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	11/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one of six residents (Resident #5) reviewed for dignity. The facility failed to conceal Resident #5's catheter bag lying in public view. This failure placed residents at risk of not having their right to a dignified existence and self-determination maintained.Findings included: Record review of Resident #5's Face Sheet, dated 10/08/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included urinary tract infection. Record review of Resident #5's Quarterly MDS assessment, dated 7/18/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required full assistance. Active diagnosis included renal failure (kidney failure). Record review of Resident #5's Comprehensive Care Plan, dated 8/01/25, reflected the resident was care planned for bladder incontinence, but the intervention did not include an intervention for the use of a catheter bag. Record Review of Resident #5's physician orders, dated 10/08/25, reflected Catheter Suprapubic catheter (16)fr 10 (cc) to close drainage system. In an observation on 10/08/25 at 8:40 AM, Resident #5 was observed with a catheter bag hanging from his bed. The catheter bag was visible from the door entrance, and it did not have a privacy bag. In an interview and observation on 10/08/25 at 8:43 AM, LVN R was shown a picture by the Surveyor of Resident #5 not having his catheter bag covered with a privacy bag. He stated the resident should have a privacy bag covering the catheter bag to protect the resident's dignity. In an interview on 10/08/25 at 10:00 AM, the DON was told and shown a picture of Resident #5 with a catheter bag and no privacy bag over it. She stated a CNA had brought this to her attention this morning and she had given him a privacy bag to cover it. She stated it was a dignity concern for the resident and the catheter bag should always have privacy bag. Record review of the facility's policy on Dignity, dated February 2021, revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the nurse call system was assessable for six of ten residents (Resident #1, #2, #3, #4, #5 and #6) reviewed for call systems access. The facility failed to ensure the call light system in Resident #1, #2, #3, #4, #5 and #6's rooms was in a position that was accessible to the residents on 10/08/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/08/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and muscle weakness. Record review of Resident #1's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of muscle weakness. Record review of Resident #1's Comprehensive Care Plan, dated 8/28/25, reflected the resident's need for ADL care and included an intervention of encouraging the resident to use the call light. In an observation on 10/08/25 at 8:34 AM Resident #1 was observed lying in bed. Her call light was hanging from the bed, near the floor, and out of reach. 2. Record review of Resident #2's Face Sheet, dated 10/08/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included repeated falls and lack of coordination. Record review of Resident #2's Quarterly MDS assessment, dated 8/05/25, reflected a BIMS score of 14 (intact cognitive response). For ADL care, it reflected the resident required total assistance. Active diagnoses included repeated falls and lack of coordination. Record review of Resident #2's Comprehensive Care Plan, dated 8/29/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/08/25 at 8:44 AM, Resident# 2 was observed lying in bed and her call light was on the floor and under her bed. 3. Record review of Resident #3's Face Sheet, dated 10/08/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included difficulty walking and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 13 (intact cognitive response). For ADL care, it reflected the resident required moderate assistance. Active diagnoses included difficulty walking and lack of coordination.Record review of Resident #3's Comprehensive Care Plan, dated 10/01/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach. In an observation on 10/08/25 at 8:49 AM, Resident #3 was observed lying in bed and her call light was observed hanging on another bed in the room, out of reach of the resident. 4. Record review of Resident #4's Face Sheet, dated 10/08/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and repeated falls. Record review of Resident #4's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required moderate assistance. Active diagnosis included history falls. Record review of Resident #4's Comprehensive Care Plan, dated 6/20/25, reflected the resident was a fall risk and an intervention included ensuring call light was within reach of the resident and encouraging the resident to use it. In an observation on 10/08/25 at 8:49 AM, Resident #4 was observed lying in bed and his call light was observed on the floor under the head of the bed, out of reach of the resident. 5. Record review of Resident #5's Face Sheet, dated 10/08/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included muscle weakness. Record review of Resident #5's Quarterly MDS assessment, dated 7/18/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required full assistance. Active diagnosis included muscle weakness. Record review of Resident #5's Comprehensive Care Plan, dated 8/01/25, reflected the resident was a fall risk and an intervention included ensuring call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/08/25 at 8:50 AM, Resident #5 was observed lying in bed and his call light was observed on the floor behind the head of the bed, out of reach of the resident. 6. Record review of Resident #6's Face Sheet, dated 10/08/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and a history of falls. Record review of Resident #6's Quarterly MDS assessment, dated 8/02/25, reflected a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required some assistance. Active diagnosis included muscle weakness. Record review of Resident #6's Comprehensive Care Plan, dated 10/02/25, reflected the resident had

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 4 residents (Resident #9, #10, #11, and #12) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #9, #10, #11, and #12 received their scheduled showers based on records reviewed for September 2025. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Included: 1. Record review of Resident #9's face sheet, dated 10/08/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis of muscle weakness. Record review of Resident #9's Comprehensive MDS Assessment, dated 07/29/25, reflected her BIMS score of 15 (intact cognitive response). The Comprehensive MDS Assessment reflected the resident required limited assistance with bathing. Record review of Resident #9's Comprehensive Care Plan, dated 9/16/25, reflected the resident required a one person assist when bathing. An attempted record review of Resident #9's Bath/Shower Sheets for the month of September 2025, was not made because the DON and ADON J could not provide any documents or records of when the resident received showers. 2. Record review of Resident #10's face sheet, dated 10/08/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis of Cerebral Palsy (neurological damage). Record review of Resident #10's Comprehensive MDS Assessment, dated 9/01/25, reflected her BIMS score of 15 (intact cognitive response). The Comprehensive MDS Assessment reflected the resident required one person assistance with bathing. Record review of Resident #10's Comprehensive Care Plan, dated 8/21/25, reflected the resident was required a one person assist when bathing. An attempted record review of Resident #10's Bath/Shower Sheets for the month of September 2025, was not made because the DON and ADON J could not provide any documents or records of when the resident received showers. In an interview on 10/08/25 at 9:00 AM, Resident #9 and Resident #10 stated they were not pleased with the care being provided since the new leadership took over. They stated they only received about one shower a week because the facility had lost a lot of CNAs and were short staffed. They stated they did not like feeling dirty. They stated it took a while for staff to answer their call lights. They stated they had to complain to the DON to get a shower. 3. Record review of Resident #11's face sheet, dated 10/08/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident had a diagnosis of morbid obesity and muscle weakness. Record review of Resident #11's Comprehensive MDS Assessment, dated 10/02/25, reflected her BIMS score of 15 (intact cognitive response). The Comprehensive MDS Assessment reflected the resident required total assistance with bathing. Record review of Resident #11's Comprehensive Care Plan, dated 10/02/25, reflected the resident was required total assistance when bathing. An attempted record review of Resident #11's Bath/Shower Sheets for the month of September 2025, was not made because the DON and ADON J could not provide any documents or records of when the resident received showers. In an interview on 10/08/25 at 9:00 AM, Resident #11 stated he had not been getting his scheduled showers on a consistent basis. He stated he only received them when he complained about it and he needed his showers. He stated there were other residents not getting their showers, and this was not right. He stated the facility had been short staffed until recently when they started hiring staff. He stated he only received one shower in the past two weeks. He stated he was scheduled for showers on Tuesday, Thursday, and Saturdays. 4. Record review of Resident #12's face sheet, dated 10/08/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnoses of muscle weakness and unsteadiness on feet. Record review of Resident #12's Comprehensive MDS Assessment, dated 10/07/25, reflected her BIMS score of 15 (intact cognitive response). The Comprehensive MDS Assessment reflected the resident required total assistance with bathing. Record review of Resident #12's Comprehensive Care Plan, dated 10/07/25, reflected the resident was required total assistance for showers and required three showers a week. An attempted record review of Resident #12's Bath/Shower Sheets for the month of September 2025, was not made because the DON and ADON J could not provide any documents or records of the resident receiving showers. In an interview on 10/08/25 at 2:00 PM, the DON was told by the surveyor of Resident #10, #11, and #12 complaint of not receiving their scheduled showers. She stated that when she first started with the facility on 9/01/25, she received complaints from residents of not receiving their showers and she

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for four of seven residents (Resident #1, #6, #7, and #8) reviewed for respiratory care. The facility failed to ensure Resident #1, #7, and #8's nasal cannulas were properly stored in a bag when not in use on 10/08/25. The facility failed to ensure Resident #6's tracheostomy hose was not on the floor but properly stored when not in use on 10/08/25. These failures could place the resident at risk for respiratory infection and not having his respiratory needs met.Findings include: 1. Record review of Resident #1's Face Sheet, dated 10/08/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included heart disease. Record review of Resident #1's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and had an active diagnosis of history of COVID-19. Record review of Resident #1's Comprehensive Care Plan, dated 8/28/25, reflected the resident's need for oxygen therapy and the use of a nasal canula. Record review of Resident #1's physician orders, dated 10/08/25, reflected Mat Titrate O2 to maintain saturation greater than 90% every shift for shortness of breath. In an observation on 10/08/25 at 8:34 AM, Resident #1's nasal canula was observed on the floor near an oxygen tank, unbagged. 2. Record review of Resident #6's Face Sheet, dated 10/08/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included tracheostomy (opening in the neck). Record review of Resident #6's Quarterly MDS assessment, dated 8/02/25, reflected a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required some assistance. Active diagnosis included tracheostomy care. Record review of Resident #6's Comprehensive Care Plan, dated 10/02/25, reflected the resident had a tracheostomy and an intervention included ensuring trach ties are secured and provide oxygen care. Record review of Resident #6's physician orders, dated 10/08/25, reflected Tube size 18 FR/10 cc may replace if dislodged and Albuterol Sulfate Inhalation Nebulization Solution 0.63 NG/3ML I inhalation via Trach In an observation on 10/08/25 at 8:43 AM, Resident #6's Trach hose (the opening) was observed on the floor. 3. Record review of Resident #7's Face Sheet, dated 10/08/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included heart failure. Record review of Resident #7's Quarterly MDS assessment, dated 9/01/25, reflected her BIMS score of 14 (intact cognitive response). The resident had an active diagnosis of heart failure. Record review of Resident #7's Comprehensive Care Plan, dated 6/26/25, reflected a plan of care for oxygen therapy by way of nasal canula. Record Review of Resident #7's physician orders, dated 10/08/25, reflected Oxygen at 2 Liters per nasal canula as needed for Oxygen saturation below 90. In an observation on 10/08/25 at 8:42 AM, Resident #7's nasal canula was observed on the floor near a chair, unbagged. 4. Record review of Resident #8's Face Sheet, dated 10/08/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included heart failure. Record review of Resident #8's Quarterly MDS assessment, dated 8/25/25, reflected his BIMS score of 12 (moderate cognitive impairment). The resident had an active diagnosis of heart failure. Record review of Resident #8's Comprehensive Care Plan, dated 8/29/25, did not reflect a plan of care for oxygen therapy. Record Review of Resident #8's physician orders, dated 10/08/25, reflected Oxygen at 2 Liters per nasal canula as needed for Oxygen saturation below 90. In an interview and observation on 10/08/25 at 8:43 AM, LVN R was shown a Resident #1, #7, and #8 not having their nasal canula bagged and Resident #6's Trach hose on the floor. He stated the hose and nasal cannulas should not be on the floor to avoid the residents from getting an infection. In an interview on 10/08/25 at 10:00 AM, the DON was told and shown pictures of Resident #1, #7, and #8 not having their nasal canula bagged and Resident #6's Trach hose on the floor. She stated the expectation was for the nursing staff to ensure all mask and nasal cannulas are bagged when not in use to avoid the resident getting an infection. She stated Resident #6's Trach hose should not have been on the floor and should be replaced to avoid contamination. In an interview on 10/08/25 at 2:40 PM, ADON J was shown pictures by the Surveyor of Resident #1, #7, and #8 not having their nasal canula bagged and Resident #6's Trach hose on the floor. He stated the hose and nasal cannulas should not be on the floor to avoid the residents from getting an infection. He stated it was the nurses' responsibility to ensure nasal cannulas were bagged and the trach hose not on the floor when they make their rounds, which