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	05/06/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for 22 (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #9, Resident #11, Resident #19, Resident # 24, Resident #26, Resident #27, Resident #32, Resident #35, Resident #36, Resident #37, Resident #42, Resident #45, Resident #44, and Resident #47, Resident #49, and Resident #54) of 22 residents reviewed for privacy and confidentiality of records.The facility failed to ensure that the Thickened Liquid List was not accessible to visitors in the Dining Room on 05/04/26 and 05/05/26.The facility failed to ensure that the Red Napkin List was not accessible to visitors in the Dining room [ROOM NUMBER]/04/26 and 05/05/26.The facility failed to ensure that the Shower Log Binder on the counter at the Nurses Station was not accessible to visitors on 05/05/26.The facility failed to ensure that the EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54) on the counter at the Nurses Station was not accessible to visitors on 05/05/26.The facility failed to ensure that 1 resident (Resident #2) Shower Sheet was not accessible on the counter at the Nurses Station on 05/05/26.These failures could place all residents at risk of exposure of their personal and medical information disclosed to unauthorized individuals including visitors and other residents, causing embarrassment, frustration, loss of dignity, decreased privacy and psycho-social well-being.Findings included:During a Dining Observation in the facility's Dining Room on 05/04/26 at 11:00 AM, revealed a posting on the Information Board beside the entrance to the Kitchen. There were 2 pieces of white paper and the first sheet of white paper was labeled as Thickened Liquid List. The second sheet of white paper was labeled, Thickened Liquids, included a subheading labeled, Mildly Thick/NTL and underneath the subheading included 4 residents names [Resident #24, Resident #28, Resident #45, and Resident #44]. The second page labeled, Thickened Liquid, included a second subheading labeled, Moderately Thick/HTL and underneath the subheading include 2 residents names [Resident #35 and Resident #1]. At the bottom of the second sheet of white paper labeled, Thickened Liquids, included a revision date of 04/22/2026.During a Dining Observation in the facility's Dining Room on 05/04/26 at 11:00 AM, revealed a posting on the Information Board beside the entrance to the Kitchen. There were 2 pieces of white paper, and the first sheet of white paper was labeled as Red Napkin Program. The second sheet of white paper was labeled, Red Napkin Program: The Red Napkin Program has been designed for those residents who have been identified as having weight loss. Our goal is to feed/offer those residents who receive a Red Napkin with their meals and ensure they eat at least 75%. Offer them a supplement if <50% of meal consumed. The second sheet of white paper was labeled, Red Napkin Program, included a subheading labeled, Red Napkin List, which included 6 residents names [Resident #1, Resident #9, Resident #11, Resident #19, Resident #37, and Resident #47]. At the bottom of the second sheet of white paper labeled, Red Napkin Program, included a revision date of 04/22/2026.During an interview with the Administrator on 05/04/26 at 2:52 AM, the state surveyor asked her about the 2 postings in the Dining Room labeled, Thickened Liquid List, and Red Napkin Program. The Administrator stated that the 2 postings did not violate the residents HIPPA and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Rights because they were posted in the Dining Room and both postings were covered by a white sheet of paper. The Administrator stated the residents room numbers were not visible on the sheet, therefore she felt that no HIPPA violations were present.During an Observation on 05/05/26 at 10:45 AM, the postings for the Thickened Liquid List and Red Napkin Program were posted in the same area as the previous observations in the facility's Dining Room on the Information Board beside the entrance to the kitchen.During an Observation on 05/05/26 at 12:17 PM, there was a Shower Log Binder observed on the counter of the unattended Nurses Station. The Shower Log Binder included a 1 Shower Sheet for 1 resident [Resident #2] and was dated 02/06/2026. The Shower Log Binder also included an EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54).During an Observation on 05/05/26 at 1:55 PM, the postings for the Thickened Liquid List and Red Napkin Program were posted in the same area as the previous observations in the facility's Dining Room on the Information Board beside the entrance to the kitchen.During an interview with the Dietary Manager on 05/05/26 at 2:04 PM, he stated that he had been employed at the facility for 4 months. He stated that he was advised by the Administrator to post the Thickened Liquid List and Red Napkin Program List were posted on the Information Board in the facility's Dining Room. He stated that both lists were revised by him every month. He stated that both lists were a tool for the volunteers and staff to assist the residents on each list with their food intake and ensure that the residents on the lists were receiving their maximum nutritional meals daily. He stated that he did not know that posting both lists on the Information Board with the residents names was a HIPPA violation. He stated that he had only worked at the facility for 4 months and was following the directives that were given to him by Management to revise and place both lists on the Information Board in the facility's Dining Room. The Dietary Manager stated that he could see how the posted information on both lists a violation of HIPPA and Resident Rights after the subject matter was brought to his attention by the state surveyor. The Dietary Manager removed both lists from the Information Board in the facility's Dining Room. He stated that he would speak with the Administrator and inform her that he would not be posting both lists on the Information Board in the facility's Dining Room. He stated that he and his staff have taken In-Service Trainings on HIPPA and ensuring residents medical charts are not visible to anyone who was not supposed to have access to the information. The Dietary Manager stated harm could be caused to a resident with having their medical information posted on the Information Board in common areas such as the Information Board in the facility's Dining Room. He stated that there was potential for residents to feel violated, uncomfortable, and their residents rights were not taken seriously. The Dietary Manager stated harm such as retaliation, dignity and teasing can occur to a resident if their information is viewed by any unauthorized person (s) that viewed any of their health information.During an interview with the ADON on 05/06/26 at 12:19 PM, she stated she had been employed at the facility for 17 years. The ADON stated she observed the state surveyor reviewing the information in the Shower Log on 05/05/26. The ADON stated the DON made the Shower Log for the CNA's to ensure the residents were provided with showers/baths during their scheduled shower/bath days. The ADON stated at the beginning of each shift, the staff are all on the computers and the Shower Log being on the Nurses Station made it easier for the CNA's to look at the Shower Log verses everyone trying to get on the computer at the same time to review different things for each resident. The ADON was advised that inside of the Shower Sheet Log for residents, there was a single sheet of paper for [Resident #2] for 02/06/26. The ADON was advised that there was an EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54) inside the Shower Log on the counter at the Nurses Station was accessible to visitors. The ADON stated that the EBP List should not have been inside of the Shower Log and was incorrectly placed inside of the Shower Log. The ADON stated that the Red Napkin List and Thickened Liquid List were not used by staff. She (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that both lists in the Dining Room were more helpful as a tool for visitors who volunteer to feed the residents. She stated the Red Napkin Program was designed to ensure that meals are enhanced for the residents for their nutritional well-being including weight loss and weight gain. The ADON stated she did not feel there was any harm or risk to residents with their medical information being accessible to visitors in the Dining Room or at the Nurses Station.During an interview with the DON on 05/06/26 at 2:26 PM, she stated she had been employed at the facility for 22 years. The DON stated that she was unaware the state surveyor observed the Thickened Liquid List, and Red Napkin Program List on the Information Board beside the facility's kitchen entrance. The DON stated that the Dietary Manager updated both lists, but she was unsure how often the lists were updated. The DON stated she had observed both lists posted on the Information Board in the facility's Dining Room on several occasions. The DON stated that she did not know that there was any issue of HIPPA violations with both lists being posted in the Dining Room. The DON stated she thought both posted lists did not violate HIPPA because they were covered by a piece of paper and did not include any residents room numbers. The DON was advised that inside of the Shower Sheet Log for residents, there was a single sheet of paper for [Resident #2] for 02/06/26. The DON was advised that there was an EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54) inside the Shower Log on the counter at the Nurses Station was accessible to visitors. The DON stated that the EBP List should not have been included in the Shower Log and an unknown staff member incorrectly placed it inside of the Shower Log. The DON stated that the Shower Log should not be placed on the counter at the Nurses Station and should not be placed anywhere for anyone other than Nursing Staff to have access to the binder. The DON stated it was the responsibility of any nursing staff member who utilized the computer or laptop to access resident information. The DON stated all employees were expected to provide full privacy and confidentiality of all patient information for all residents. The DON stated it was her expectation that residents' health information was to always remain private to prevent HIPPA violations. The DON stated she would begin In-Service Training to all staff on privacy and confidentiality of the residents' information and HIPAA protection for residents. She stated that the facility follows the HIPAA Guidelines in relation to the Health Insurance Portability and Accountability Act of 1966. The DON stated the failure to not protect the resident information may result identity theft due to the medical information being accessible. She stated that there was no potential of harm if someone who was not authorized to view the patient health records gained access to the records.During an interview with the Administrator on 05/06/26 at 2:42 PM, she stated she had been employed at the facility for 22 years. The Administrator stated that she was unaware there was any issue with the Thickened Liquid List, and Red Napkin Program List on the Information Board beside the facility's kitchen entrance relating to HIPPA. The Administrator stated that the Dietary Manager updated both lists from PCC (is a cloud-based electronic health record (EHR) platform specifically designed for the long-term and post-acute care (LTPAC), but she was unsure how often the lists were updated. The Administrator stated she had observed both lists posted on the Information Board in the facility's Dining Room on several occasions and did not think anything was wrong with it. The Administrator stated she thought both posted lists did not violate HIPPA because they were covered by a piece of paper and did not include any residents room numbers. She stated that both lists had been posted on the Information Board for a long period of time. She stated that purpose of the Red Napkin Program was a red napkin was wrapped around the silverware at mealtime, which meant the resident was experiencing weight loss and they were to be fed enhanced food or pasta during their meals. She stated if there was a new staff member employed and he/she were not familiar with the residents, they would go to the Information Board and look at the special instructions for the residents. She stated that the Red Napkin Program, and Thickened Liquid Lists were a safety precaution for the residents and there had not been any visitors observed opening the lists to see what the lists were used for. The (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator was informed that inside of the Shower Sheet Log for residents, there was a single sheet of paper for [Resident #2] for 02/06/26. The Administrator was advised that there was an EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54) inside the Shower Log on the counter at the Nurses Station was accessible to visitors. The Administrator stated she did not know that the EBP List was included in the Shower Log. The Administrator stated the EBP List should not be included in the Shower Log. The Administrator stated that the Shower Log should not be placed on the counter at the Nurses Station and should not be placed anywhere for anyone other than Nursing Staff to have access to the binder. The Administrator stated there were not any potential harm or risks to residents with their medical information being accessible to visitors or anyone who was not authorized to view them.Record review of the Shower Log Binder at the Nurses Station revealed, Shower Sheet Log for residents, there was a single sheet of paper for [Resident #2] for 02/06/26. The EBP List for 14 residents (Resident #1, Resident #2, Resident #3, Resident #5, Resident #6, Resident #26, Resident # 27, Resident #32, Resident #36, Resident #37, Resident #42, Resident #47, Resident #49, and Resident #54) including their names, rooms and the reason each resident was on EBP.Record review of the facility's In-Service Training records from 02/01/26 to 05/04/26 revealed there were no In-Service Trainings conducted on residents' privacy during this period.Record review of the facility's policy, Resident Rights, revised 01/2022, did not provide any information regarding HIPPA, Protected Health Information (PHI), and/or Safeguarding Electronic Records.Record review of the facility's policy, Safeguarding of Resident Identifiable Information, dated 07/2017 and reviewed and revised 12/1/2025, reflected the following: Policy:It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records.Policy Explanation and Compliance Guidelines:1. A facility may not release information that is resident-identifiable to the public.4. Medical records shall not be left in open areas where unauthorized persons could access identifiable resident information.8. Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. These paper notes and reminders will be disposed of in a way that will not compromise resident's personal or medical information.Record review of the facility's policy, HIPAA Security Measures, dated 05/09/2009 and reviewed and revised 12/1/2025, reflected the following:Policy:It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and /or records that are in electronic format.Policy Explanation and Compliance Guidelines:1. Facility leadership will ensure the implementation of policies and procedures to prevent, detect, contain, and correct any security violations.a. A risk analysis will be performed, consisting of an accurate and thorough assessment of the potentialrisks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the facility or business associate of the facility.b. Security measures will be implemented to manage risks and vulnerabilities as identified in the risk analysis.c. Appropriate sanctions will be applied against any employee who fails to comply with the facility's security policies and procedures.2. The facility will designate a security official who is responsible for the development and implementation of the facility's security policies and procedures.3. Only appropriate employees will have access to electronic protected health information. These employees will receive appropriate training related to the security of the information for which they have access.4. The facility will implement policies and procedures to address security incidents, including identification and response to suspected or known incidents; mitigation, to the extent practicable, harmful effects of any security incidents; and documentation of security incidents and their outcomes.8. Physical safeguards will be implemented that limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety.1. The facility failed to ensure food in the facility's dry storage area and refrigerator areas were labeled and dated according to guidelines.2. The facility failed to seal open items in plastic bags, containers, and boxes in the dry storage pantry, refrigerator, and freezer areas.3. The facility failed to ensure that expired items in the dry storage area were removed.4. The facility failed to ensure that dented cans were removed in the dry pantry area and were separated from the other canned food.5. The facility failed to ensure that the A/C vents in the kitchen's food preparation area were cleaned.These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other food-borne illnesses.Findings Included:An Observation of the kitchen during the brief initial tour of the kitchen on 05/04/26 at 9:04 AM, revealed the following:Kitchen:* 2 A/C Vents above the Food Preparation area were dusty.Dry Pantry area:* 3 packages of 24 oz. red raspberry gelatin mix were not labeled with an expiration date.* 2 packages of 30 oz. instant refried beans were not labeled with an expiration date.* 1 package of 5 lb. cornbread muffin mix was not labeled with an expiration date.* 1 package of 24 oz. peppered gravy mix with an expiration date of 03/16/26.* 1 box labeled Emergency Food included 6 cans of 6 lb. 12 oz. beef ravioli in tomato and meat sauce with an expiration date of 03/17/26.* 4 cans of 1 gallon mayonnaise with an expiration date of 05/01/25.* 1 box of 16 oz. cornstarch was undated and was unsealed and exposed to air.* 1 jar of 4.5 oz cherries with stems were unsealed and exposed to air. * 2 cans of 4.16 lb. tuna light chunk in water were unsealed and exposed to air.* 1 bag of 1 lb. corn chips were unsealed and exposed to air.* 1 plastic container labeled, thickener, was unsealed and exposed to air.* 1 package of hot dogs unsealed and exposed to air.* 1 package of white bread unsealed and exposed to air.* 1 dented can of 6.75 oz. classic con carne with beans.* 1 dented can of 6 lb. diced beets.* 5 cans of 6 lb. 11 oz. crushed pineapples.Refrigerator area:* 1 clear plastic container with a green lid was not labeled and was unsealed and exposed to air.* 1 clear plastic container with a red lid labeled, chocolate fudge topping, was unsealed and exposed to air.* 1 clear plastic container with a green lid labeled, cranberry sauce, was unsealed and exposed to air.* 1 gallon of fat free Italian dressing was unsealed and exposed to air.Freezer area:* 1 box of 10 lb. natural pork sausage patties were unsealed in an unsealed box and exposed to air.* 1 box of pancakes were unsealed in an unsealed box and exposed to air.* 1 box of beef patties were unsealed in an unsealed box and exposed to air.* 1 box of green beans were unsealed in an unsealed box and exposed to air.During an interview with the Dietary Manager on 05/04/26 at 6:14 AM, he stated that he had been employed at the facility for 4 months. The Dietary Manager stated he had a total of 6 staff members in the kitchen, which included 2 staff members per shift. The Dietary Manager was informed about the state surveyors findings during the initial brief tour of the kitchen on 05/04/26, which included dented cans, labeling, expired and unsealed items in the dry storage, refrigerator, and freezer areas. He stated that the items that were found by the state surveyor were overlooked by mistake by himself and all kitchen staff. He stated that he performed weekly checks in the facility's kitchen dry storage, refrigerator, and freezer areas. He stated that the items that were found by the State Surveyor were not found by his staff and himself during their weekly inspections. He stated every day he performed a brief tour of the kitchen's dry storage, refrigerator, and freezer areas. He stated that all staff in the facility's kitchen were responsible for ensuring that the items in the dry storage, refrigerator, and freezer areas in the kitchen are labeled, including the name of the item(s), the date the item(s) were stored and the items(s) use by date. He stated that all items in the facility's dry storage, refrigerator, and freezer areas were to be sealed and closed and expired items, if found were to be immediately thrown in the trash. The Dietary Manager (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated all staff are scheduled to ensure items in the kitchen's dry pantry, refrigerator, and freezer areas were not expired, unsealed, including dented cans should be thrown away immediately. He stated after the state surveyor's findings in the kitchen, all staff will be directed to perform an audit of everything in the kitchen to ensure there are not any unopened and expired items in the dry pantry, refrigerator and freezer areas and the dented cans were removed from the facility's kitchen. He stated his expectation was for all kitchen staff to immediately throw away any items that are expired or opened in the kitchen's dry pantry, refrigerator and freezer areas and notify him of what was found and/or thrown away. He stated that if staff were to find dented cans, the dented cans were to be immediately removed from the shelf and placed in the designated area with a white sheet of paper labeled, Dented Cans, which was in his Office. He stated staff had received several in-services relating to food preparation, storage, and labeling and immediately remove any expired items and the removal of dented cans. The Dietary Manager stated all kitchen staff have been reeducated and retrained on Food Storage, Food Safety and Food Preparation via in-service training. He stated that the staff also have been reeducated on using the First In, First Out (an asset management and valuation method where the oldest inventory, stock, or data items are processed, sold, or used first) procedures to ensure there were not any expired food items throughout the dry pantry, refrigerator, and freezer areas facility's kitchen. The Dietary Manager stated he would immediately notify all kitchen staff on all shifts of the findings of the state surveyor's initial brief tour of the kitchen and provide In-Service Trainings on food storage, labeling and ensuring that dented cans were removed from the shelf and placed in the designated area for dented cans. He stated that the In-Service Training beginning on 05/04/26 will include reeducation on removing expired items from the shelf and utilizing the FIFO method. He stated if staff were to find any food items such as expired items, her expectation was they immediately throw away the item(s) and inform him about the item(s) that were thrown away. He stated if any item (s) were not labeled and/or dated, his expectation was for the staff members(s) who found the error to inform him of their findings and all kitchen staff would be reeducated and retrained via in-service training. The Dietary Manager stated all kitchen staff were to ensure items in the kitchen's dry pantry, refrigerator, and freezer areas were not expired, unsealed, labeled, dated, and dented cans should be removed. He stated the kitchen staff were reeducated and retrained through in-service training regularly, which was monthly and/or as needed. The Dietary Manager stated all staff inspect the ceiling and A/C vents in the facility daily. He stated if the A/C vents were dirty or had dust, he would notify the Maintenance Supervisor. He stated he signed the Cleaning Schedule for the A/C vents on 05/04/26. He stated he would immediately notify the Maintenance Supervisor via text message that the A/C vents needed to be cleaned. He stated he would add the maintenance of the A/C vents in the In-Service Training with all kitchen staff for 05/04/26. He stated that he could not recall when the kitchen staff received their previous in-service training on Food Storage was taken. He stated if anyone ate food from the kitchen that was expired, dented cans, and unsealed containers or bags, and dusty A/C vents there was risk of becoming very ill, due to cross-contamination and food-borne illness, which caused stomach aches, vomiting and diarrhea.During an interview with Dietary Aide A on 05/06/26 at 2:01 PM, he stated he had been employed at the facility for 20 years. He stated that he was unaware there were expired and unsealed items in the dry storage, and refrigerator areas on 05/04/26. Dietary Aide A stated he was unaware that dented cans were observed in the facility's dry storage area on 05/04/26. Dietary Aide A stated he was unaware that 2 A/C vents in the kitchen above the food preparation area were observed to be dusty on 05/04/26. Dietary Aide A stated that the Dietary Manager informed the kitchen staff about the state surveyors findings during the initial brief tour of the kitchen on 05/04/26. He stated all the staff were responsible for labeling and storing the items on the shelf and making sure the expiration dates was on everything in the facility's kitchen dry storage, refrigerator, and freezer areas. Dietary Aide A stated dented cans should not be on the same shelf as other cans to prevent food-borne illness. Dietary Aide A stated dented cans were to be immediately removed from the shelf with the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other dented cans and placed in the designated area labeled Dented Cans, which was in the Dietary Managers Office. He stated that all kitchen staff received previous education and training from In-Services Trainings from the Dietary Manager. Dietary Aide A stated the in-service trainings on food storage included the FIFO method and making sure the A/C vents were cleaned. Dietary Aide A stated there was a daily Cleaning Schedule posted in the facility's kitchen that had a checklist of items to be audited including the cleaning of all A/C vents in the facility's kitchen. Dietary Aide A stated if he observed food that was expired and/or unsealed, and not labeled in the dry pantry, refrigerator, and/or freezer areas, he would immediately trash the item(s), then immediately notify the Dietary Manager of his findings. Dietary Aide A stated that prior to 05/04/26, the Dietary Manager provided several in-service training courses for all kitchen staff on food storage, handling, preparation, and ensuring the A/C vents were cleaned. He stated all the staff were responsible for labeling and storing the items on the shelf and checking the expiration dates on everything in the dry storage, refrigerator, and freezer areas in the facility's kitchen. He stated if he observed any food item(s) that was expired and/or unsealed, and not labeled in the facility's dry pantry, refrigerator, and/or freezer, he would immediately trash the item (s), then immediately notify the Dietary Manager of his findings. Dietary Aide A stated if someone ingested food from the facility's kitchen dry pantry, refrigerator and freezer areas that were unsealed or expired, from dented cans, and dusty A/C vents, they were at risk of food-borne illness from cross-contamination and could become sick. He stated that any ingestion of food that had been unsealed or expired, or from dented cans, and dusty A/C vents can cause a person to have stomach issues including stomach aches, diarrhea and vomiting.During an interview with the Maintenance Supervisor on 05/06/26 at 3:02 PM, he stated he had been employed at the facility for 6 months. He stated that the Dietary Manager told him on 05/04/26 that the state surveyor observed the 2 A/C vents above the food preparation area in the facility's kitchen needed to be cleaned. He stated on 05/04/26, he cleaned all the A/C vents in the kitchen. He stated that prior to 05/04/26, he last cleaned the A/C vents in the facility's kitchen weekly. He stated that he did not have a cleaning schedule for the cleaning of the A/C vents but would change the A/C filters at the beginning of each month. He stated that the cleaning of the A/C vents included taking them down and washing them off with soap and water. He stated anyone can send a text message to him to request repairs including the kitchen staff. The Maintenance Supervisor stated typically the Dietary Manager will send him a text message, give him a call, or send a text message in the facility's group text message chat and tell him if any repairs were needed. He stated that the risks of residents or anyone eating any food that was prepared underneath A/C vents that were dusty and unclean was the potential for dust particles to fall from the A/C vents counts fall into the food and be ingested. He stated that there was potential for some harm to anyone that ingested any dust that had fallen from the A/C vents, but he was unsure what kind of harm could be caused.Record review of the Kitchen's Cleaning Schedule for January 1, 2026 - May 4, 2026, reflected signatures by kitchen staff for inspecting all racks, ceiling, air vents, and fire extinguishers for dust/debris.Record review of the facility's Maintenance Log for January 1, 2026 - May 4, 2026, reflected no entries for the A/C vents in the facility's kitchen.Record review of facility's policy titled, Food Storage, dated 2023 reflected, Policy:Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination.Procedure: .7. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods.a. Old stock is always used first (first in - first out method or FIFO). The person designated to manage stock should be trained to rotate it properly.b. Food should be dated as it is placed on the shelves if required by state regulation.c. Date marking should be visible on all high risk food to indicate the date by which a ready-to-eat TCS food should be consumed, sold or discarded.d. Food will be stored and handled to maintain the integrity of the packaging until ready for use. Food stored in bins may be removed from its original packaging.8. Plastic containers with tight (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	05/06/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated.12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code. (Also see policy on Use of Leftovers later in this chapter.) Check state regulations as some states may allow shorter time frames for the use of leftovers.13. Refrigerated food storage:. f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded.g. All foods should be stored to allow air circulation.h. Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed.14. Frozen Foods:a. All freezer units should be kept clean.c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded.d. All foods should be stored to allow adequate air circulation.Record review of the facility's policy titled, Cleaning and Disinfection of Environmental Surfaces, dated December 2025 reflected, Policy Statement:Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and OSHA Blood-borne Pathogens Standard.Policy Interpretation and Implementation:1.Food storage areas shall be clean at all times.2.The dietary manager, or his/her designee, will check refrigerators and freezers at least daily.Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level 1 residents with mental illness were provided with a PASRR Level 2 evaluation for 1 of 5 residents (Resident #3), reviewed for resident assessment. Resident #3's PASRR Level 1 screening did not reflect mental illness, and the resident did not have a PASRR Level II evaluation. This could place residents at risk of not receiving necessary specialized services to meet their individual needs.The findings were: Record Review of Resident #3s Care Plan dated 05/28/2025, reflected: 03/08/2026: The resident will show decreased episodes of s/s of depression related to diagnosis of Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). 05/28/2025: The resident will maintain the ability to make own decisions independently and establish own goals related to diagnosis of schizoaffective disorder (a rare mental illness that affects how a person thinks, feels, and behaves). Record review of Resident #3's quarterly MDS assessment, dated 04/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. BIMS was not indicated. His diagnoses included Schizoaffective Disorder Bipolar Type (a rare mental illness that affects how a person thinks, feels, and behaves that includes bouts of hypomania or mania and sometimes major depression), Unspecified Dementia (diagnosis given when a person has clear signs of dementia, but the exact type hasn't been identified) Hypertension (a condition in which the blood against the artery wall is too high), and Seizures (a sudden burst of electrical activity in the brain). Record review of Resident #3's PASRR Level 1 screening, dated 04/01/2023, reflected the resident did not have a mental illness was checked as no. Resident #3 did not have a PASRR Level II evaluation completed. An interview on 05/06/2026 at 2:30 PM with MDS Coordinator revealed she did not know why Resident #3 had a negative PASRR Level 1 screening. She stated she was responsible for ensuring information is correct and accurate. MDS Coordinator stated the resident was at risk of not getting the proper care needed with a negative PASARR Level 1 screening. An interview on 05/06/2026 at 2:55 PM with the Administrator revealed she did not know why Resident #3 had a negative PASRR Level 1 screening. She said the MDS Coordinator was responsible for checking for accuracy of PASARR Level 1 screenings. Administrator stated the resident was at risk for denied services that could enhance their quality of life. Review of the facility policy, PASRR Requirements Level 1 and Level II Screen Policy and Procedure, dated 03/2022, reflected: 2. Review the Level I screen at least quarterly and assure that it is filed in the medical record and accurately reflects the resident/patient's status. 3. Ensure that the appropriate State-designated agency is contacted for any resident/patient requiring a Level II screen either upon preadmission, annually, or upon learning of an SMI/ID diagnosis which was previously unknown or undetermined.