

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Lindan Park Care Center LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092</p> <p>Based on observations, interviews, and record review, the facility failed to notify the resident's physician consistent with his or her authority, when there was a change in condition for 1 of 1 resident (Resident #1) reviewed for notification of changes.</p> <p>The facility failed to promptly notify Resident #1's physician when a change in condition was discovered by RN A (Registered Nurse) on Resident #1 on 1/26/2025 at 5:16 AM. The physician was not notified of the change in condition by RN A (Registered Nurse).</p> <p>This deficient practice could place residents at risk of not having their physician informed when there was a change in condition resulting in a delay in medical intervention and decline in health.</p> <p>Findings included:</p> <p>Record review of Resident #1's Care Plan, dated 01/30/25, revealed that the resident was a [AGE] year-old male. He was admitted to the facility on [DATE]. Diagnoses of lack of coordination, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, heart failure, secondary hypertension, type 2 diabetes mellitus with other diabetic arthropathy, hyperlipidemia, chronic kidney disease, pneumonia, chronic pulmonary disease.</p> <p>Record review of Resident #1's Annual MDS (Minimum data set) Assessment, dated 01/09/2025, reflected Resident #1 had a BIMS (Brief Interview for Mental Status Test) score of 10 (Moderate Cognitive Impairment). Resident #1 was assessed to require assistance with ADLs (Activities of Daily Living) including the following: transfers, personal hygiene, showers, and dressing. Resident was oxygen dependent due to suffering from Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Record review of Resident #1's electronic medical records reflected Resident #1 had a progress note on 1/26/2025 that was entered by RN (Registered Nurse) A at 5:16 AM. The progress note stated that resident #1's o2 (Oxygen) was low 77%. The resident was repositioned and provided Albuterol Sulfate Inhalation Nebulization Solution (breathing treatment). After the breathing treatment the residents o2 (Oxygen) was checked again at 5:23 AM. The o2 (Oxygen) had increased to 83-85%. The resident did not complain of pain. The resident was to be monitored. RN B (Registered Nurse) was made aware.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's electronic medical records reflected Resident #1 had o2 (Oxygen) checked on 1/26/2025 that was entered by RN B (Registered Nurse) at 8:19 AM. The progress note stated that resident #1's o2 (Oxygen) was 90%.</p> <p>Record review of Resident #1's electronic medical records reflected Resident #1 had O2 (Oxygen) checked on 1/27/2025 that was entered by RN C (Registered Nurse) at 3:08 AM. The progress note stated that resident #1's o2 (Oxygen) was 88%. The resident was being sent to the hospital related to respiratory distress. The resident's pulse was checked to be beating at 55 bpm (Beats Per Minute). The physician, responsible party, and VA (Veterans Affairs) Nurse was promptly notified by RN C (Registered Nurse) when the resident was transferred to the hospital.</p> <p>Interview on 1/30/2025 at 10:30 AM with RN A (Registered Nurse) revealed that RN A (Registered Nurse) did not follow the facility policy by notifying the physician of a change in condition. He stated that he came into the resident's room at the start of his shift around 10 PM on 1/25/25. The resident was doing fine and his o2 (Oxygen) levels were at 91%. Later, he checked the resident before shift change and discovered that the o2 (Oxygen) levels had dropped to 77%. He stated that the resident was laying on his side with his bed a little elevated. RN A (Registered Nurse) reposition the resident and performed a breathing treatment which raised his o2 (Oxygen) levels back to 85%. He stated that this resident usually has an o2 (Oxygen) level of around 85% when he is sleeping. He stated that he later checked his o2 (Oxygen) again with RN B (Registered Nurse) and the o2 (Oxygen) level was 90%. The patient was talking and acting normal. There was no concern. He stated that he didn't see any respiratory issue because his breathing was normal. It wasn't fast or labored.</p> <p>Interview on 1/30/2025 at 11:30 AM with Physician D revealed that RN A (Registered Nurse) did not follow the facility policy by notifying the physician of a change in condition. He stated that the facility did not notify him of the residents o2 (Oxygen) dropping to 77%. He stated that the resident was not in the best of health. The resident suffered from Chronic Obstructive Pulmonary Disease (COPD) and heart issues. He stated that if he had known that the resident's oxygen had dropped to 77%, he would have recommended the facility to perform a breathing treatment. If the resident responded well to the breathing treatment, then he would have kept him in the facility to be monitored. He stated that if a patient was having o2 (Oxygen) levels at 77 then he should have been notified either way.</p> <p>Record Review of the Facility Change in a Resident's Condition or Status dated December 2024 states that when a change in a resident's condition or status occurs the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).</p> <p>1) The nurse will notify the residents Attending Physician or physician on call when there has been a(an):</p> <p>A. Accident or incident involving the resident;</p> <p>B. Discovery of injuries of an unknown source;</p> <p>C. Adverse reaction to medication;</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. Significant change in the resident's physical/emotional/mental condition;</p> <p>E. Need to alter the resident's medical treatment significantly;</p> <p>F. Refusal of treatment or medications two (2) or more consecutive times);</p> <p>G. Need to transfer the resident to a hospital/treatment center;</p> <p>H. Discharge without proper medical authority; and/or</p> <p>I. Specific instruction to notify the Physician of changes in the resident's condition.</p> <p>2) A significant change of condition is a major decline or improvement in the resident's status that:</p> <p>A. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting)</p>