STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675113	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Park IN Plano	3208 Thunderbird LN 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 15 residents (Resident #1) reviewed for abuse. The facility failed to keep Resident #1 free from physical abuse by the Private Sitter on 01/30/2026. This failure could place residents at risk of abuse, harm, pain, mental anguish and emotional distress. Findings included: There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by F-600. Record review of Resident #1's face sheet, dated 02/05/2026 and reviewed 02//05/2026 at 2:30 p.m., revealed a [AGE] year-old male, admitted [DATE], diagnoses included urinary neoplasm (cancer), dementia (cognitive dysfunction), chronic kidney disease (loss of kidney function resulting in a buildup of fluid and/or electrolyte dysfunction), and aortic aneurysm (bulge in the wall of the hearts main artery). Record review of Resident #1's MDS, dated [DATE], revealed he was severely cognitively impaired with a BIMS score of 04. Resident #1 had no documentation of verbal or physical behavioral symptoms directed towards others. This MDS revealed Resident #1 did not exhibit rejection of care behaviors, used a walker and/or wheelchair for mobility, and was totally dependent upon staff for toileting, showers, and lower body dressing. Record review of facility's Event Nurses Note, dated 01/30/2026 at 3:21 p.m., revealed for Resident #1 that no pain was reported, but resident had a bruise noted to the top of left hand and the sitter was escorted out of the facility. Record review of Resident #1's Radiology Results (x-ray scan), dated 02/01/2026 at 1:40 p.m., of his left arm revealed no fracture or dislocation. During an observation and interview on 02/05/2026 at 10:30 a.m. and 3:37 p.m., Resident #1 did not respond to questions due to his cognition. During an attempted interview on 02/05/2026 at 1:40 PM and 3:38 p.m., a voicemail message was left for Resident #1's Private Sitter at the telephone number provided by the facility without a return call. Record review of facility provided Witness Statement, undated, revealed the Private Sitter's written statement revealed she worked for [AGENCY]. The Private Sitter's written statement revealed she, . brought [Resident #1] to the living area where all the residents were watching a movie and [Resident #1] began to act inappropriately while trying to. stop bringing his penis out. I stopped him by using my hand to tap on him. I was told to leave the facility because they feel it was wrong for me to hit/teach . his hands. During an interview on 02/05/2026 at 1:21 p.m., LVN A stated she was passing by Resident #1 with his Private Sitter in the hallway on 01/30/2026 and heard an audible pop similar to that of a slap. She stated she then went to determine where the sound came from and observed the Private Sitter's arm extended out towards Resident #1's hand. LVN A stated she asked Resident #1's Private Sitter what happened, and Resident #1's Private Sitter said hit Resident #1's hand because he was moving his hand towards his genital area. LVN A stated Resident #1's Private Sitter said she hit his (Resident #1's) hand to keep him from doing it [touching his genitals.] She stated she removed the sitter from the area and told the sitter, You don't do that, you are supposed to re-direct [behavior.] She stated the Private Sitter got upset and that was when the facility's Social Worker arrived to see what happened. During an interview on 02/05/2026 at 1:33 p.m., the Social Worker stated Resident #1 was newly admitted and (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the family was privately funding a private sitter from [Agency.] She stated the day of the incident, she was sitting in her office when she heard what sounded like a slap. She stated she arrived to the area and observed LVN A state to the Private Sitter that what she did was wrong. The Social Worker stated LVN A then reported to her that the Private Sitter hit the resident. She stated she and LVN A then reported this abuse to the Administrator and DON immediately. During an interview on 02/05/2026 at 2:13 p.m., the DON stated Resident #1 was recently admitted and did have a private sitter. She stated she never witnessed or was aware of any previously abusive behavior from the Private Sitter prior to 01/30/2026. She stated she did not witness the event, but staff did and reported it to her once the Private Sitter was removed from Resident #1's care. She stated she interviewed the Private Sitter and escorted her out of the facility. She stated she was able to receive a written witness statement from the Private Sitter outside of the facility on 01/30/2026 prior to her leaving the parking lot. She stated staff intervened immediately and reported it to her per facility policy and training. During an interview on 02/05/2026 at 4:17 p.m., the Administrator revealed he was notified of the incident promptly and stated the facility intervened immediately. He stated that Resident #1's provider, family, Private Sitter's employment, and local law enforcement were notified of the incident. Additionally, the facility conducted a QAPI meeting with leadership and completed facility-wide in-services on abuse, neglect, and exploitation policy and procedures. He stated Resident #1 was monitored closely after the incident for any trauma or decline in status. He stated he conducted a comprehensive investigation with the facility's DON in response to the incident; the resident was currently functioning at his baseline, and when interviewed Resident #1 did not recall the incident. Record review of a facility Ad Hoc QAPI Meeting signature sheet, dated 01/30/2026, revealed the Administrator, DON, Social Worker, and other leadership staff met in response to the incident. Record review of facility in-service, dated 01/30/2026, reflected Abuse/Neglect training was conducted on 01/30/2026. All staff were educated on the Abuse, Neglect, and resident rights policy. Further record review revealed documentation of multiple signatures from various disciplines via in person and electronic communication. Record review of Safe Surveys completed by the Social Worker, dated 01/30/2026, for eight residents revealed no abuse, neglect, and/or exploitation concerns. Record review of facility policy titled, Abuse/Neglect, dated rev. 05/09/2017, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident. Record review of facility policy titled, Private Sitter Policy, dated rev 01/15/2016 revealed, Resident sitters are employed by the resident and/or families for private duty sitting. Although the sitters are employees of the resident or responsible family member, the sitter must agree to uphold all facilities policy and procedures. 2. Each resident's medical care and supervision is the responsibility of the nursing facility. Sitters are to only perform such personal services as bathing, dressing, and grooming and/or ambulation assistance. The resident's responsible party will be responsible for outlining tasks for the sitter within the parameters of the facilities policy.