that interferes with daily life), hypertension (high blood pressure), and generalized anxiety disorder (ongoing excessive worry and nervousness that interferes with daily life.) The resident required partial/moderate assistance with shower/bathing. The resident was independent in aspects of mobility but required supervision/touching assistance for tub/shower transfers. Record review of Resident #72's Comprehensive Care Plan dated 08/07/2025, did not reflect an ADL Focus. Record review on 08/24/2025 of facility shower documentation dated August 2025 reflected Resident #72's shower/bath days were Mondays, Wednesdays, Fridays. The shower/bathing documents reflected he was bathed/showered on the following days: 08/2/2025 (Saturday), 08/05/2025 (Tuesday), 08/12/2025 (Thursday), and 08/13/2025 (Wednesday). Record review of facility shower sheet documentation dated 08/13/2025 with an unspecified time, completed and signed by CNA I reflected a shower was not given to Resident #72 due to no towels. During an observation and interview with Resident #72 on 08/24/2025 at 11:15 AM, he was observed lying in his bed and appeared to be well-groomed. Due to cognitive functioning, he was unable to provide reliable information regarding his showering/bathing. In an interview on 08/25/2025 at 1:15 PM with CNA G, she reported she ensured that all of the residents she was assigned to received their showers during her shift. She reported the only thing that would keep her from not bathing residents was when they were understaffed. She stated she brought that issue up to human resources and it was addressed. She stated they had hired more people. She said there were times some residents did miss a shower due to that but it had improved. In an interview on 08/25/2025 at 1:25 PM with CNA J, he reported that if a resident refused a shower, it was documented in their electronic health record. He stated the only reason a resident would not get a shower or bath was if the facility was short staffed or if they were low on supplies. He stated there was a time recently he was not able to shower/bathe residents because there were no towels. (continued on next page)		

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 08/26/2025
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.			
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He stated he reported that issue to the next shift. He stated it was not typically documented if a resident was not showered or bathed due to no supplies. He stated if the linen closet was not stocked with towels, he would go to housekeeping to let them know. He stated housekeeping sometimes did have extra towels and sometimes they did not. In an interview on 08/25/2025 at 1:45 PM with LVN A, she stated there had been issues with getting all residents bathed and showered. She stated the only thing that would get in the way of that task was that towel laundry needed to be done quicker. She stated that had been an ongoing issue. In an interview on 08/26/2025 at 3:30 PM, Regional Compliance Nurse stated during every morning meeting they go over the shower sheets to see who refused and who was showered. He stated the refusals are documented on the shower sheets and in the resident's electronic health record. He denied low staffing as a reason as to why residents would miss a shower. He stated he had not been made aware that laundry was an issue and preventing residents from getting their showers. He stated the facility recently bought about 500 towels. He reported the residents were supposed to be offered showers per the schedule so that the residents were well groomed and maintained clean. On 08/25/2025 the facility showering/bathing policy was requested and was not provided by the facility by the time of exit.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, clean, comfortable and homelike environment for 1 (Bathroom [ROOM NUMBER]A/B) of 6 bathrooms reviewed for environmental concerns. The facility failed to ensure the bathroom located in room [ROOM NUMBER]A/B was effectively cleaned, as there was a large pile of feces located on top of a board that had been placed over the bathtub, as well as dried feces that appeared to have been smeared on top of the board. This failure could affect all residents, staff, and the public by placing them at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: Observation of the bathroom located in room [ROOM NUMBER]A/B (memory care unit) on 08/26/25 at 1:08PM revealed there was a large pile of feces located on top of a board that had been placed over the bathtub, as well as dried feces that appeared to have been smeared on top of the board. There was a strong odor of feces in the bathroom. During an interview with the Regional Compliance Nurse on 08/26/25 at 1:10PM, he confirmed the presence of feces in the bathroom located in room [ROOM NUMBER]A/B. The Regional Compliance Nurse obtained cleaning supplies and gloves in order to clean the bathroom. During a subsequent interview with the Regional Compliance Nurse on 08/26/25 at 2:38PM, he stated he confirmed housekeeping staff knew about the presence of the feces in the bathroom located in room [ROOM NUMBER]A/B. He stated these staff advised that they saw the feces in the restroom prior to the lunch meal service, and they planned on waiting until after the meal service was completed to clean the feces. The Regional Compliance Nurse stated the risk of this included residents not having a hygienic or homelike environment. Review of the facility's Resident Rights policy, undated, reflected, .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- 1. 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. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. 2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that PRN orders for psychotropic drugs were limited to 14 days and could not be renewed, unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication for one (Resident #66) of six residents on psychoactive medication in that: The facility failed to ensure that Resident #66 had orders for psychotropic medication Lorazepam (brand name Ativan, a medication in the benzodiazepine class used to reduce anxiety, help with sleep, or control seizures) that did not contain PRN orders beyond 14 days without an end date and reassessment. This failure could place residents at risk for receiving unnecessary medications and adverse drug reactions. Record review of Resident #66's annual MDS dated [DATE], reflected the [AGE] year-old female resident was admitted to the facility on [DATE] and had moderate cognitive impairment, as indicated by a BIMS score of 9. This score suggested the resident experienced some difficulty with memory and orientation but was still able to engage in conversation and participate in decision-making with support. Diagnoses included chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe), hypothyroidism (underactive thyroid gland that did not make enough hormone), muscle wasting and atrophy (when a part of the body, like a muscle or tissue, shrinks or wastes away from lack of use or disease), major depressive disorder (severe, persistent sadness and loss of interest that interferes with daily life), generalized anxiety disorder (ongoing excessive worry and nervousness that interferes with daily life), Type 2 diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications). Record review of Resident #66's Comprehensive Care Plan dated 05/28/2025, reflected a Medication Focus: [Resident] requires antidepressant medication Depression [sic]. Goal: [Resident] will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions: Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (Specify: antidepressant drugs being given). Medication Focus: The resident requires anti-psychotic medications. Goal: [Resident] will be/remain free from drug related complications, including movement disorder, discomfort, constipation/impaction or cognitive/behavioral impairment through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Discuss with MD, family re [sic] ongoing need for use of medication. Medication Focus: [Resident] uses anti-anxiety medications. Goal: [Resident] will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. ANTIANXIETY SIDE EFFECTS: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. PARADOXICAL SIDE EFFECTS: mania, hostility and rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #66's Pharmacy Order Summary Report dated 08/26/2025 reflected an order for Lorazepam 0.5 mg oral tablets, with a start date of 06/20/2025. The order instructed that one tablet be given by mouth every 12 hours as needed for anxiety. The report did not state an end date for the medication. Record review of Resident #66's Medication Regimen Review, re: Psychotropic Medication Review: PRN Psychotropic, dated 05/02/2025 reflected a pharmacist recommendation of discontinuing Lorazepam Oral Tablet 0.5 mg unless there was a clinical rationale to continue the medication. The signing physician did not include a rationale in continuing the medication and their response checked on the form showed they agreed with the recommendation and was signed on 06/05/2025. Record review of Resident #66's monthly MAR, dated June 2025 reflected Lorazepam was administered to Resident (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#66 on 06/01/2025, 06/02/2025, 06/03/2025, 06/04/2025, and 06/05/2025. Record review of Resident #66's monthly MAR, dated July 2025 reflected Lorazepam was administered to Resident #66 on 07/04/2025, 07/05/2025, 07/06/2025, 07/14/2025, 07/15/2025, 07/25/2025, 07/26/2025, 07/28/2025, 07/29/2025, and 07/30/2025. Record review of Resident #66's monthly MAR, dated August 2025 reflected Lorazepam was administered to Resident #66 on 08/02/2025, 08/04/2025, 08/05/2025, 08/06/2025, 08/07/2025, 08/08/2025, 08/11/2025, 08/12/2025, 08/14/2025, and 08/15/2025, 08/16/2025, 08/18/2025, 08/20/2025, 08/22/2025, 08/25/2025, and 08/26/2025. In an interview on 08/26/2025 at 11:46 AM, Regional Compliance Nurse stated the ADON was responsible for following up with gradual dose reductions (slowly lowering a medication's dose over time to see if it is still needed or to reduce side effects safely). RN F reported the ADON was responsible to make sure residents who were on PRN antipsychotic medications were assessed every 14 days for the resident to continue with the medication. RN F stated the ADON had only been working at the facility for a couple of weeks, and they would begin an audit on all pharmacy recommendations. RN F stated the risk for residents continuing PRN medications past 14 days was that they might no longer benefit from the medication. Review of the facility policy undated, titled Psychotropic Medication, reflected: The facility will ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Residents should only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Also, residents will only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotic. Based on a comprehensive assessment of a resident, the facility will ensure that: Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs; Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for antidepressant, hypnotic, and antianxiety drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document the rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for one (Resident #8) of six residents reviewed for PASRR services. The facility failed to ensure Resident #8 was properly screened for PASRR services. This failure could place residents at risk of not receiving specialized PASRR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Record review of Resident #8's quarterly MDS Assessment, dated 07/11/25, revealed a [AGE] year-old-male admitted to the facility on [DATE] and had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Diagnoses included: dementia in other diseases classified elsewhere (memory loss and thinking problems caused by another medical condition, rather than Alzheimer's itself), other bipolar disorder (a mood disorder causing unusual swings between high (manic) and low (depressive) moods), and major depressive disorder (a mental health condition causing severe, persistent sadness and loss of interest that interferes with daily life. Resident #8 required setup assistance with eating and oral hygiene. For toileting hygiene, putting on/taking off footwear, and personal hygiene, showering/bathing, upper body dressing, and lower body dressing, the resident required substantial assistance with the helper doing more than half the effort to complete the activity. Record review of Resident #8's PASRR Level I screen, dated 06/14/24, reflected the resident did not have a history of mental illness. Record review of Resident #8's Comprehensive Care plan dated 07/14/2025 reflected a medication focus: [Resident] requires anti-psychotic medications Behavior management [sic]. Goal: [Resident] will reduce the use of psychoactive medication through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD (medical doctor) to consider dosage reduction when clinically appropriate. Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. Under [XXXX] management. Antidepressant Medication Focus: [Resident] requires antidepressant medication. Goal: [Resident] will be free from discomfort or adverse reactions related to antidepressant therapy through the next review date. Interventions: Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of (Specify: anti-depressant drugs being given.) Behavior Problem Focus: [Resident] has a behavior problem of attention-seeking and accusatory behaviors, distorting the truth in attention seeking efforts and/or making false allegations, making negative statements about staff, excessive calling out for nursing staff but when the nursing staff go to attend to him, he states he is not ready for them, that he is watching his favorite television show. Goal: Reductions or absence or false accusations/attention seeking. Interventions: Encourage resident to participate in his care Give the resident as many choices as possible about care and activities. Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. An interview on 08/26/25 at 11:46 AM with the MDS Nurse revealed she was responsible for entering PASRR information. The MDS Nurse reported the PASRR Level 1 for Resident #8 was received from a hospital upon his admission to the facility and was documented as it was. The MDS Nurse reported the resident did not receive an updated evaluation upon or after his admission to the facility and he did not receive a PASRR Level 2 screening. The MDS Nurse stated the resident was at risk of not receiving PASRR services. During an interview on 08/26/25 at 12:16 PM with Regional Compliance Nurse, he stated that the MDS Nurse was responsible for PASRR screenings. He reported he was unaware of how the resident's screening (continued on next page)		

Department of Health & Human Services
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was missed. He reported the resident was at risk to miss out on PASARR services if his PL 1 was incorrect. A request on 08/25/2025 at 2:25 PM was made to review the facility's PASRR process and policy and was not provided by the time of exit.		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #33) of 5 residents reviewed for quality of care. The facility failed to ensure Resident #33 received ordered treatments for a skin abrasion she sustained on her arm. This failure placed residents at risk of having untreated skin conditions, which could lead to delays in treatment and worsening of conditions. Findings included: Record review of Resident #33's Face Sheet, dated 08/26/25, reflected she was a [AGE] year-old female, who was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), and abnormalities of gait and mobility (deviations from a normal walking pattern, impacting how a person moves and their ability to maintain balance and coordination). Record review of Resident #33's MDS Assessment, dated 07/21/25, reflected she had a BIMS score of 03, indicating she had severe cognitive impairment. Record review of Resident #33's Nurse's Note, dated 08/19/25, reflected she was noted to have a small abrasion to her left forearm. Resident #33 was unable to state how the abrasion occurred. Record review of Resident #33's Physician's Orders, dated 08/20/25, reflected an order to apply A&D Ointment to bilateral arms (both the left and right arms of a person) every day until resolved (healed). Observation of Resident #33 on 08/24/25 at 10:25AM revealed she had a bandage on her left arm, dated 08/20/25. An attempted interview with Resident #33 on 08/24/25 at 10:25AM revealed she was confused and unable to participate in a reliable interview due to cognitive impairment. Resident #33 stated she could not recall how she obtained the injury to her left arm. During an interview with LVN H on 08/24/25 at 10:30AM, she stated she was the assigned weekend nurse for Resident #33. She confirmed the bandage on Resident #33's left arm was dated 08/20/25 and stated it appeared as though the skin tear had not been treated since that time. She stated Resident #33's orders were for the skin tear to be treated daily. LVN H stated she most recently worked with Resident #33 on 08/23/25 and did not treat the skin tear per physician's orders, because she was occupied with a different resident who had sustained a change in condition. LVN H stated she planned on treating Resident #33's skin tear and changing the bandage this morning (08/24/25). LVN H stated the risk of not treating skin tears/wounds as ordered included the potential for infection. During an interview with the DON on 08/26/25 at 2:57PM, he stated the facility's expectation was for skin treatments to be completed per physician's orders. He stated the risk of not treating skin tears/wounds as ordered was the potential for delayed healing. Record review of the facility's Medication Orders policy, dated 03/2025, reflected, .Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the current physician order sheet, the telephone order sheet, if it is a verbal order, and the Medication Administration Record (MAR). The facility did not provide a policy related to following physician's treatment orders.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two (Residents #54 and #79) of three residents reviewed for pressure ulcers. The facility failed to provide appropriate treatment to Residents #54 and #79 on 08/24/25. This failure placed residents at risk for decline in quality of life and the wounds being infected or deteriorating. Findings include: Review of Resident #79's face sheet dated 08/26/25 revealed she was a [AGE] year-old male, he was originally admitted on [DATE]. Admitting diagnoses included, Type 2 diabetes, muscle weakness, dementia, anemia, gangrene, non-pressure chronic ulcer, need assistance with personal care. Review of Resident #79's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15, indicating no cognitive impairment. The resident had a pressure ulcer, and he was at risk for the development of pressure ulcer. Review of Resident #79's care plan initiated 04/11/25 reflected the resident had a pressure ulcer or potential for pressure ulcer development, facility goal was for the resident's pressure ulcer to show signs of healing and remain free from infection. Review of Resident #79's physician summary dated 08/26/25 reflected an order dated 07/17/25; coccyx (located at the lower end of the spine) clean with wound cleanser, apply dakins moistened fluffed gauze and cover with abdomen and border foam every day for stage 4 pressure ulcer (a severe form of skin breakdown that extends through all layers of the skin and into underlying tissues, such as muscle, tendon, or bone). Review of Resident #54's face sheet dated 08/26/25 revealed she was a [AGE] year-old male, he was originally admitted on [DATE]. His diagnoses included hypertension, dementia, muscle weakness, need for assistance with personal care and non-pressure chronic ulcer for right heel and midfoot. Record review of Resident #54's quarterly MDS assessment, dated 05/15/25 reflected a BIMS score of 03 indicating his cognitive status was severely impaired. The resident was dependent on staff for activities of daily living. Review of Resident #54's care plan initiated 02/10/25 revealed resident had a pressure ulcer or potential for pressure ulcer development, and the facility goal was for the resident's pressure ulcer to show signs of healing and remain free from infection. Review of Resident #54's physician summary dated 08/26/25 reflected an order dated 08/22/25; stage 3 pressure ulcer (a deep skin injury that extends through the dermis (second layer of skin) and into the subcutaneous tissue (fat layer). lateral left ankle, clean with wound cleanser, pat dry and apply collagen and calcium alginate cover with bordered form dressing every day. Another orders reflected stage 3 pressure ulcer lateral left foot, clean with wound cleanser, pat dry and apply collagen and calcium alginate cover with bordered form dressing every day. Observation and interview on 08/24/25 at 11:05 am of Resident #79 reflected he was resting in bed watching television. The resident stated he had a wound to his left foot and to the sacrum area. He stated the wound care had not been completed, the last time wound care was completed was Friday (08/22/25). He stated most of the time the wound care was not completed on the weekends. In an observation of wound care on 08/24/25 at 02:20 pm on Resident #79 with RN B revealed the resident had wounds to his sacrum area and on the right toes. During wound care, the resident did not have a dressing on the wound to the sacrum prior to the wound care. In an observation on 08/24/25 at 03:10 pm of Resident #54 reflected the resident was in bed. During a wound assessment with RN B, revealed the resident had wounds to the left foot and the dressings were dated 8/22/25 and the wound to the left buttock did not have a dressing on it. In an interview on 08/24/25 at 03:22 pm with RN B revealed she did not complete wound care for the residents on 08/23/25. RN B stated she was busy, and she was unable to complete the wound cares. She stated she did not inform anyone that she was unable to complete (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Landmark of Plano Rehabilitation and Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1621 Coit Rd Plano, TX 75075	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wound cares. RN B stated failure of the wound care not being completed per the physician orders could lead to wound infection and or sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). RN B stated she was expected to complete wound care per the orders, and if she was not able to, she was supposed to inform the ADON/DON, but she did not. In an interview on 08/26/25 at 12:50 pm with ADON E revealed he was not aware RN B did not complete wound care on 8/23/25 until 8/24/25 when the surveyor questioned RN B. He stated he expected the staff to complete wound care per the orders and if she could not, she was supposed to inform him or the DON, but she did not. ADON E also stated RN B was also to inform the night nurse that wounds were not completed, so the night nurse could help but RN B did not. ADON E stated wound care was to be completed per physician orders to prevent them from getting worse or being infected. In an interview on 08/26/25 at 02:15 pm with the DON, he stated each hall had an ADON who made sure that the wound care, or resident care was completed per the orders. He expected the charge nurse to notify the on-call staff if she was not able to complete wounds care or inform the night nurse, but the charge nurse did not inform anyone. The DON stated failure to provide wound care to the residents could lead to the wounds being infected or getting worse. Record review revised 05/05/25 and titled Pressure Injury: Prevention, Assessment and Treatment, reflected, Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (Resident #73) of 6 residents reviewed for accidents and hazards. The facility failed to ensure Resident #73 did not have access to disposable razors. This failure could place residents at risk of injury or harm, as well as contribute to avoidable accidents. Findings included: Record review of Resident #73's Face Sheet, dated 08/26/25, reflected he was an [AGE] year-old male, who was admitted to the facility on [DATE], with diagnoses including dementia (a group of symptoms affecting memory, thinking and social abilities), abnormalities of gait and mobility (deviations from a normal walking pattern, impacting how a person moves and their ability to maintain balance and coordination), and need for assistance with personal care (when a person requires help with daily activities like bathing, dressing, or toileting due to a chronic health issue, physical disability, or aging). Record review of Resident #73's MDS Assessment, dated 06/25/25, reflected he had a BIMS score of 15, indicating he was cognitively intact. Resident #73 was identified as requiring partial/moderate assistance for personal hygiene (such as shaving). Review of Resident #73's Care Plan, dated 07/14/25, reflected no identified focus areas, goals, or interventions related to shaving. Observation of Resident #73 on 08/24/25 at 10:53AM revealed he was ambulating in his room. He was clean, well-groomed, and appropriately dressed. He was free from any odors. There were no concerning marks or bruises noted on his person. He displayed no apparent signs or symptoms of distress. Observation revealed there were two disposable razors placed in an open drawer of Resident #33's bedside table. During an interview with Resident #73 on 08/24/25 at 10:55AM, he reported he used the disposable razors located in the drawer of his bedside table to shave his face as needed, but facility staff assisted him with all other ADL's. During an interview with the DON on 08/24/25 at 11:00AM, he stated Resident #73 should not have had access to razors. He stated facility staff should supervise and assist residents with ADL's, such as shaving. The DON stated the risk of residents having access to razors included the potential for injury. A request was made to the Administrator for the facility's policy related to accident hazards (including not allowing residents to have access to potentially dangerous items, such as razors) on 08/25/25 at 3:18PM but was not provided prior to exit.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #80) of 4 residents reviewed for oxygen administration. The facility failed to follow Resident #80's physician order for continuous oxygen. This failure could place residents at risk of receiving incorrect or inadequate oxygen support and could result in a decline in health. Findings included: Record review of Resident #80's Face Sheet, dated 08/26/25, reflected she was an [AGE] year-old female, who originally admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease with (acute) exacerbation (a sudden worsening of chronic obstructive pulmonary disease symptoms including shortness of breath), respiratory arrest (a serious medical condition caused by apnea or respiratory dysfunction), and dependence on supplemental oxygen (a condition where an individual requires supplemental oxygen due to respiratory disorders or other medical conditions). Record review of Resident #80's MDS Assessment, dated 07/13/25, reflected she had a BIMS score of 11, which indicated she had moderate cognitive impairment. Resident #80 was identified as requiring oxygen therapy. Record review of Resident #80's Physician's Orders, dated 08/26/25, reflected she had an order for continuous oxygen (2-5 liters per minute) for ineffective air exchange. The start date for this order was 08/20/25. Record review of Resident #80's Care Plan, dated 05/19/25, reflected she utilized oxygen therapy. Identified goals included for Resident #80 to have no signs or symptoms of poor oxygen absorption. Interventions included for Resident #80 to have continuous oxygen via nasal cannula, with settings at 2 liters per minute. Observation of Resident #80 on 08/24/25 at 9:43AM revealed she was ambulating throughout the facility in her wheelchair. Resident #80 had a portable oxygen tank hanging from her wheelchair; the oxygen level indicator reflected the oxygen tank was empty. During an interview with Resident #80 on 08/24/25 at 9:43AM, she stated she was unable to feel any oxygen coming from her nasal cannula and needed the oxygen tank replaced. During an interview with RN B on 08/24/25 at 9:55AM, she stated Resident #80 had a physician's order for continuous oxygen therapy. She confirmed the portable oxygen tank that Resident #80 was using had run out of oxygen and was empty. RN B stated she last checked the portable oxygen tank earlier this morning (unknown what time), and oxygen was being delivered at that time. RN B stated the risk of a resident not receiving continuous oxygen as ordered included the potential for shortness of breath, increased heartrate, and confusion. During an interview with the DON on 08/26/25 at 2:57PM, he stated the expectation for residents with physician's orders for continuous oxygen was for these residents to always have access to oxygen. The DON stated the risk of a resident not receiving continuous oxygen as ordered included not getting enough oxygen and the potential for shortness of breath. Record review of the facility's Oxygen Administration policy, dated 02/13/07, reflected, .Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions (low levels of oxygen in the blood) caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40% oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator. All sources require humidification to prevent drying of mucous membranes and thickening of respiratory secretions if used routinely.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, ensure all drugs were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to these drugs for 1 (Resident #73) of 5 residents reviewed for medication storage. The facility failed to ensure Resident #73 did not have unsecured multivitamins in his room. This failure could place residents at risk of not being monitored for their medications, adverse reactions, and drug diversion. Findings included: Record review of Resident #73's Face Sheet, dated 08/26/25, reflected he was an [AGE] year-old male, who was admitted to the facility on [DATE], with diagnoses including dementia (a group of symptoms affecting memory, thinking and social abilities), abnormalities of gait and mobility (deviations from a normal walking pattern, impacting how a person moves and their ability to maintain balance and coordination), and need for assistance with personal care (when a person requires help with daily activities like bathing, dressing, or toileting due to a chronic health issue, physical disability, or aging). Record review of Resident #73's MDS Assessment, dated 06/25/25, reflected he had a BIMS score of 15, which indicated he was cognitively intact. Record review of Resident #73's Physician's Orders, dated 08/26/25, reflected there were no orders for Resident #73 to self-administer medications. There was not an order for multivitamins. Observation of Resident #73 on 08/24/25 at 10:53AM revealed he was ambulating in his room. Observation revealed Resident #73 was noted to have a bottle of multivitamins on his bedside table. During an interview with Resident #73 on 08/24/25 at 10:55AM, he reported he did not self-administer his multivitamins; he stated his family member brought them to the facility at some point, and he was not sure why they were on his bedside table. During an interview with the DON on 08/24/25 at 11:00AM, he stated Resident #73 was unable to safely self-administer medications. The DON stated the bottle of multivitamins on Resident #73's bedside table should have been appropriately secured and stored in the facility's medication cart. The DON stated the risk of unsecured medications (including multivitamins) included the potential for drug interactions. Record review of the facility's Medication Storage in the Facility policy, dated 03/25, reflected, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Residents #79 and #2) reviewed for infection control. 1. RN B failed to complete hand hygiene while providing wound care and incontinent care to Resident #79. 2. CNA C failed to complete hand hygiene while providing incontinent care to Resident #2. This failure could place residents at risk for infections and cross contamination. Findings included: Review of Resident #79's face sheet dated 06/26/25 revealed he was a [AGE] year-old male, he was originally admitted on [DATE]. Admitting diagnoses included hypertensive heart disease with heart failure, Type 2 diabetes, muscle weakness, dementia, and abnormalities of gait and mobility. Review of Resident #79's care plan initiated on 04/11/25 reflected, the resident had bowel incontinence. Goal, will not have complications r/t, bowel incontinence. Intervention, check resident every two hours and assist with toileting as needed. The resident had bladder incontinence. Goal, will remain free from skin breakdown due to incontinence and brief use. Intervention, check resident at least every two hours and assist with toileting as needed. Review of Resident # 79's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15, indicating no cognitive impairment, he was dependent on staff for toileting, and he was always incontinent of bowel and bladder. Review of Resident #2's face sheet dated 06/26/25 revealed he was a [AGE] year-old male, and he was admitted on [DATE]. Admitting diagnoses included hypertension, muscle weakness, dementia and need for assistance for personal care. Review of Resident #2's care plan initiated 07/14/25 reflected, the resident had a selfcare deficit with activities of daily living. Goal, the resident was to maintain or improve the level of function, and the interventions revealed the resident required total assistance with toileting. Review of Resident #2's significant of change MDS dated [DATE] reflected, the resident had a BIMS score of 00, indicating severe cognitive impairment. He required maximum assistance with toileting, and he was always incontinent of bowel and bladder. Observation on 08/24/25 at 02:20 pm with RN B revealed the resident was in bed and he was placed on enhanced barrier precaution due to the wounds. RN B explained and positioned Resident #79 for wound care, but the resident indicated he needed to be provided incontinent care. Then RN B gathered the supplies to provide incontinent care. RN B cleaned the resident, the resident was soiled with urine and feces. After cleaning the resident, the staff used the same gloves to apply the clean brief on the resident. After completing the incontinent care, the staff completed hand hygiene and provided the resident with wound care. The resident had a wound to the sacrum area (Posterior part of the pelvis, below the lumbar vertebrae and above the coccyx). The staff cleaned the wound, and after cleaning the wound the staff did not complete any form of hand hygiene or change gloves. She applied the clean dressing on the resident and labeled and dated it. In an interview on 08/24/25 at 02:43 pm with RN B regarding infection control, she stated she was supposed to change gloves and clean hands after cleaning the resident during incontinent care before applying the clean brief, and she was also supposed to clean hands and change gloves after cleaning the resident's wound before applying the clean dressing, but she forgot. RN B stated she was supposed to complete hand hygiene and change gloves to prevent cross contamination. Observation on 08/25/2025 at 01:25 pm revealed CNA C providing incontinent care to Resident #2. CNA C was observed entering the room and gloved. CNA D was in the process of providing care to the resident, when CNA C stated she wanted to provide care to the resident. CNA C proceeded to clean the resident; the resident was soiled with bowel and urine. After cleaning the resident CNA C applied the clean brief without any form of hand hygiene. In an interview on 08/25/25 at 01:48 pm with CNA C she stated she was aware she was supposed to complete hand hygiene after cleaning the resident, but she did not have hand sanitizer. She stated regardless of changing the gloves she was supposed to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complete hand hygiene for infection control, to prevent cross contamination. In an interview on 08/26/25 at 12:30 pm with ADON E he stated he was the infection preventionist. He stated he expected the staff to maintain infection control during care. He stated the staff were to complete hand hygiene after providing care to the resident before applying the clean brief and clean dressing. He stated he had in-serviced staff on infection control last week, but did not give a specific date. Review of the facility policy revised 01/08/23 and titled Infection Control Plan: Overview, reflected, Infection Control The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. INTENT The intent of this policy is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination.		