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	12/10/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for one of five residents (Resident #4) reviewed for resident rights. The facility failed to ensure Residents #4's call light was answered in a timely manner. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings include: Record review of Resident #4's facility face sheet, dated 11/10/25, revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral edema (swelling in the brain), chronic respiratory failure with hypoxia (improper gas exchange), diabetes (blood sugar, is too high) and acute kidney failure (reduction in kidney function). Record review of Resident #4's quarterly MDS assessment, dated 08/26/25, indicated she had a BIMS score of 15, which indicated she was cognitively intact. She was partial/moderate assistance with toileting hygiene and dependent with toilet transfers. Record review of Resident #4's comprehensive care plan, dated 08/28/25, indicated: I am resistant to care r/t Anxiety with interventions: If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. I have the potential to demonstrate verbally abusive behaviors r/t Ineffective coping skills, Mental / Emotional illness, Poor impulse control. [Resident #4] has a behavior problem r/t Delusions (Thinking her gown is wet when it is not, thinking she is hearing staff members engaging in sexual activity outside of her room), Resident [#4] has a history of making false allegations against staff. During an interview on 11/12/25 at 10:10 AM with Resident #4, she stated on 11/09/25 she pushed the call light quite a few times. Resident #4 stated she waited about 15 minutes and then called 911. Resident #4 stated the police came to her room and then they went to the front desk and spoke with someone. Resident #4 stated the police returned to her room and staff had told the police they sent someone in her room to change her, but they had not. Resident #4 stated the staff lied to the police because it would be crazy for her to refuse for someone to change her. Resident #4 stated the police did not seem to care and acted as though it was another day. During an interview on 11/12/25 at 11:40 AM with CNA A, she stated Resident #4 only came out of her room for showers and therapy. CNA A said Resident #4 never complained to her about anything. CNA A said she was not aware of Resident #4 requesting help and having to call 911. CNA A stated it was expected for Resident # 4's call light to be answered promptly. During an interview on 11/12/25 at 2:25 PM with RN F, she stated Resident #4 kept her call light on due to being needy. RN F said right after you finished doing something for Resident #4 and left her room, the call light would be on within 5 minutes . RN F said they would ask Resident #4 if she needed anything before they left her room and she would say no but then turn the call light back on. RN F stated Resident #4 would say she did not want something, then staff left her room and she turned on her light and wanted the exact same thing staff just did for her. RN F said one day she was going to check her blood sugar, and she said no because she did not understand why the doctor wanted them to check it. RN F stated Resident #4 would then call the staff back and ask if they still had the equipment to do it. RN F stated Resident #4 changed her mind a lot and she appeared as though she was a very angry person. RN F stated once staff had just left Resident #4's room and Resident #4 called 911 to tell them she needed something. RN F said it was more of a behavior. RN F said they constantly went in and out of her room. RN F said Resident #4 never complained to her about staff refusing to assist her or taking too long to respond to her call light. RN F said Resident #4 was care-planned for these behaviors, and they charted on her behaviors. RN F stated the DON constantly checked in with Resident #4. RN F stated when the DON was not in the facility, staff checked in with Resident #4. During an interview on 11/13/25 at 2:55 PM, LVN G stated Resident #4 refused to allow CNA B to enter her room on 11/9/25. LVN G stated she went to Resident #4's room and asked her why she did not want CNA B to change her. LVN G stated Resident #4 said CNA B took her brief off and did not give her a blanket. LVN G stated she asked Resident #4 if she put CNA B out of the room and Resident #4 said, Yes, I put her out of the room, I just do not like her. LVN G stated she told Resident #4 that CNA B provided care for you yesterday and you liked her and Resident #4 responded, Well, today I do not like her. LVN G stated she sent a different CNA to Resident #4's room and Resident #4 put that CNA out too. LVN G stated then Resident #4 stated CNA B could come finish what she started. LVN G stated when she exited Resident #4's room, the CNAs were picking up trays and the police arrived and she escorted them to Resident #4's room. LVN G stated the police came to the nursing station and was asking a ton of questions, and Resident #4

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right and the facility made prompt efforts to resolve grievances the resident may have for one of three residents (Resident #2) reviewed for grievances. The facility failed to respond to two of Resident #2's grievances with an appropriate resolution to his concerns. This deficient practice could place facility residents at risk for a decreased sense of self-worth, a decline in quality of life, and loss of dignity.Findings include: A record review of Resident #2's, undated, face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included anxiety (feeling of worry, dread, or fear), diabetes, major depressive disorder (persistent sadness, hopelessness, and loss of interest in activities), morbid obesity, multiple sclerosis (autoimmune disease that affects the central nervous system). A record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated the resident was cognitively intact. Resident #2 experienced feeling down, depressed, or hopeless 12-14 days (nearly every day). A record review of Resident #2's care plan, with a target date of 12/9/25, revealed Problem: I use antidepressant medications, and benzodiazepines, interventions: Monitor/document/report to MD PRN ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. A record review of Resident #2's grievance form, dated 11/5/25, revealed Tonight dinner served consisted of vegetable soup and baked potato, the baked potato was very under cooked and hard essentially making it inedible. Vegetable soup was the only side.[DM] interviewed Resident [#2] and discussed Resident #2's preferences. Interview on 11/10/25 at 3:30 PM with Resident #2 revealed he had spoken with the ADM and gave him a grievance form. Resident #2 stated 10 minutes later the DM approached him in therapy and informed him he would like to meet with him when he was finished. He stated the DM should have apologized to him first for the undercooked baked potato. He stated instead, the DM asked him if he asked the dietary staff to reheat the baked potato. He stated the DM should have discussed the grievance with the kitchen staff about why it happened and then addressed it with him. He stated the DM did not take any responsibility. He stated this was last Wednesday (11/5/25). Resident #1 stated the DM nor the ADM had not followed up with him directly regarding the status of the grievance. Resident #2 stated this situation made him feel targeted and discouraged from reporting issues in the future. Interview on 11/12/25 at 12:50 PM with the DM revealed on his first day at the facility (11/5/25), the ADM asked him to address a grievance with Resident #2 regarding an undercooked baked potato. The DM stated he went to meet with Resident #2 and informed him it was unfortunate that it happened and if it ever happened again, to let someone in the kitchen know at that time, opposed to two days later so they could give him a different one or prepare something different. Interview on 11/13/25 at 4:55 PM with the ADM revealed Resident #2 brought him a 3-day old baked potato and grievance form on 11/5/25. The ADM stated he gave the grievance form to the new DM on his first day (11/5/25) and asked him to follow up with Resident #2. The ADM stated Resident #2 concluded due to him giving his grievance form to the DM it was a breach of confidentiality. The ADM stated normally the Department Head would meet with the resident and discuss the grievance in a timely manner within 24 hours unless it was over the weekend. The ADM stated since 11/5/25, he had not received the resolution. Record review of the facility's, undated, policy Grievance Resolution revealed The resident's grievance will be resolved promptly and the decision conveyed to the resident in writing. 6. The Grievance Officer will complete the review of the grievance and provide a written response to the resident or resident representative which includes: i. Date the grievance/concern was received.ii. Summary of grievance presented.iii. Investigation steps involved.iv. Findings of the investigation.v. Resolution outcome and actions taken andvi. Date the decision was issued.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #1) of one resident observed during a transfer. RN A and CNA B failed to transfer Resident #1 safely when they failed to use a gait belt and independently lifted Resident #1 under her armpits when transferring Resident #1 from the floor to her wheelchair on 10/12/25. This failure could affect the residents by placing the residents at risk for discomfort, pain, and/or injury. Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE], with the following diagnoses: coronary artery disease (the coronary arteries, which supply blood to the heart muscle, become narrowed or blocked), hypertension (a condition where the force of blood against the artery walls in consistently too high), renal insufficiency (where the kidneys are not working as well as they should to filter waste, regulate blood pressure, and manage body fluids), hyperlipidemia (a condition characterized by high levels of lipids), and non-Alzheimer's disease (memory impairment). Resident #1 required partial/moderate assistance (helper does less than half the effort.) for sit to stand and chair/bed-to-chair transfer. Resident #1's BIMS score of four indicated she was severely cognitively impaired. Review of Resident #1's Care Plan dated 10/07/25, reflected, Resident #1's ADL Self Care Performance deficit related to dementia: transfers: I can bear weight, pivot, use arms to support, ambulates using walker Record review and interview on 10/14/25 at 7:36 AM, revealed the ADM, the DON and the Surveyor reviewed the video provided by Family Member C regarding the transfer incident of Resident #1 on 10/12/25. The video was recorded on 10/12/25 with an unknown time and revealed RN A and CNA B and Resident #1 were standing next to Resident #1's bed in Resident #1's room. RN A and CNA B transferred Resident #1 from the floor to her wheelchair. RN A and CNA B both placed their arms under the resident's arm pits and had Resident #1 place her arms to her side and lifted the resident from the floor without a gait belt. The ADM and the DON both stated that the video showed an inappropriate transfer of Resident #1 when RN A and CNA B both placed their arms under the resident's arm pits and did not use a gait belt. The DON identified RN A and CNA B as the staff members in the video. The ADM and the DON both said there had been no reports or concerns regarding RN A or CNA B's care and treatment of the residents. The ADM said the employees had received training with a competency checkoff on appropriate transfer and gait belt usage. The DON and the ADM both stated the expectation was for staff to use gait belts rather than to place their arms under a resident's arm pit to transfer a resident. The ADM and the DON both stated the risk of an inappropriate transfer could result in injury to the residents. The DON stated they teach staff to use a gait belt for all transfers for safety and to prevent injury to themselves and the residents. Interview on 10/15/25 at 10:07 AM with Family Member C revealed she had not provided the video on 10/12/25 of Resident #1 being transferred by two staff members inappropriately by her armpits to the facility yet. Observation and attempted interview on 10/14/15 at 11:29 AM, revealed Resident #1 was up in her wheelchair in her room. Resident #1 was smiling and appeared to be in a good mood. Resident #1 could not answer questions appropriately. Interview on 10/14/25 via the telephone at 7:52 AM with CNA B regarding the observation of the video of Resident #1's transfer on 10/12/25 revealed CNA B acknowledged she was the staff member in the video. CNA B acknowledged she did not use a gait belt for the transfer and had been trained on safe transfers. CNA B knew Resident #1 was a one-person assist with transfers and to always use a gait belt. CNA B was asked about the placement of her arms in the pictures from the video and CNA B stated she had her arms under Resident #1's armpits which was incorrect. CNA B stated she would use a gait belt for transfers and not place his arms under the Resident's armpits during transfers moving forward. CNA B stated that the risk of transferring a resident inappropriately could result in fracture of resident's arm. Interview on 10/14/25 via telephone at 8:00 AM with RN A regarding the observation of the video of Resident #1's transfer on 10/14/25 revealed RN A acknowledged he was the staff member in the pictures from the video. RN A acknowledged he did not use a gait belt for the transfer and had been trained on safe transfers. RN A knew Resident #1 was a one-person assist with transfers and to always use a gait belt. RN A was asked about the placement of his arms in the pictures from the video and RN A stated he had his arms under Resident #1's armpits which was incorrect. RN A stated he would use a gait belt for transfers and not place his arms under the Resident's armpits during transfers moving forward. RN A stated that the risk of transferring a resident inappropriately could result in a fracture. Interview on 10/14/15 at 6:56 AM with

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for one of five residents (Resident #2) reviewed for dietary services. The facility failed to provide food served that was palatable and thoroughly cooked to Resident #2. This failure could place residents at risk of weight loss, altered nutritional, status, and diminished quality of life. Findings include: A record review of Resident #2's, undated, face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included anxiety (feeling of worry, dread, or fear), diabetes, major depressive disorder (persistent sadness, hopelessness, and loss of interest in activities), morbid obesity, multiple sclerosis (autoimmune disease that affects the central nervous system). A record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated the resident was cognitively intact. Resident #2 experienced feeling down, depressed, or hopeless 12-14 days (nearly every day). A record review of Resident #2's care plan, with a target date of 12/9/25, revealed Problem: I am at risk for nutritional problem R/T Morbid Obesity (BMI over 40). I have unexpected weight gain r/t Overeating, I request double portions on all meals and I have a lot of snacks in my room which I eat as needed, interventions: If weight is not within range, contact a physician. [Doctor's name], the registered dietitian is aware of the resident weight gain. Educated the resident about the importance of cutting down on snacks and not eating double portions on all meals, he verbalized understanding. He got Boast [sic] stuck in his refrigerator in his room and drink as needed. During an observation on 11/11/25 revealed the following:12:18 PM - 500 - 800 Halls meal trays delivered on tray cart12:23PM - 100 - 400 Halls meal trays delivered on tray cart During an observation on 11/11/25 at 12:29 PM in the facility's only dining room revealed residents assembled at multiple tables eating lunch. Interview on 11/10/25 at 3:30 PM with Resident #2, he stated one day the food may be good, then the next day it was not. Resident #2 stated it was hard to tell at this time if the food was going to get better. Resident #2 stated on 11/5/25, he was served an undercooked baked potato and the vegetable soup was lukewarm. Resident #2 stated the quality of the food being served was hit or miss. He stated he had not discussed the food with the DM. Interview on 11/12/25 at 11:40 AM with CNA A, she stated he had not received a lot of complaints about food. CNA A stated one day last week, Resident #2 received a half baked potato that was not fully cooked. CNA A stated Resident #2 saved the potato from the day before. CNA A stated she remembered the day because he showed it to her last Thursday (11/6/25) on his shower day. CNA A stated Resident #2 was served the baked potato the day before on Wednesday (11/5/25). CNA A stated Resident #2 saved the baked potato to show the ADM the next day, so she placed it in a bag for him because he had it laying out next to his sink. CNA A stated Resident #2 never complained to her about the food except for the undercooked baked potato. CNA A stated in the dining room they were not allowed to pass the trays until a nurse was present. CNA A stated they passed out the drinks first and then the meal trays. CNA A stated they only had 2 residents who required assistance with eating. CNA A stated once the trays were delivered to the halls, the nurse checked off on the trays, and then the CNAs delivered the trays to the rooms. During an interview on 11/12/2025 at 12:30 PM, the State Surveyors requested the DM provide a sample tray with regular texture meal items, same portions and resident set up. The sample tray will be the last tray served. Test Tray - Lunch at 12:45 PMBaked Chicken = 178.2 Pasta with Pesto Sauce = 170.3 Mixed Veggies = 164.5 Dinner Roll = Room temperature and softButterscotch Pudding with [NAME] Cracker Crumbles = 41.2 Fruit Punch = 40.0 During an interview on 11/12/2025 at 12:50 PM with the DM, he stated on his first day (11/5/25), the ADM had him address a grievance regarding an undercooked baked potato from over the weekend. The DM stated he went to meet with Resident #2 and informed him it was unfortunate that it happened and if it ever happened again, to let someone in the kitchen know at that time, opposed to two days later so they could give him a different one or fix him something different. The DM stated he had a meeting with all the residents yesterday (11/11/25) to introduce himself and to let them know changes were coming. The DM stated he informed the residents that he could not change anything that may have happened prior to him starting at the facility. In an interview on 11/13/25 at 4:55 PM with the ADM, he stated Resident #2 brought him the baked potato 3 days after it was served. The ADM stated they switched food vendors on 9/1/25 when they purchased the facility and he received compliments saying the food was better. The ADM stated residents were allowed to request alternate meals. The ADM stated his expectation

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from each resident's bedside for one of five residents (Resident #1) reviewed for call lights. The facility failed to answer Resident #1's call for assistance in a timely manner due to a malfunction with her call light. This failure could place residents at risk of injury, pain, hospitalization, and a diminished quality of life.Findings include: Record review of Resident #1's facility face sheet, dated 11/10/25, revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included cervical disc disorder (affecting the neck's spinal discs, causing pain and discomfort), fusion of spine (surgery to connect two or more bones in any part of the spine), osteoporosis (bones become weak and are likely to break) and anxiety (feeling of fear, dread, and uneasiness). Record review of Resident #1's quarterly MDS assessment, dated 10/23/25, indicated she had a BIMS score of 13, which indicated she was cognitively intact. She was substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toileting transfers. Record review of Resident #1's comprehensive care plan, dated 08/01/25, indicated she was a moderate risk for falls and had an intervention to include 1/4 side rails to aid in mobility and positioning, resident must be able to use rails independently with only prompting and cueing. During an interview on 11/10/25 at 2:45 PM with Resident #1, she revealed she never requested the police to come, she asked them to call the facility for her. She stated after waiting for what she believed was two hours, she called 911 to have them call the facility for her. Resident #1 stated the new company took over on 9/1/25 and she spoke to the DON, the ADON, Nurses and CNAs, but not the ADM. Resident #1 stated the call light turned on in her room, at its will, and sometimes it did not work in the hall. Resident #1 said it took about 2 hours for someone to come on 11/8. Resident #1 stated the ADM gave her a bell on Monday (11/10/25) and staff now came when she rang her bell. In an interview on 11/12/25 at 11:40 AM with CNA A, she stated Resident #1 was having issues with her call light before she started working at the facility. CNA A said there was a shortage with the wire because it happened several times since she started. CNA A said they offered to move Resident #1, but she did not want to move to a new room. CNA A said Resident #1 complained about the light not working on Monday (11/10/25) and they gave her a call bell. CNA A said they could hear the bell at the front desk. CNA A stated Resident #1 never complained about staff taking too long. CNA A stated she was unsure if Resident #1 ever requested a call bell prior to this incident. CNA A said she was not sure if Resident #1 had ever called 911, but she knew for certain she had never called while she was working. CNA A said the MTD did some work on the call light weeks ago, but it kept happening. CNA A stated that was why they offered her to move rooms, but she declined. In an interview on 11/12/25 at 2:25 PM with RN F, she stated Resident #1 said her call light was not working and they would fix it and then it would stop working again. RN F stated they provided her with a call bell on Monday (11/10/25). RN F said the call light was having issues for about two weeks. RN F stated staff completed regular checks on her. RN F said she was unsure if Resident #1 was offered the chance to move to another room. RN F said the DON went to her room daily to address her needs and ensured they were being met. RN F stated Resident #1 had not complained during her shift and she never called 911 due to staff not answering her call light. In an interview on 11/12/25 at 3:55 PM with the DON, she stated Resident #1 stated her call light worked off and on. The DON stated whenever Resident #1 would report her call light was not working, the MTD checked it and reported back that it worked. The DON stated she confirmed Monday (11/10/25), one time when she checked the call light, it did not work for her. The DON stated Resident #1 told her she called 911 on Saturday (11/8/25) because no one was answering her call light. The DON stated she told Resident #1 evidently it may be a shortage with her call light because the resident had been reporting it was not working and when we checked it, sometimes it worked and sometimes it did not, so it was something wrong with the call light. The DON stated she texted the ADM on Monday (11/10) and asked him if he could get Resident #1 a call bell and the ADM went to the store and purchased her a call bell. The DON stated the call light had a shortage and the MTD had to call a technician to come out. In an interview on 11/13/25 at 9:50 AM, the MTD stated he checked Resident #1's call light 1-2 times a week. The MTD said the first time was 2 months ago. The MTD stated maybe once or twice there was a delay when he checked it. The MTD stated a technician should be called to come out to inspect the call light because they had the tools to do so. The MTD stated it