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	01/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092 Based on observations, interviews, and record review, the facility failed to notify the resident's physician and responsible party consistent with his or her authority, when there was an injury of unknown origin for 1 of 1 resident (Resident #1) reviewed for notification of changes. The facility failed to promptly notify Resident #1's physician, and Resident #1's responsible party when an injury of unknown origin was discovered on Resident #1. The physician and responsible party were not made aware of the injury of unknown origin until Resident #1 was admitted to the hospital for unrelated treatment. This deficient practice could place residents at risk of not having their physician or responsible party informed when there was a change in condition resulting in a delay in medical intervention and decline in health. Findings included: Record review of Resident #1's Care Plan, dated 01/03/25, revealed that the resident was a [AGE] year-old female. She was admitted to the facility on [DATE]. Diagnoses of dementia, diabetes, schizophrenia, depression, secondary hypertension, poor impulse control, impaired visual function, impaired communication problem, impaired decision-making, short-term memory loss, asthma, and poor nutrition. Resident #1 had behaviors that included rubbing inner thigh, hitting, and kicking. Record review of Resident #1's Annual MDS Assessment, dated 04/3/2024, reflected Resident #1 had a BIMS (Brief Interview for Mental Status Test) score of 3 (Severe Cognitive Impairment). Resident #1 was assessed to require assistance with ADLs including the following: transfers, personal hygiene, showers, and dressing. Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 12/31/2024 that was entered by LVN A. The progress note stated that there was a large area of purplish-blue discolorations on bilateral inner thigh seen during ADL care. The resident could not explain how she received the discoloration. There was no open area. The ADON was made aware. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/03/2025 at 9:40 AM with Director of Nursing B revealed that LVN A did not follow the facility policy by notifying the responsible party, physician, administrator, director of nursing of the injury of unknown origin. He stated that if he had been notified when the injury of unknown origin was discovered on 12/31/2024, he would have made sure that all notifications were made. LVN A was no longer an employee at the facility. The facility performed an in-service training on who to report and notify to if an injury of unknown origin was discovered and an abuse/neglect training. In an interview on 1/03/2025 at 11:00 AM, Administrator D stated that she was not notified of Resident #1 being found with an injury of unknown origin in a timely manner. She stated that she did not find out about the injury of unknown origin that occurred on 12/31/2024 until 1/02/2025, when she returned from the holiday. Her expectation was for a nurse to assess a resident anytime a resident was found to have an injury of unknown origin and notify the administrator, director of nursing, physician, and responsible party of the resident with an injury of unknown origin. The injury of unknown origin should have been reported to the physician by LVN A after she assessed Resident #1 and discovered the inner thigh bruising. She stated that the facility has a policy in place for these situations and that LVN A failed to follow the policy. LVN A has been terminated and the facility has performed in-services on abuse, neglect, and reporting. Interview on 1/03/2025 at 12:30 PM with Assistant Director of Nursing C revealed that ADON C was made aware of the injury of unknown origin on 12/31/2024. Assistant Director of Nursing was working at the facility with LVN A when the injury of unknown origin was discovered on 12/31/2024. ADON C assessed Resident #1 with LVN A at the end of her shift before leaving the facility on 12/31/2024. She stated that there was a skin assessment that was performed earlier in the day and there was nothing notable on the skin assessment. When she saw the resident herself, she did not see anything that was a woah moment, but she did see a small discoloration. It was her understanding that LVN A was going to log the incident and notify the administrator, director of nursing, physician, and responsible party of the injury of unknown origin. ADON C stated that she had a conversation with LVN A before she left and stated that LVN A understood that it was her responsibility to document the injury of unknown origin. She stated that she did not notify the physician, responsible party, or report the injury of unknown origin herself because she thought that LVN A was going to do it. Interview on 1/03/2025 at 1:50 PM with Physician G revealed that the facility did not notify the physician of the injury of unknown origin on Resident #1's inner thigh that was discovered on 12/31/2024. The physician stated that he was already in the process of treating her for the redness that had occurred on her right eye on 12/18/2024. He stated that he believed the redness was a result of a hemorrhage to one of the eye vessels. The blood eventually pooled over time and presented itself as a bruise. He stated that resident #1 is likely to bruise easily as a result of being on blood thinners. He also stated that since this resident was someone who could easily bruise an injury of unknown origin could occur to her inner thigh during repositioning, changing, transferring, or the resident pushing down on her thigh with her hands. The resident has a behavior of pushing down on her thigh with her hands. He stated that he never saw the bruising on Resident #1's inner thigh. The facility did notify Physician G about the resident being sent to the hospital on 1/01/2025. He stated that he was at the facility when Resident #1 was discharged to the hospital. Interview on 1/03/2025 at 2:00 PM with Responsible Party #1 revealed that the facility did not notify Responsible Party #1 of the injury of unknown origin. Responsible Party #1 was made aware of the injury of unknown origin by the Responsible Party #2. The facility did notify Responsible Party #1 about the resident being sent to the hospital on 1/01/2025 for labored breathing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/03/2025 at 2:30 PM with Responsible Party #2 revealed that the facility did not notify Responsible Party #2 of the injury of unknown origin. Responsible Party #2 was made aware of the injury of unknown origin by the hospital staff during her visit to see Resident #1 at the hospital. The facility did notify Responsible Party #2 about the resident being sent to the hospital on 1/01/2025 for labored breathing. Record Review of the Facility Abuse & Neglect Reporting Policy dated December 2024 states that when an injury of unknown origin occurs the facility staff will identify the staff member responsible for the initial reporting, investigation of alleged violations & reporting abuse, & to determine the direction of the investigation. Facility will be in compliance with Federal regulations and State specific reporting requirements. An immediate report will be filed with the Department of Health and Human Services for alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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.

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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** 49092 Based on interviews and record review the facility failed to report abuse, neglect, exploitation, or critical incidents for 1 of 1 resident (Resident #1) reviewed for reporting. The facility failed to report an injury of unknown origin in a timely manner, that was discovered on 12/31/2024, to HHSC. The facility reported the injury of unknown origin on 1/02/2025. This failure could place clients at risk for abuse, neglect, and incidents. Findings included: Record review of Resident #1's Care Plan, dated 01/03/25, revealed that the resident was a [AGE] year-old female. She was admitted to the facility on [DATE]. Diagnoses of dementia, diabetes, schizophrenia, depression, secondary hypertension, poor impulse control, impaired visual function, impaired communication problem, impaired decision-making, short-term memory loss, asthma, and poor nutrition. Resident #1 had behaviors that included rubbing inner thigh, hitting, and kicking. Record review of Resident #1's Annual MDS Assessment, dated 04/3/2024, reflected Resident #1 had a BIMS (Brief Interview for Mental Status Test) score of 3 (Severe Cognitive Impairment). Resident #1 was assessed to require assistance with ADLs including the following: transfers, personal hygiene, showers, and dressing. Record review on 01/03/25 of TULIP revealed that the facility did not report the injury of unknown origin in a timely manner. The facility was required to report the incident within 24 hours of discovering the incident. The facility failed to do so by reporting the incident on 1/02/2025. Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 12/31/2024 that was entered by LVN A. The progress note stated that there was a large area of purplish-blue discolorations on bilateral inner thigh seen during ADL care. The resident could not explain how she received the discoloration. There was no open area. The ADON was made aware. Interview on 1/03/2025 at 9:40 AM with Director of Nursing B revealed that the report was submitted to the Texas Health and Human Services on 1/02/2025. DON B stated that the report was submitted late because the nurse that was working during the holiday schedule did not follow the facility policy by reporting the injury of unknown origin to the responsible party, physician, administrator, director of nursing, and the Texas Health and Human Services. He stated that if he had been notified when the injury of unknown origin was discovered on 12/31/2024, he would have made sure that all notifications were made. LVN A was no longer an employee at the facility. The facility performed an in-service training on who to report and notify to if an injury of unknown origin was discovered and an abuse/neglect training. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/03/2025 at 11:00 AM, Administrator D stated that she was not notified of Resident #1 being found with an injury of unknown origin in a timely manner. She stated that she did not find out about the injury of unknown origin that occurred on 12/31/2024 until 1/02/2025, when she returned from the holiday. Her expectation was for a nurse to assess a resident anytime a resident was found to have an injury of unknown origin and notify the administrator, director of nursing, physician, and responsible party of the resident with an injury of unknown origin. The injury of unknown origin should have been reported to the state by LVN A after she assessed Resident #1 and discovered the inner thigh bruising. She stated that the facility has a policy in place for these situations and that LVN A failed to follow the policy. LVN A has been terminated and the facility has performed in-services on abuse, neglect, and reporting. Interview on 1/03/2025 at 12:30 PM with Assistant Director of Nursing C revealed that ADON C was made aware of the injury of unknown origin on 12/31/2024. Assistant Director of Nursing was working at the facility with LVN A when the injury of unknown origin was discovered on 12/31/2024. ADON C assessed Resident #1 with LVN A at the end of her shift before leaving the facility on 12/31/2024. She stated that there was a skin assessment that was performed earlier in the day and there was nothing notable on the skin assessment. When she saw the resident herself, she did not see anything that was a woah moment, but she did see a small discoloration. It was her understanding that LVN A was going to log the incident and notify the administrator, director of nursing, physician, and responsible party of the injury of unknown origin. ADON C stated that she had a conversation with LVN A before she left and stated that LVN A understood that it was her responsibility to document the injury of unknown origin. She stated that she did not notify or report the injury of unknown origin herself because she thought that LVN A was going to do it. Record Review of the Facility Abuse & Neglect Reporting Policy dated December 2024 states that when an injury of unknown origin occurs the facility staff will identify the staff member responsible for the initial reporting, investigation of alleged violations & reporting abuse, & to determine the direction of the investigation. Facility will be in compliance with Federal regulations and State specific reporting requirements. An immediate report will be filed with the Department of Health and Human Services for alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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.