STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675870	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindan Park Care Center LP	1510 N Plano Rd Richardson, TX 75081

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #1) of 6 residents reviewed for accuracy of medical records. The facility failed to ensure Resident #1's Care Plan did not include an inaccurate diagnosis of Parkinsonism. This failure could place residents at risk for medication and /or treatment errors and omissions in care. Findings included: Record review of Resident #1's face sheet, dated 12/19/24, reflected a [AGE] year-old male, with an admitted [DATE]. Resident #1 had a diagnosis of Multiple Sclerosis (Chronic disease that affects the central nervous system), Major Depressive Disorder (mental illness that can affect the way a person thinks, feels, and functions), Elevated [NAME] Blood Cell Count, Bipolar Disorder (Mental illness that causes extreme shifts in mood, energy, activity, and concentration), Other Frontotemporal Neurocognitive Disorder (Progressive brain disease), Other Lack of Coordination, and Personal History of Traumatic Brain Injury. There was no diagnosis of Parkinsonism on the face sheet. Record review of Resident #1's MDS asssessments dated 07/05/24, 07/20/24, and 09/15/24 did not reflect any diagnosis of Parkinson's Disease or Parkinsonism. Record review of Resident #1's care plan, with an initial date of 06/28/24, reflected an updated, dated 07/24/24, reflected the following: I have limited physical mobility r/t Parkinsonism Disease Process Date Initiated: 07/24/2024 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675870	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindan Park Care Center LP	1510 N Plano Rd Richardson, TX 75081

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 07/24/2024 In an interview on 12/19/24 at 12:32 PM, the DON stated Resident #1 did not have Parkinson's Disease. He stated he was not sure why his care plan noted Parkinsonism. The DON stated he would correct the care plan. He stated the Director of Therapy must have added that to the care plan. The DON stated the MDS nurse was responsible for reviewing the care plan for accuracy before it was put into effect. The DON stated the risk of inaccurate information on the care plan was the resident could get incorrect care based on the plan. In an interview on 12/19/24 at 1:20 PM, the Director of Therapy stated the DON showed her Parkinsonism was noted on Resident #1' care plan, but it was in an area that she would not complete. The Director of Therapy stated the MDS nurse was the one that would usually fill in that area of the care plan. In an interview on 12/19/24 at 1:26 PM, the MDS Nurse stated she did not know how Parkinsonism got on Resident #1's care plan. The MDS Nurse stated she did not see where Resident #1 had a current diagnosis of Parkinsonism, but stated she would go review his file to see if it was ever listed anywhere in the past. In an interview on 12/19/24 at 1:35 PM, Resident #1's Nurse Practitioner stated Resident #1 did not have a diagnosis of Parkinsonism listed on his chart. She stated she did not recall Resident #1 ever having a diagnosis of Parkinsonism. In a follow-up interview on 12/19/24 at 1:57 PM, the MDS Nurse stated she reviewed Resident #1's hospital paperwork and other documents he admitted to the facility with, and she did not see any diagnosis of Parkinsonism. The MDS Nurse stated so far, she was not able to determine who added Parkinsonism to Resident #1's care plan. The MDS Nurse stated the risk of incorrect information on the care plan was inaccurate treatment for the resident. In an interview on 12/19/24 at 2:37 PM, the Administrator stated staff had been messing up on care plans for a long time now. She stated she would try to figure out who made the mistake and correct it. The Administrator stated the risk of inaccurate information on a resident's care plan was a financial issue from the administrator standpoint, and for clinical, the resident could possibly receive the wrong medication. Record review of the facility's policy titled, Charting and Documentation, dated 12/2023, reflected the following: Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675870	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindan Park Care Center LP	1510 N Plano Rd Richardson, TX 75081

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.