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	04/01/2026

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

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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. Based on interviews, and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 5 of 5 confidential residents reviewed for call lights. The facility failed to ensure call lights were answered in a timely manner. This failure could place residents at risk for decreased quality of life, self-worth and dignity.Findings included: During confidential interviews with 5 residents, reported call light response time was greater than 30 minutes. Record review of Resident Council Meeting Minutes indicated the following: - 12/30/25 complaints were made regarding call light response times,- 1/30/26 complaints were made regarding call light response from nursing staff, and that staff would come into the room to turn the call light off and not assist with their needs,- 2/26/2026 call light response was poor at times, and- 03/27/2026 call light response was poor at times. During confidential interview resident stated that it takes up to an hour to respond to her call bell. During confidential interview resident stated that the staff are slow at responding to call lights. Resident stated that she had waited up to an hour before someone had come on but could not state a date. Resident stated that she had not reported this to anyone, just figured they would get to me when they could. During an interview on 03/31/2026 at 2:34 PM, LVN B stated that she had not received any call light response time complaints. LVN B stated that all staff were able to answer call lights. She stated that the facility expectation of call light response time was to answer immediately. LVN B stated they had in-service in March on call light response time. During an interview on 04/01/2026 at 3:00 PM, the DON stated he expected his staff to answer call lights timely. The DON said that all his staff were to answer call lights and if they could not take care of the problem, they needed to get someone who could. The DON said the call light should never stay on longer than five minutes and anything over that time was too long. The DON said there was no reason that the staff should not answer the call lights or go in and turn the light off without fulfilling the residents request. The DON stated that if a facility staff member could not fulfill resident request the resident light should remain on and that staff member was to go get someone who could assist. During interview on 04/01/2026 at 3:32 PM, the ADM stated that his expectation of his staff was that they answered residents call lights as soon as possible. The ADM stated that the risk to the resident if staff did not answer call light would be dependent on the need of the residents, but safety concerns for falls and injuries to residents. Record review of facility in-service on Rounding and Answering call lights 03/24/2026 revealed the importance of responding promptly to call lights to ensure resident safety, satisfaction and quality of care. Record review of facility policy titled Answering the Call Light undated revealed the following:The purpose of this procedure is to ensure timely responses to the residents' requests and needs.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for nutritive value, flavor, and appearance for 10 confidential residents and 2 (Residents #31 and #23) of 7residents reviewed for cold food. The facility failed to provide palatable food served at an appetizing temperature to10 confidential residents and Residents #31 and #23. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction with the meals served and weight loss.The findings included: Record review of Resident #31's Quarterly MDS Assessment, dated 01/01/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 15. Her cognitive skills were intact. Her diagnoses included end-stage renal disease and schizophrenia. Record review of Resident #23's Quarterly MDS Assessment, dated 01/02/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 10. Her cognitive skills were moderately impaired. Her diagnoses included stroke, diabetes, and non-Alzheimer's dementia. During an interview on 3/30/2026 at 1:14 PM, Resident #23 stated that the food is not good, it was always cold, on a rare occasion it was lukewarm. Resident #23 stated she did not feel if she told anyone that it would get fixed. Stated she did not ask staff reheat her food. During an interview on 3/30/2026 at 1:33 PM, Resident #31 stated that the food was always cold never hot, she stated that she told residents council. Observation of food cart on 03/31/2026 at 12:25 PM, revealed a non-insulated food cart on hall 500 with 10 food trays. Two staff members observed passing trays. During a confidential interview on 03/31/2026 at 10:34 AM, 10 residents stated that they received cold food if they ate in their room. Residents stated that it was not dietary fault as the dietary staff gets the food out, but the carts have sat on the hall for five to ten minutes before staff would pass the trays. During an interview on 03/31/2026 at 2:07 PM, CNA F stated that she had received one or two cold food complaints. CNA F stated that when she received a cold food complaint that she would take the tray and rewarm the tray in the microwave. During interview on 03/31/2026 at 2:34 PM, LVN B stated that she had received cold food complaints. She stated that she reported it to the previous DON and put in grievances five months ago. LVN B stated that since then she had not received any complaints. Record review of resident council meeting minutes dated 02/26/2026 revealed new meal cart is not insulated, which caused food to cool faster. Record review of January, February and March 2026 grievance log and no complaints of cold food. Record review of seven residents weights and no significant weight loss noted. During interview on 04/01/2026 at 3:00 PM, the DON stated that he was not aware of any cold food complaints. The DON stated that his expectation of his staff were that they needed to pass the food trays as soon as dietary department delivered them to the halls. During interview on 04/01/2026 at 3:32 PM, the ADM stated that his expectation of his staff was that food be served to residents at a safe and appetizing temperature. The ADM stated that the nursing staff was responsible for ensuring food trays were delivered as soon as the dietary staff brought the trays to the hall so that the residents who ate in their rooms received meals at appetizing temperatures. The ADM stated if food was not served at an appetizing temperature, it could have caused residents to not want to eat their food which could have led to weight loss. Record review of meal trays in-service dated 3/24/2026, revealed staff are to ensure that all residents have meal trays offered, regardless of whether residents eat or not. Unless resident is nothing by mouth. Staff are to feed residents as needed and ensure food order matches what's on the tray and trays are passed in a timely manner. Record review of facility policy Nutritional Management undated revealed, The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Requested meal service policy via email on 04/01/2026 at 1:25 PM. Did not receive it prior to exit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 10 confidential residents and one (Resident #40) of seven residents reviewed for frequency of snacks. The facility failed to ensure residents were offered snacks at bedtimes within a window of 14 hours and 45 minutes between the evening meal and breakfast the following day. This failure could affect all residents who received snacks by placing residents at risk for, unplanned weight loss, and side effects from low blood sugar without snack, and diminished quality of life.Findings included: Record review of Resident #40's face sheet, dated 01/01/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Metabolic encephalopathy (a broad term for brain dysfunction resulting from chemical imbalances, systemic disease, or organ failure rather than structural damage), Chronic Obstructive Pulmonary Disease (acute flare-up, worsening of symptoms, increased breathlessness, cough, or sputum production beyond normal daily variations), Type 2 Diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), Severe protein-calorie malnutrition (a life-threatening condition caused by extreme, prolonged dietary deficiency of calories and protein, characterized by >20% body weight loss, significant muscle wasting, and edema), Spinal stenosis (the narrowing of spaces in the spine, compressing nerves and the spinal cord), and Spinal stenosis (the narrowing of spaces in the spine, compressing nerves and the spinal cord). Record review of Resident #40's MDS, dated [DATE], reflected a BIMS score of 10, indicating moderate impairment in cognitive function. Resident #40 required substantial to maximal assistance with care, meaning staff provided more than half of the effort, and active diagnoses of Diabetes During an interview with Resident #40 on 03/31/26 at 2:10 PM stated that she would like to get snacks at bedtime because she was diabetic and needed them but had never been offered any snacks. Resident stated that she had not asked for a snack. During confidential interviews 10 residents said they have not been provided snacks on a consistent basis. Residents stated that snacks are kept at the nurse's station and are not passed out, but if they are able to ambulate themselves they are able to get snacks from the nurses station. During interview on 03/31/2026 at 2:34 PM, LVN B stated that the snacks were placed at the nurses station and the aides took snacks to the bed bound residents and if residents asked for snacks they would be provided with a snack. LVN B stated the risk to residents who did not receive a snack might cause them to be hungry or unfulfilled. During interview on 04/01/2026 at 3:00 PM, the DON stated that dietary department delivered snacks daily to the nurses station and the CNAs passed them out. The DON stated the risk to the resident if they did not receive snacks would be mainly for diabetic residents if their blood sugar dropped. During interview on 04/01/2024 at 3:15 PM, the DM stated they place resident snacks at the nursing station daily before they leave for the day. During interview on 04/01/2026 at 3:32 PM, the ADM stated snacks were offered at bedtime to residents, nursing department and anytime a resident request a snack. The ADM stated the clinical staff were to offer bedtime snacks after dinner. The ADM stated if resident were not offered snacks, residents would be hungry and diabetic residents could have an effect on their blood sugars. The ADM stated residents can ask for snacks and nursing department can provide snacks. Record review of Snacks/Supplement in-service dated 03/24/2026 signed by 12 employees stated: All CNAs and nursing staff are responsible for ensuring that ordered snacks and nutritional supplements were delivered to resident accurately. I understand that this is for multiple reasons: weight management, (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound healing or chronic conditions. Record review of the resident roster dated 3/30/2026 reflected a census of 55 residents. Record review of the posted Meal Service Times in the dining room revealed the following:Breakfast - 7:45 AMLunch - 12:00 PMEvening meal - 5:00 PMThere is no posting to advise any residents about a snack or availability of type of snack after specified times. Record review of the Facility Policy Offering/Serving Snacks undated revealed It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preference and requested on a daily basis. Policy Explanation and Compliance Guidelines: 1.The nursing staff offers snacks to all residents in accordance with the residents' needs, preference and request on a daily basis. 2.All diabetic residents are provided with a bedtime snack.

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety The facility failed to ensure food items in the dry storage room were properly stored, sealed, and protected from exposure to air.The facility failed to ensure food items in the walk-in refrigerator were properly stored, sealed, and protected from exposure to air.The facility failed to ensure that only disposable paper towels were disposed of in the garbage receptacle at handwashing sink #1.The facility failed to ensure the presence of a garbage receptacle at handwashing sink #2.These failures could place residents at risk for food-borne illness, cross contamination, and infection.During an observation on 03/30/2026 at 9:22 a.m., the following was revealed: Handwashing sink #1 had garbage receptacles that contained items other than disposable paper towels, including food and plastic wrap.Handwashing sink #2 did not have a garbage receptacle.During an interview on 03/30/2026 at 9:25 a.m., the Dietary Manager stated that staff using handwashing sink #2 disposed of used paper towels by walking them to the garbage receptacle located at handwashing sink #1. She did not identify any concerns with staff walking wet paper towels to the nearby garbage receptacle.During an observation of the dry storage room on 03/30/2026 at 9:31 a.m., the following was revealed:1 can Butterscotch pudding 112 oz, (7 lbs.), dent on top of can on seal. The written/delivery date was 02/24/2026, no expiration or best by date.1 can Black eyed peas 104 oz, (6 lb. 8 oz), dent on top of the can on seal. The written/delivery date was 03/17/2026. Best by date 12/18/2026.1 can Mild cheddar cheese sauce 106 oz (6 lbs. 10 oz), dent on the side of the can. The written/delivery date was 03/16/2026. No best by date or use by date.1 can Marinara sauce 105 oz, (6 lbs. 9 oz), dent on the side of the can. The written/delivery date was 03.05.2026. No best by date or use by date.2 cans of diced tomatoes and green chilies, 1 lb. 12 oz, dent on the top seal. The written/delivery date was 03/19/2026, best by date 09/12/2027.2 cans of diced tomatoes and green chilies, 1 lb. 12 oz, dent on the side of the can. The written/delivery date was 03/19/2026, best by date 09/12/2027.2 cans of Beef raviolo in tomato and meat sauce, 108 oz (6 lbs. 12 oz), dent on the side of both cans. The written/delivery date was 01/29/2026, best by 09/07/2027.1 large white bin containing sugar was noted with an open date of 01/06/2026 and a useˆby date of 04/06/2026. The plastic lid was cracked from one end to the other, allowing exposure to air. The cracked lid had been taped; however, the tape was observed to be peeling off, leaving the bin not fully sealed.During an interview on 03/30/2026 at 10:10 a.m., the DM stated that delivery trucks arrived on Tuesdays and Fridays and that dietary aides and herself were responsible for stocking deliveries. She stated that the staff member stocking food items was responsible for checking cans for dents and that dented cans were removed from use and placed in her office. She further stated that, per the facility's dated can policy, any can with a dent would not be used, regardless of the size of the dent. She further stated that staff were responsible for dating cans upon receipt and that, if no bestˆby date was present, the product was typically considered usable for one year from the delivery date. She said when products are opened, they should be sealed and closed with the open date and the use by date written on the product.She stated that she notified the Maintenance Director regarding the broken bin and informed the Administrator in December; however, the bin had not been replaced. She stated she had not yet notified the new Administrator. The DM stated that serving food exposed to air or food from dented cans could result in resident illness. She added that the factors that led to these failures is she's short staffed, she has 1 cook and 1 dietary aide for breakfast and lunch, with a cook and another dietary aide that comes in and overlaps for a couple hours before the first 2 employees go home.During an observation of the walk-in refrigerator on 03/30/2026 at 10:29 a.m., the following was revealed:1 Kosher dill spears 128 fl. oz. (1 gallon) opened, no receive, open or best by date.1 Deluxe Mayonnaise 128 fl. oz. (1 gallon) opened, no (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive, open or best by date.1 sweet and sour sauce 1 gallon, opened, no receive or open date, best by date 10/07/2027.1 gallon zipper bag with sliced cheese, receive date 03/24/2026, best by date 04/24/2026, exposed to air.During an interview conducted on 03/30/2026 at 10:54 a.m., the [NAME] stated that all kitchen staff were responsible for stocking deliveries. She stated that dented cans were placed in the DM's office and that the size or location of the dent did not matter. She further stated that, if she was unsure whether a can was dented, she would ask the DM, who made the final decision. The [NAME] stated that the dates written on the cans reflected the date the items were received. She stated that, if residents were served food that was left open or food from dented cans, residents could become sick.In a record review of the facility's Food Receiving and Storage, dated November 2022, revealed: Dry Food Storage.3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in - first out system.Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.Review of the U.S. FDA Food Code 2022, Chapter 3, 3-202.15 Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. If the integrity of the packaging has been compromised, contaminants.may find their way into the food.Review of the U.S. FDA Food Code 2022 reflected: . Section 6-301.20 Disposable Towels, Waste Receptacle. Waste Receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Residents #31, #23, and #6) of seven residents, reviewed for infection control. The facility failed to ensure CNA/MA D performed hand hygiene between Residents #31 and #23 during medication administration.The facility failed to ensure CNA E performed hand hygiene during incontinence care for Resident #6. This failure placed residents at risk for healthcare associated cross contamination and infections.Findings included: Review of Resident# 31's Quarterly MDS Assessment, dated 01/01/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 15. Her cognitive skills were intact. Her diagnoses included end-stage renal disease and schizophrenia. Review of Resident 23's Quarterly MDS Assessment, dated 01/02/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 10. Her cognitive skills were moderately impaired. Her diagnoses included stroke, diabetes, and non-Alzheimer's dementia. An observation on 03/31/26 at 9:05 AM of medication administration with CNA/MA D revealed she administered medications to Resident #31. CNA/MA D returned to the medication cart and did not perform hand hygiene. CNA/MA D prepared medication for Resident #23, administered them, returned to the medication cart, and CNA/MA D did not perform hand hygiene. An interview on 03/31/26 at 9:25 AM with CNA/MA D revealed she did not know she was supposed to perform hand hygiene between residents. She said she had never been trained to. CNA/MA D did say it was important to perform hand hygiene between residents because of spread of infection. Review of Resident 6's Annual MDS Assessment, dated 02/19/26, reflected the resident was an [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 11. His cognitive skills were moderately impaired. His diagnoses included end-stage renal disease, diabetes, and schizophrenia. An observation on 04/01/26 at 1:22 PM of incontinence care for Resident #6 revealed CNA E prepared supplies. CNA E put on gloves, removed the resident's brief and changed gloves. CNA E cleaned the resident's penis and scrotum and changed gloves and did not perform hand hygiene. CNA E cleaned the resident's buttocks, changed gloves, and did not perform hand hygiene. CNA E laid down a clean brief, changed gloves, and did not perform hand hygiene. CNA E applied barrier cream to the resident's buttocks, changed gloves, and did not perform hand hygiene. CNA E fastened the resident's brief. An interview on 04/01/26 at 1:30 PM, CNA E revealed she was supposed to perform hand hygiene when she changed gloves. CNA E said she had been trained to perform hand hygiene but did not do it this time because of nerves. CNA E said it was important to perform hand hygiene for infection control. An interview on 04/01/26 at 1:20 PM, DON revealed staff were supposed to perform hand hygiene between residents and staff were trained to do so. The DON said she monitored hand hygiene 1-2 times per week. The DON said hand hygiene was important to prevent the spread of infection. Record review of the facility in-service, Proper Hand-washing Technique, dated 03/24/26, reflected: All nurses and CNAs are to wash hands using either hand sanitizer or soap and water before and after every encounter with residents. This will prevent the spread of infection and bacteria.The in-service was not signed by CNA/MA D or CNA E. Record review of the facility policy, Hand Washing/Hand Hygiene, revised October 2023, reflected: The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident and/or resident's representative(s) in writing of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 3 (Resident #5, Resident #40, and Resident #45) of 6 residents reviewed for discharge planning. The facility failed to notify the residents or the residents' representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understand for Resident #5, #40, and #45.The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #5, #40, and #45.These failures could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. A record review of Resident #5's face sheet, dated 03/31/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Osteomyelitis of the lower leg (a serious bacterial or fungal bone infection), Type 2 Diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), Atherosclerosis of native arteries of extremities with gangrene (a severe, chronic condition where plaque buildup causes extreme arterial narrowing, restricting blood flow to limbs), Type 2 Diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), Severe protein-calorie malnutrition (a life-threatening condition caused by extreme, prolonged dietary deficiency of calories and protein, characterized by >20% body weight loss, significant muscle wasting, and edema), and Hallux rigidus (a common form of degenerative arthritis causing pain, swelling, and stiffness in the big toe joint, often leading to an immovable joint).A record review of Resident #5's MDS, dated [DATE], reflected a BIMS score of 12/15, indicating moderate cognitive impairment or some memory problems. Resident #5 required maximum to dependent assistance with care, meaning staff provided more than half, to all the effort.A record review of Resident #5's progress note dated 03/16/2026, indicated Resident #5 was sent to the ER, due to Avascular necrosis (the death of bone tissue due to interrupted blood supply). There was no evidence that a transfer or discharge notice had been provided to Resident #5 in writing or to the LTC Ombudsman. In an interview on 03/31/2026 at 12:05 p.m., Resident #5 revealed she had never received a written letter when she was sent to the emergency room. She also stated she would have liked to receive a letter from the facility for her records.2. A record review of Resident #40's face sheet, dated 01/01/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Metabolic encephalopathy (a broad term for brain dysfunction resulting from chemical imbalances, systemic disease, or organ failure rather than structural damage), Chronic Obstructive Pulmonary Disease (acute flare-up, worsening of symptoms, increased breathlessness, cough, or sputum production beyond normal daily variations), Type 2 Diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), Severe protein-calorie malnutrition (a life-threatening condition caused by extreme, prolonged dietary deficiency of calories and protein, characterized by >20% body weight loss, significant muscle wasting, and edema), Spinal stenosis (the narrowing of spaces in the spine, compressing nerves and the spinal cord), and Spinal stenosis (the narrowing of spaces in the spine, compressing nerves and the spinal cord).A record review of Resident #40's MDS, dated [DATE], reflected a BIMS score of 10/15, indicating moderate impairment in cognitive function. Resident #40 required substantial to maximal assistance with care, meaning staff provided more than half of the effort.A record review of Resident #40's progress note dated 12/23/2025, indicated Resident #40 was sent to the ER, due to their oxygen being at 85%, she (continued on next page)

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	676363	A. Building B. Wing	04/01/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was lethargic, could not keep her eyes open, and had a temperature of 104.5. There was no evidence that a transfer or discharge notice had been provided to Resident #40 in writing or to the LTC Ombudsman. In an interview on 03/31/2026 at 12:45 p.m., Resident #40 revealed she had never received a written letter when she was sent to the emergency room. She also stated it did not bother her that she did not receive one.3. A record review of Resident #45's face sheet, dated 03/31/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Systolic Congestive Heart Failure (the heart's left ventricle becomes too weak or enlarged to contract properly), Type 2 Diabetes mellitus without complications (indicates the presence of high blood sugar but without established damage to nerves, eyes, kidneys, or the cardiovascular system), Obstructive and Reflux Uropathy (a urinary tract disorders where urine flow is blocked or flows backward into the kidneys), Chronic Kidney Disease (the long-term, irreversible loss of kidney function, causing waste buildup, fluid retention, and blood pressure issues), and Presence of urogenital implants (refers to the existence of artificial materials or devices in the urinary or reproductive tracts, typically used to treat incontinence, or structural issues).A record review of Resident #45's MDS, dated [DATE], reflected a BIMS score of 15/15, indicating the resident was cognitively intact. Resident #45 was mostly independent and completed activities without staff assistance; however, she required staff set-up or clean-up assistance for tub/shower transfers.A record review of Resident #45's progress note, dated 11/16/2025, reflected that Resident #45 was sent to the emergency room due to shaking, only able to verbalize her name, reported having pain, was disoriented to other questions asked, and was unable to recognize staff or her roommate. There was no evidence that a transfer or discharge notice had been provided to Resident #45 in writing or to the LTC Ombudsman.In an interview on 03/31/2026 at 1:33 p.m., Resident #45 revealed she had never received a written letter when she was sent to the emergency room. She also stated she would have liked to receive a letter from the facility so she could have more details about why she was sent to the ER.During an interview on 03/31/2026 at 2:05 p.m., LVN A revealed that she did not provide a written notice to the resident or the resident's responsible party when a resident was transferred to the emergency room. She explained that she notified the responsible party by telephone at the time of the transfer.During an interview on 03/31/2026 at 2:18 p.m., the ADON revealed that she did not provide written notices or letters to residents or their responsible parties when residents were transferred to the emergency room. She explained that she and the nursing staff notified the responsible party by telephone at the time of the transfer. The ADON further stated that no written information, including resident names, was provided or sent to the LTC Ombudsman.During an interview on 03/31/2026 at 2:47 p.m., the DON revealed that written transfer or discharge notices were not issued to residents or their responsible parties when residents were sent to the emergency room. He stated that notification was provided by a telephone call made by nursing staff to the responsible party at the time of the transfer. The DON further indicated that he believed information regarding discharged residents was forwarded to the LTC Ombudsman by the Social Worker.An attempt was made to contact the facility's LTC Ombudsman; no response was received, and the voicemail was not returned.During an interview on 04/01/2026 at 10:08 a.m., the SW revealed that she was not aware of any written letters or notices being provided to residents or their responsible parties when residents were transferred to the emergency room. She further indicated that she had not been aware that a list of discharged residents was required to be sent to the LTC Ombudsman. During an interview on 04/01/2026 at 10:32 a.m., the Administrator stated that the facility did not provide written transfer or discharge notices to residents or their responsible parties when residents were sent to the emergency room. He explained that residents were verbally informed of the transfer, and the responsible party was notified by telephone at the time of the transfer. The Administrator further stated that, if a written notice were provided, it would clearly communicate the reason for the resident's discharge; however, he acknowledged that this practice was not occurring at the facility.In a record review of the facility's Discharge Summary and Plan, dated December 2006, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that the facility's policy addressed only residents who discharged to a private residence or another nursing care facility.Regulation S483.15(c)(3) states Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and(iii) Include in the notice the items described in paragraph (c)(5) of this section.S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;(ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged ;(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment that described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #37) of three residents reviewed for care plans. 1. The facility failed to ensure Resident #37 was positioned correctly to provide care and services that promote the highest practical well-being while being fed. This failure could place residents at risk for choking and aspiration.Findings included: Record Review of Resident #37's annual MDS assessment, dated 02/06/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The BIMs score was blank, but cognitive skills for daily decision-making were severely impaired. The resident was dependent on staff for eating and was on a mechanically altered diet. His diagnoses included heart failure, end-stage renal disease, Alzheimer's disease, seizure disorder, malnutrition, respiratory failure, and dysphagia (difficulty swallowing). Record review of Resident #37's Order Summary report, dated 08/20/25, reflected:Pureed texture, nectar consistency liquids. Record review of Resident #37's Care Plans, revised 03/06/26, reflected the risk for nutritional complications related to dysphagia. Diet: pureed texture, nectar consistency.Facility interventions reflected: Resident in chair at 90 degrees for all food and fluid intake. Record review of an in-service for Resident #37, dated 03/24/26, reflected:Proper Positioning when Feeding Resident #37.Resident needed to be positioned upright at a 90-degree angle. Pillows could be used to support positioning.Signed by LVN C and CNA/MA D. An observation and interview on 03/30/26 at 1:05 PM, revealed Resident #37 was being fed by LVN C. The resident was being fed a puree diet. He was seated in a geri-chair that was leaning back, he was not at a 90-degree angle. He was not coughing or choking. LVN C said the resident was supposed to sit upright to eat, but it required two staff to sit him up. LVN C stood up and adjusted the geri-chair and the resident was able to sit upright. LVN C said the resident was at risk for choking due to being laid back to eat. LVN C said the resident was supposed to be at a 90-degree angle to eat. An observation and interview on 03/31/26 at 12:42 PM revealed CNA/MA D fed Resident #37 a bite of pureed food while he was leaning back in his geri-chair. CNA/MA D said she could not sit him up because he would slide out of the chair. The DON walked over to the table and sat up the resident's geri-chair. CNA/MA D said the resident was not supposed to be lying down to eat. An interview on 03/31/26 at 12:50 PM revealed the DON said the staff received an in-service on how to feed Resident #37. The DON said the resident was at risk for choking if he was left lying down in his geri-chair to eat. In an interview on 03/31/26 at 12:55 PM, CNA/MA D revealed the resident was supposed to be at a 90-degree angle to eat. CNA/MA D said she did not sit up the resident's geri-chair because she did not know the geri-chair could be positioned to an upright position. CNA/MA D said Resident #37 was at risk for choking if he was fed while laying down. An interview on 04/01/26 at 12:10 PM with the DON revealed Resident #37 had not suffered from aspiration. The DON also said the facility was ordering the resident a new wheelchair to sit in to eat upright. A follow-up interview on 04/01/26 at 12:15 PM with LVN C revealed she received an in-service regarding Resident #37. LVN C said she did not sit up the geri-chair because she was afraid the resident would slide out of the geri-chair. LVN C said the resident had never slid out of the geri-chair. Review of the facility policy, Positioning the Resident, not dated, reflected: .Positioning the Residentd. Maintain natural spinal curves: Stabilize pelvis. Chest up and forward. Head erect.