STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676363	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mustang Park Therapy and Living Center	4501 Plano Parkway Carrollton, TX 75010

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #6) reviewed for accidents and hazards. The facility failed to ensure Resident #6 did not exit the facility through an unknown door and walk 2.7 miles to a free-standing emergency department where he was found outside. The noncompliance was identified as PNC. The noncompliance began on 03/13/2025 and ended 03/14/2025. The facility corrected the noncompliance before the survey began. This failure could place residents at risk of harm and serious injuries. The findings include: Record review of Resident #6's wandering risk assessment, dated 01/31/2025, reflected a score of 4, which indicated a low risk for elopement. Record review of Resident #6's Quarterly MDS (tool used to assess health status) Assessment, dated 02/13/2025, reflected a BIMS (screening tool to assess cognitive status) was not completed because the resident was rarely/never understood. The staff assessment indicated the resident had moderately impaired cognition for daily decision making. Record review of Resident #6's Comprehensive Care Plan, dated 03/09/2025, reflected Resident #6 had impaired cognitive function/dementia or impaired thought processes related to neurological symptoms: Aphasia. Interventions included Administer meds as ordered. Date Initiated: 02/21/2025. I need supervision/assistance with all decision making. Date initiated 02/21/2025. Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date initiated 02/21/2025. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #6's Comprehensive Care Plan, dated 03/09/2025 and updated 03/14/2025, reflected Resident #6 was an elopement risk as evidenced by 03/13/2025 2200 (10 PM) last seen in facility - 3/14/25 2:00 (2 AM) Return to facility. Elopement with Hospital Visit, returned to facility. One intervention was 3/13/2025 ELOPEMENT . 1:1 (one on one staff-resident) care for continuous monitoring due to elopement incident to begin on resident return to facility and end on transfer to secure unit/facility. Date Initiated: 03/14/2025. Record review of Resident #6's Face Sheet, dated 04/15/2025, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included cerebral infarction (blood flow to a part of the brain is blocked, dementia (decline in mental ability that interferes with daily life), aphasia (disorder that affects communication), anxiety disorder with behaviors (persistent worry and fear about everyday situations) and major depressive disorder (persistent feelings of sadness and loss of interest in activities once enjoyed). Observation of all exit doors on 04/15/2025 at 1:20 PM revealed the doors closed and locked properly and alarms could be heard at the nurses' stations. During a telephone interview on 03/25/2025 at 9:45 AM (before midday), a nurse at the hospital ER (department equipped to provide emergency care) stated she was told a bystander saw Resident #6 at a free-standing (not attached to a hospital) ER and called EMS (responds to medical emergencies and transports to appropriate hospital).The ER nurse stated she did not know what time the resident was picked up. She stated when Resident #6 arrived at the hospital ER, he did not have any complaints and could not tell them what he was doing or why he went to the free-standing emergency room . She stated Resident #6 was given medication for anxiety and blood pressure. She stated Resident #6 said he was hungry and thirsty, so they fed him and let him hang out. The ER Nurse stated during her break a co-worker was talking to Resident #6 when he received a call from nursing facility staff. The ER Nurse stated her co-worker talked to the facility staff and was told Resident #6 somehow got out of the facility. She stated her co-worker told the facility staff where Resident #6 was. The ER Nurse stated the ADON came to the hospital to pick up Resident #6. The ER Nurse stated they were concerned because the nursing facility did not know the resident was out of the building for that long. During an interview on 03/25/2025 at 2:30 PM (after midday), the ADON stated LVN E called him on 03/14/2025 about 1:30 AM to notify him Resident #6 was missing. The ADON stated LVN E told him he had not seen Resident #6 during his shift, which began on 03/13/2025 at 10:00 PM. The ADON stated LVN E told him CNA C did not see Resident #6 when he made rounds at 11:00 PM. The ADON stated he told LVN E he should have been notified at 11:00 PM when they could not find the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADON stated he called LVN A, who was Resident #6's nurse the previous shift on 03/13/2025 from 2:00 PM to 10:00 PM. The ADON stated LVN A said just before 10:00 PM Resident #6 told him he was going to his room to lay down and LVN A saw the resident before he left the facility. The ADON stated LVN A called him on 03/14/2025 at 2:12 AM and told him Resident #6 was at the hospital emergency room . The ADON stated he understood Resident #6 called LVN A who spoke with a nurse in the emergency room . The ADON stated he drove to the hospital to pick up Resident #6 and hospital staff told him there was no need to admit Resident #6. The ADON stated hospital staff told him EMS brought the resident to the hospital ER after he was seen outside a free-standing ER and said he needed help. The ADON stated he returned Resident #6 to the facility where he was placed on one-on-one monitoring until he discharged later that day to another facility. The ADON stated upon his return from the hospital, he immediately did a head count to ensure all residents were accounted for. He stated he contacted the administrator, the director of nurses, the residents family, and the resident's doctor. He stated a wander assessment was completed for all residents, door lock codes were changed, and staff members received in-service training on resident elopement. He stated LVN E was no longer employed at the facility. The ADON stated he believed the resident left the faciity on [DATE] during shift change between 10:30 PM- 11:00 PM. The ADON stated Resident #6 may have exited during shift change, while staff members were entering and leaving the facility, since the door did not alarm. During an interview on 03/25/2025 at 2:55 PM, LVN A stated he was Resident #6's nurse from 2:00 PM-10:00 PM on 03/13/2025. He stated Resident #6 went to his room about 10:00 PM and he was in his room when LVN A left about 10:15 PM. LVN A stated it was after 1:00 AM on 03/14/2025 when Resident #6 called from his cell phone. LVN A stated Resident #6 was aphasic and when trying to communicate his words would get jumbled. He stated if you catch the first couple of words, you can usually figure out what the resident was trying to say. LVN A stated the resident gave the phone to a nurse who said the resident was in the hospital ER. LVN A stated he contacted the ADON and told him where the resident was. An interview was attempted with CNA C on 03/25/2025 at 3:10 PM and was unsuccessful. During an interview on 03/25/2025 at 3:54 PM, the Administrator stated on 03/14/2025 at 11:00 PM staff noticed Resident #6 was not in his room. She stated the resident was rarely in his room. She stated he was usually in the court-yard or the day room. She stated staff did not think much about it, because Resident #6 was only in his room to sleep. She stated she was not sure what time facility staff notified the ADON Resident #6 was not at the facility. She stated facility staff searched all the rooms, closets, offices, common areas, storage areas, and outside the building. She stated a facility nurse spoke with Resident #6 on his cell phone and he gave his phone to a nurse who reported the resident was at the hospital emergency room . She stated the ADON was called, and he went to the hospital and brought Resident #6 back to the facility. The Administrator stated a full skin assessment was completed when the resident returned to the facility, and he had no pain or injury. The Administrator stated the resident was placed on one-on-one monitoring until he was discharged to a facility with a locked unit on 03/14/2025. An interview was attempted with LVN E on 03/25/2025 at 4:23 PM and was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/25/2025 at 4:35 PM, the DON stated a wandering assessment was completed for all residents on admission and then quarterly. She stated Resident #6 had not displayed exit seeking behavior prior to the elopement. The DON stated after Resident #6 eloped, his care plan was updated and an elopement risk was completed for all residents. She stated no other resident triggered for elopement risk. The DON stated if a resident were exit seeking, the social worker would be notified to look for a secure unit. During an interview on 03/26/2025 at 1:35 PM, the Social Worker stated she was responsible for sending out referrals to find placement. She stated after Resident #6 was able to get out of the building, he could no longer stay at the facility. She stated Resident #6 was placed on one-on-one monitoring until he was transferred to another facility on 03/14/2025. She stated the facility provided in-service training and went over elopement protocols. During an interview on 03/26/2025 at 2:20 PM, CNA B stated she worked 2:00 PM-10:00 PM on 03/13/2025. CNA B stated during her shift Resident #6 kept asking for the time. She stated Resident #6 came out of his room with his coat when he saw she was getting ready to leave and LVN A distracted him. CNA B stated she later realized Resident #6 had asked for the time so he would know when to be at the door. She stated he was not around the door when she left the facility after her shift. CNA B stated LVN A called her on 03/14/2025 at about 1:30 AM and said the ADON texted him that Resident #6 had left the facility. She stated a few minutes later, Resident #6 called her from the hospital ER and she called LVN A on her tablet so the three could communicate. She stated Resident #6 was aphasic and difficult to understand. She stated other people were heard in the background and it took about 10 minutes of them asking Resident #6 to give the phone to someone before he did. CNA B stated the person who took the phone could not provide information about Resident #6 but told them where he was. She stated LVN A notified the ADON. During an interview on 04/15/2025 at 1:15 PM, the Administrator stated Resident #6 was not a known elopement risk. She stated criteria which indicated a resident was high risk for elopement included going to a door, pushing on a door, not re-directable, or exiting the facility. She stated prior to accepting a resident, they always asked the family if there were attempts to leave the home. She stated if they had left home or attempted to but were unsuccessful, they were not accepted. She stated they did not accept a resident from another facility who had this concern. The Administrator stated staff attended elopement in-service training and participated in elopement drills after Resident #6 left the building. She stated training included what to do if staff noticed someone was missing or trying to leave. She stated if a resident was not seen, staff should check to see if they signed out. She stated if not, staff should check every room in the facility and around the outside of the building. She stated if the resident was not found, the police were to be notified. She stated some residents were more independent and if a resident was not seen when staff was rounding, they must look until they lay eyes on the resident. The Administrator stated some resident rooms had a camera but the facility had not placed any cameras inside or outside of the building. An interview attempt with Resident #6's family member on 04/15/2025 at 1:53 PM was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 03/25/2025-03/26/2025 and 04/15/2025-04/16/2025 were conducted with multiple staff members which included the Administrator, DON, ADON, LVN A, CMA F, CNA G, Receptionist, Social Worker, CNA B, CNA H, CNA I, LVN J, Maintenance Supervisor, Environmental Services, RN K, Speech Therapist, Physical Therapist, and CNA L. Interviews across multiple shifts revealed staff members received elopement in-service training and participated in elopement drills. The elopement in-service training/drills reflected each staff member was designated an assigned search area and provided a census to cross reference and ensure each resident was present. Staff was educated that when rounding they must lay eyes on each resident. If a resident was not in their room when rounding, staff must search every room in the facility to ensure they were in the building and safe. If a resident was not located, staff must initiate the elopement procedure. If a resident was not located inside or outside the building, police, family, and the physician must be notified. No lack of knowledge or procedure was identified. The facility initiated the following interventions prior to the state surveyor entry on 03/25/2025: Record review of Resident #6's clinical file on 03/25/2025 at 11:15 AM reflected the following: -A full skin assessment of Resident #6, dated 03/14/2025, was completed with no injuries or pain. -Resident #6's Comprehensive Care Plan was updated on 03/14/2025 after the resident exited the building. - Record review of Resident #6's risk assessment, dated 03/14/2025, reflected a score of 11, which indicated a high risk for wandering. -The facility provided a log, dated 03/14/2025, of 1:1 (constant observation) staff monitoring from 2:45 AM until Resident #6 discharged on [DATE] at 4:30 PM. -The medical doctor, psychiatrist, director of nurse, administrator, and Resident #6's family member were notified of the elopement on 03/14/2025. -Documentation of elopement drills and education with all employees beginning with 1st shift staff on 03/14/2025. The elopement drills and education included all residents must be visualized upon making rounds, and if they were not seen initially, the staff must conduct a search of the immediate area. If the resident is not located, they initiate the elopement procedures and notify all relevant parties. No lack of knowledge or procedure was identified. -Elopement drills and in-service training , signed by staff members on 03/14/2025, were cross referenced with the facility staff list to ensure all staff were educated. Record review of the facility's policy Elopements, dated 3/15/2022, reflected .4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e. Emergency Management, Rescue Squads, etc.); d. Provide search teams with resident identification information; and e. Initiate and extensive search of the surrounding area. Record review of the facility's policy Wandering, Unsafe Resident, revised 3/01/2022, reflected 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) . 7. Staff will notify the Administrator and Director of Nursing immediately, and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on observation, interview, and record review the facility failed to provide appropriate or obtain from an outside resource routine dental services, to the extend covered under the State plan, and emergency dental services to meet the needs of each resident for 1 of 6 residents (Resident #1) reviewed for dental. The facility failed to provide proper dental care and assure the denture concerns were addressed with Resident #1. This failure could place residents at risk of not receiving the care needed to maintain their highest, practicable, physical, social, and psychosocial level of well-being. Findings include: Record review of Resident #1's face sheet, dated 03/28/25, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Chronic Obstructive Pulmonary Disease (lung disease that leads to breathing issues), Dysphagia (difficulty swallowing food or liquids), and Bipolar Disorder (shifts in mood, energy, and activity levels). Record review of Resident #1's Care Plan, dated 08/09/24, reflected Resident #1 was on a regular diet, with regular consistency. Record review of Resident #1's quarterly comprehensive MDS assessment, dated 02/24/25, reflected Resident #1 has a BIMS score of 15, which indicated Resident#1's cognition was intact. Section L on the MDS assessment reflected Resident #1 had no problems with dental care. Record review of a dental treatment note, dated 01/17/25, reflected Resident #1 was seen by the dentist and the document noted new dentures were delivered to Resident #1, the dentures were tried on, and Resident #1 was satisfied with the fit. Record review of a dental treatment note, dated 01/27/25, reflected Resident #1 was seen by the dentist and the document noted, F/F not fitting, got them last week. In an observation and interview on 03/28/25 at 10:30 AM, Resident #1 did not have his bottom dentures in his mouth. Resident #1 stated his bottom dentures did not fit, which made it hard for him to eat certain foods. He stated he was unable to eats items like chicken or pork chops, and he had to cut up food items like hamburgers. Resident #1 stated if he left the bottom denture in his mouth, it would have caused pain, but he never wore the bottom denture. Resident #1 stated he told someone in January of this year that his dentures did not fit properly. Resident #1 stated he recently told the ADON about two weeks ago about his dentures not fitting. Resident #1 stated the ADON told him he would contact the dentist to get the issue resolved. Resident #1 stated he told the ADON he did not want to see the mobile dentist the facility used and wanted to go into an actual dentist office. Resident #1 stated the ADON stated he would check on a few things and let him know what could be done for the denture concern. Resident #1 stated the ADON had not followed up about the concern. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/25 at 11:58 AM, the Social Worker stated she was not aware or had been informed Resident #1 had issues with his dentures. She stated if she was aware she would have put Resident #1 on the list to be seen by the dentist. The Social Worker stated if Resident #1 was in pain, she would have sent an email to have him seen by the dentist immediately. The Social Worker stated a virtual appointment could have been made, so the dentist could see the issue with Resident #1's dentures as well. She stated the doctors and dentists will upload their own notes, and then it was the responsibility of the nursing staff to review those notes and follow-up with any orders or concerns. In an interview on 03/28/25 at 12:53 PM, the ADON stated Resident #1 complained to him about his denture problem. The ADON stated in January, Resident #1 first said his dentures fit, but a few days later told him they did not fit well. He stated Resident #1 stated the bottom denture was too big. The ADON stated Resident #1 felt the dentist the facility used was not suitable, and the resident asked to be sent out to another dentist. He stated he told him he would look into it and see what his insurance approved. The ADON stated he first told him about two weeks ago, and he still needed to check Resident #1's insurance. The ADON stated he did not follow up on the denture concern, because Resident #1 had not complained about it in two weeks. The ADON stated he did not let the Social Worker know or document the concern on Resident #1's electronic record. The ADON stated he felt there was no risk, because Resident #1 saw the dentist within two months of admitting to the facility, and he stated he felt there was no risk since Resident #1 had not complained within the last two weeks. The ADON stated if he knew it was still a concern he would have followed-up immediately. The ADON stated the resident actually gained weight, so he did not think there was a risk. The ADON stated he should have let the DON or the Social Worker know about Resident #1's denture concern. In an interview on 03/28/25 at 1:38 PM, the DON stated she was not aware Resident #1 had an issue with his dentures. She stated she was not aware he was unable to eat certain items. The DON stated the ADON never told her Resident #1 voiced concerns to him, and he did not document the concern for her to review. The DON stated if she knew she would have notified the Social Worker and had her follow up immediately. The DON stated the risk of Resident #1 not having proper fitting dentures was his inability to eat a proper diet. In an interview on 03/28/25 at 2:20 PM, the Administrator stated she was unaware Resident #1 had issue with his dentures. She stated the Social Worker handled it today once she became aware. She stated Resident #1 was on the list to be seen the next time the dentist visited. The Administrator stated there was no risk, because the resident was seen twice in January and the dentist noted they would follow up regarding the bottom denture. The Administrator stated Resident #1 would be seeing the dentist during the next visit on 04/17/25. Record review of the facility's policy, titled, Dental Services, dated 11/01/17, reflected the following: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.