

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Fair Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2815 Martin Luther King Jr Blvd Dallas, TX 75215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 (Resident #2) of 3 residents reviewed for accident prevention. The facility failed to ensure Resident #2's bed was placed in the lowest position to assist in fall prevention. This failure could prevent residents from having an environment that was free and clear of accidents and hazards. Findings included: Record review of Resident #2's Face Sheet, dated 10/23/2024, reflected he was an [AGE] year-old male admitted on [DATE]. Relevant diagnoses included muscle spasms, lack of coordination, and muscle weakness. Record review of Resident #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, he had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive impairment) and for ADL care it reflected assistance for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #2's Comprehensive care plan dated 09/28/24 reflected the resident was care planned for falls, and one of the interventions was to have the bed in a low position. In an observation on 10/23/24 at 08:00 AM, Resident #2 was observed laying in his bed sleeping. The bed was raised and not lowered to the lowest position. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675417	Facility ID: 675417 If continuation sheet Page 1 of 6

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 10/23/24 at 08:17 AM, the DON was shown Resident #2's bed area. She stated that the resident was care planned as a fall risk and was required to have his bed place in the lowest position, except when he was eating. She stated that the resident had just finished his breakfast. However, she was advised that the resident was observed for over 15 minutes and the bedside table was still in the same location, and there was no staff observed on the floor. She stated the floor nurse was running late, so she was the floor nurse. She had the bedside table moved away from the bed and lowered the bed to its lowest position. She stated the resident had not had a fall in quite some time. She agreed that the bed should be placed in the lowest position to limit the residents from injuring themselves if they fell out of the bed, and Resident #2's sleep area should be free of any hazards in order to assist in fall prevention. The facility's policy Preventive Strategies to Reduce Fall Risk (October 5, 2016), reflected The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 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 for 2 (Resident #1 and #4) of 4 residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #1's nasal cannula, for the oxygen concentrator, was placed in a sanitary container when not in use. 2. The facility failed to ensure that Resident #4's oxygen tubing (flexible tube used to deliver oxygen to the nose through two prongs) was changed. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Record review of Resident #1's Face Sheet, dated 10/23/2024, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included COPD, and history of pneumonia. Record review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected, he had a Brief Interview for Mental Status (BIMS) score of 8 (severe cognitive impairment) and for ADL care it reflected assistance for transfers, toileting, and bathing, and the resident was totally dependent for assistance. Record review of Resident #1's Comprehensive care plan dated 09/30/24 reflected the resident was care planned for oxygen therapy as needed, and one of the interventions was to monitor for respiratory distress and provide oxygen therapy when needed. Review of Resident #1's Physician Order, dated (10/23/2024), reflected If oxygen saturation level is below 85%, on room air, offer @ 2 LPM., recheck in 15 minutes. An observation on 10/22/24 at 01:11 PM revealed Resident #1's oxygen machine was running and her nasal cannula was sitting on top of her nightstand, exposed to air borne contaminants. Review of Resident #4's Face Sheet, dated 10/23/24, reflected that Resident #4 was a [AGE] year-old female admitted on [DATE]. Resident #4 was diagnosed with COPD (Chronic Obstructive Pulmonary Disease: lung disease that blocks airflow and makes it difficult to breathe) and Asthma (airway narrows and can make breathing difficult). Review of Resident #4's Quarterly MDS (Minimum Data Set) Assessment, dated 10/06/2024, reflected that Resident #4 had moderate cognitive impairment with a BIMS score of 9. Resident #4 was administered oxygen therapy for COPD. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's Comprehensive Care Plan, dated 08/15/2024, reflected that Resident #4 Needs Oxygen constantly or intermittently to aid in breathing. Interventions included O2 at 2 liters per minute. Assist resident in keeping O2 cannula positioned and report any increased breathing difficulty to nurse. Resident may also need the head of the bed elevated to make breathing easier. Review of Resident #4's Physician Order, dated (02/19/2023), reflected Change O2 tubing/water every week on Sunday and PRN every night shift every Sun. An observation on 10/22/24 at 09:10 AM revealed Resident #4 sitting up in bed looking at her cell phone. Resident #4 received oxygen therapy, via a nasal cannula, which was connected to an oxygen concentrator next to her bed. There was a piece of blue tape attached to the oxygen tubing that was dated 10/07/24. An observation on 10/23/24 at 08:50 AM revealed the oxygen tubing was still dated 10/07/24. In an interview and observation on 10/22/24 at 01:13 PM, LVN K was shown Resident #1's nasal cannula being unbagged on top of the nightstand, and she stated the resident had a habit of just taking off her nasal cannula to smoke and do other things, and they must remind her to place it in the bag. He stated that the resident was care planned for this behavior. He was advised that the resident was observed waiting to smoke a cigarette near the door for over 15 minutes and no one was observed checking her room to ensure that her nasal cannula was bagged. He stated that the resident's nasal cannula should be bagged when not in use to prevent an infection. In an interview and observation on 10/23/24 at 08:17 AM, The DON was advised of Resident #1's nasal cannula not being bagged when she was not using the oxygen concentrator. She stated the resident had a habit of just taking off the nasal cannula and not bagging it. She stated they had care planned it and had several discussions with the resident. She stated that it was the nurse's responsibility to check rooms to ensure the resident's nasal cannula was bagged. She stated the risk of not bagging the nasal cannula, when not in use, could result in an infection. During an interview on 10/23/24 at 09:00 AM, RN A stated the oxygen tubing was changed weekly on Sunday nights. RN A stated the tubing should have been changed on Sunday night, and that she was going to get new tubing and change it. She said it was important to be sure the tubing was replaced to maintain hygiene and prevent infection. During an interview 10/23/24 at 12:30, the DON stated that the facility's policy was for the oxygen tubing was to be changed every Sunday night by the night shift nurse, and as needed. She stated that the oxygen tubing could collect dust and debris, and cause it to malfunction. Review of the facility's undated policy Oxygen Administration reflected that The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen . The resident will be free from infection.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on interviews and record review, the facility failed to ensure that all drugs and biologicals were accurately dispensed and administered to meet the needs of each resident when 1 (Resident #3) of 6 residents were reviewed for pharmaceutical services. The facility failed to ensure that Resident #3 did not miss doses of medication that was to be administered at bedtime. This failure could place residents at risk of not receiving their medications as ordered by their physician. Findings included: Review of Resident #3's Face Sheet, dated 10/23/24, reflected that Resident #3 was a [AGE] year-old female admitted [DATE] with cerebral infarction (stroke: blood flow to the brain is blocked) affecting left non-dominant side, left elbow contracture (permanent tightening of the muscle), and unspecified pain. Review of Resident #3's Quarterly MDS (Minimum Data Set: screening tool to assess health status) Comprehensive Assessment, dated 10/02/24, reflected that Resident #3 had moderate cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 9. Resident #3 was treated for a contracture of her left elbow, other specified joint contracture, and unspecified . Review of Resident #3's Comprehensive Care Plan, dated 10/13/24, reflected that Resident #3 will remain free of complications or discomfort related to hemiparesis. One intervention was to Give medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #3's Physician Orders, dated 09/02/24, reflected an order for Methocarbamol Oral Tablet 750 MG (Methocarbamol) Give 1 tablet by mouth at bedtime related to OTHER MUSCLE SPASM (M62.838). Review of Resident #3's Medication Administration Record, dated 10/23/24, reflected that during the month of September 2024, Resident #3 did not receive Methocarbamol on September 13th, September 17th, September 19th, and September 24th. During October 2024, Resident #3 did not receive Methocarbamol October 2nd, October 4th, and October 15th. In an interview on 10/24/24 at 09:15 AM, Resident #3 stated that she did not always get her Robaxin (the name brand of Methocarbamol) at bedtime. She stated that when a nurse did not bring it, she asked for it, but there were times she never got it. The resident stated that this medication helped with pain at night and that it was worse when she missed a dose. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 10/23/24 at 10:30 AM, she stated that the unsigned boxes on the MAR (Medication Administration Record) meant that the resident did not get medication on those dates. She stated that was a medication error, and she would investigate to see which nurses did not administer medication as ordered. Review of the facility's policy Medication Administration Procedures, revised 10/25/17, reflected All nurses administering medication must sign and initial the designated area of each resident's medication/treatment administration record. Defining the schedules for administering medication to: Maximize the effectiveness (optimal therapeutic effect) of the medication .the Director of nurses and/or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence.		