STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675417	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Park Health & Rehabilitation Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Residents #22) reviewed for ADL care. CNA G failed to ensure Resident #22 was provided her shower as scheduled on the 2:00 PM to 10:00 PM shift on 5/12/25. This failure could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. Findings included: Record review of Resident #22's Admission Record dated 5/12/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Record review of Resident #22's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 9 indicating moderately impaired cognition. Her diagnoses included hypertension (high blood pressure); stroke; hemiparesis (muscle weakness or partial paralysis on one side of the body often caused by a stroke); contractures (permanent shortening and stiffening of the muscles, tendons and ligaments) of the hand and elbow anxiety disorder; and pain. She required Substantial/Maximum assistance for showering and bathing. Record review of Resident #22's Care Plan Report reflected the following entries: Focus: [Resident #22] has hemiparesis r/t stroke, dated initiated on 12/6/17. Interventions: Bathing: I require Extensive x1 staff with bathing/showering . Focus: The resident has a behavior problem r/t Refusal of showers, dated revised 4/3/24. Interventions: Anticipate and meet [Resident #22's] needs .Caregivers to provide opportunity for positive interactions, attention. Stop and talk with him/her as passing by . Record review of Resident #22's ADL records dated May 2025 reflected an entry for bathing Monday, Wednesday and Friday on the 2 PM to 10 PM shift. All scheduled dates were signed as completed including one on 5/12/25 at 5:47 PM by CNA G. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #22's Progress Notes reflected the following entry dated 5/13/25 at 3:04 PM: . [Resident #22] mentioned that her shower was missed on yesterday evening. she was offered one now but declined, stating that she didn't want to throw her schedule off. Reassured that it wouldn't but she continued to decline. informed that she should let the staff know if she decides that she would like to take one this evening. The entry was signed by the DON. There were no other entries located in the progress notes related to Resident #22's shower which was due on 5/12/25. Record review of a shower schedule sheet dated 12/12/24 reflected the following [Station number] 2-10 showers.Notify nurse of EVERY refusal . DO Not change the schedule, if there are any issues report them to the DON/ADON. The schedule was divided by sections reflecting which rooms were scheduled for showers on Monday/Wednesday/Friday and those scheduled on Tuesday/Thursday/Saturday. Resident #22's room number was reflected as scheduled on Monday/Wednesday/Friday on the 2 PM to 10 PM shift. Observation and interview on 5/12/25 at 11:49 AM revealed Resident #22 was in her room, sitting up in her chair eating her lunch. She appeared well-dressed and groomed. Resident #22 stated she did not always get her showers as scheduled because the staff did not always get to her. She stated she was supposed to receive a shower every Monday, Wednesday, and Friday on the 2 PM to 10 PM shift. She stated, I'm due for one today but I might not get one because I'm going to want to lay down, they don't always want to get me up. She was unable to recall whether she had received her shower which would have been due on 5/9/25. During an observation and interview on 5/13/25 at 10:58 AM, Resident #22 was observed self-propelling from her room into the hall. She stated she had not received a shower as scheduled the evening before on 5/12/25. Resident #22 stated a CNA H stayed late and had cleaned her up before she went home and the following CNA, CNA G never offered her a shower. Resident #22 stated she did not wish to get anyone in trouble but just wanted to get her showers. Resident #22 declined to speak further about her showers as she was heading to an activity. During an interview and record review on 5/13/25 at 11:52 AM, RN C stated residents were scheduled for baths on certain days and shifts and presented a binder which held the Shower Schedule sheet. RN C stated the CNAs were to report any skin conditions or refusals directly to the charge nurse and document the showers and baths provided into the computer kiosk (resident records). RN C stated the nurses were responsible for checking the computer to ensure they were completed and report any refusals to the oncoming shift so another attempt could be made. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/13/25 at 1:36 PM, Resident #22 was observed in bed and CNA H was leaving her room. CNA H stated she had just assisted her back to bed for a nap. CNA H stated she worked the 6 AM to 2 PM shift and it was her fourth day working at the facility. CNA H stated she stayed over the previous evening to help because someone had called in sick. CNA H stated she has assisted with a bed bath and a shower the previous evening, but neither was with Resident #22. CNA H stated she knew who needed a bath based on the Shower Schedule and kiosk (resident records), but it was her first time helping the 2 PM to 10 PM staff and she did what they (staff) had asked her to do. CNA H stated she had provided incontinent care to Resident #22 before leaving at 7 PM and the resident had not mentioned anything about a shower to her. CNA H stated, if Resident #22 had said anything to her about a shower, she would have told her charge nurse or the other aides before she left. During an interview on 5/13/25 at 1:40 PM, Resident #22 stated she never asked CNA G for a shower after CNA H left for the evening. Resident #22 stated CNA H changed her before she left, and Resident #22 had mentioned the shower to CNA G, but Resident #22 knew CNA G was heading home. Resident #22 stated CNA G should have known it was her night for a shower and never offered her one. Resident #22 stated she did not mention it to CNA G when she came in later to change her because Resident #22 knew it was close to the end of her shift. Resident #22 stated she never mentioned it or complained to her Charge Nurse because it had happened before, and nothing had changed. During an interview on 5/13/25 at 2:00 PM, LVN F stated he worked the 2 PM to 10 PM shift and was Resident #22's Charge Nurse. LVN F stated he knew the resident's bathing schedule by referring to the schedule kept at the nurse's station. LVN F stated the CNAs documented the showers provided in the kiosk and report any refusals to them. He stated, if a resident refused to be bathed, they were supposed check on the resident and make another offer. If the resident continued to refuse, they documented the refusal and informed the oncoming nurse. He stated he checked the computer to determine the showers were completed based on the CNAs' documentation and stated her shower due on 5/12/25 had been documented as completed. LVN F stated he was unaware Resident #22 had missed a shower on 5/12/25. LVN F stated the risk to the residents not receiving showers included skin breakdown and loss of dignity. During an interview on 5/13/25 at 2:09 PM, CNA G stated she worked the 2 PM to 10 PM shift and rotated halls. She stated she knew which residents required bathing on her shift based on the Shower Schedule and information in the computer. She stated Resident #22 did not get a shower as scheduled on 5/12/25 because, She (Resident #22) went to bed, to be honest she likes [CNA I] to do them. CNA G stated she did not offer Resident #22 a shower because another aide was working her hall earlier in the shift and then stated, by the time I got to her Resident #22 said it was too late, I did offer. CNA G stated when showers were provided to residents and the showers were documented in the computer. When asked why she had documented Resident #22's shower as completed at 5:47 PM on 5/12/25, she replied, If I'm not mistaken, I think one of the girls said she gave it, I really can't say. She stated she had documented it because Mondays were one of Resident #22's shower days, she thought CNA H had done it and was not sure if she had access to the computer yet. She stated it was her mistake and she should not have done it. She stated she had been moving from hall to hall and should have confirmed it was done. CNA H stated, if a resident refused a shower, she was supposed to have documented the refusal in the computer and informed the Charge Nurse. CNA G stated the risk of residents missing showers included body odor, skin breakdown, dry skin and loss of dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/25 at 3:45 PM, the DON stated she had been made aware of Resident #22 missing her shower and the documentation error. DON stated she had just checked in on the resident around 3:00 PM [5/13/25] and offered to provide one at that time, but she had declined. She stated CNAs were aware they were to report any missed showers to the Charge Nurse. DON stated the risk to residents for missing showers was skin breakdown and loss of dignity. Record review of the facility's undated policy titled, Bath, Tub/Shower reflected the following: Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed. Goals: 1. The resident will experience improved comfort and cleanliness by bathing. 2. The resident will maintain intact skin integrity. 3. The resident will be free from soil, odor, dryness, and pruritus following bathing. Procedure: 1. The resident will receive assistance with bathing according to their resident centered plan of care .

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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** 28637 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one of five (Resident #22) residents reviewed for pharmacy services. The Facility failed to ensure nursing staff ordered medications in a timely manner for Resident #22 resulting in her missing a scheduled morning dose of Robaxin used to control her muscle spasms on 5/13/25. This failure placed the residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings included: Record review of Resident #22's Admission Record dated 5/12/25 reflected a [AGE] year-old female originally admitted to the facility on [DATE]. Record review of Resident #22's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 9 indicating moderately impaired cognition. Her diagnoses included hypertension (high blood pressure); stroke; hemiparesis (muscle weakness or partial paralysis on one side of the body often caused by a stroke); contractures (permanent shortening and stiffening of the muscles, tendons and ligaments) of the hand and elbow anxiety disorder; and pain. Record review of Resident #22's Care Plan Report reflected the following entries: Focus: [Resident #22] has hemiparesis r/t stroke dated revised on 7/26/21. Interventions: .Give medications as ordered. Monitor/document for side effects and effectiveness. Pain management as needed. See MD orders . Record review of Resident #22's Order Summary Report dated 5/12/25 reflected an order for methocarbamol (Robaxin) Oral Tablet 750 mg one tablet two times a day. The order was dated 3/31/25. Record review of Resident #22's Medication Administration Record dated 5/1/25 through 5/31/25 reflected the following entry: Methocarbamol Oral Tablet 750 mg give one tablet by mouth two times a day. The entry dated 5/13/25 AM reflected the code 9 (other/See Nurse Note) indicating the medication had not been administered. Entered by MA E. Record review of Resident #22's Progress Notes reflected the following entries: 5/13/25 2:26 PM: Contacted pts [Nurse Practitioner name] NP regarding pts missed dosage of Methocarbamol 750mg. Med has been ordered. Pt had no s/s reported. Signed by LVN D. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/13/25 at 1:36 PM, Resident #22 was observed lying in bed. She stated they had new staff at the facility, and she did not believe they were ordering her medications correctly. Resident #22 stated she was told the evening before (05/12/2025) they were running out of her Robaxin, and she received her last one at bedtime on 5/12/25. She stated, today they said I had to wait until tonight for it. Medication Aide said she had to talk to the nurse about it. I'm supposed to get it in the morning and at bedtime, I didn't get it this morning. Resident #22 stated the staff needed to order her medication sooner before they ran out, so she did not have to wait for the pharmacy. She stated she needed the medication for pain. Resident #22 stated she was doing ok with her pain at the time but they need to have meds for us. During an interview on 5/13/25 at 1:54 PM, RN C, stated MA E had asked her to reorder Resident #22's Robaxin that morning [5/13/25] and stated she was previously unaware she was low. During an interview on 5/13/25 at 2:00 PM, LVN F stated he was Resident #22's Charge Nurse on the 2 PM to 10 PM shift. LVN F stated he saw the facility had run out of her Robaxin the on 5/12/25 after administering her bedtime dose, and had reordered it from the pharmacy at that time. LVN F stated the pharmacy made deliveries on Monday through Friday in the evenings before 10:00 PM. LVN F stated medications should be reordered once the medications hit the blue line (last row area on a medication punch card highlighted blue to indicate the final doses available) and that it was best to order the medications when they were about a week away from running out. LVN F stated he had worked a double shift on 5/11/25 and had administered both her doses that day (05/11/2025). LVN F stated he should have reordered the medications then when he noticed Resident #22 was running low and could not explain why he did not. He stated the medication was not available in the facility's ekit [emergency supply of medication stocked at the facility]. LVN F stated they were very busy but it was a mistake and was overlooked. LVN F stated the risk of running out of medications depended on the type of medication and included pain, or increased behaviors. During an interview on 5/13/15 at 3:45 PM, the DON stated medications should be ordered once the doses remaining hit the 'blue line' depending on the number of doses due per day and early enough to ensure there was enough stock so that pharmacy delivery was reasonable. DON stated generally, if a medication was ordered by noon, they would be delivered the same day unless it was a weekend. The DON stated all nurses had been trained on medication ordering as part of their orientation. DON stated the risk to residents running out of medications depended on the medication type and therapeutic use. During an interview on 5/14/25 at 8:05 AM, the DON stated she had assessed Resident #22 and had spoken with Resident #22's Nurse Practitioner. DON said they had received an alternate medication-Baclofen [a muscle relaxant used for muscle spasms] which was available in the facility's ekit and had initiated the doses. During an interview on 5/14/25 at 10:15 AM, MA E stated she had informed the nurse on 5/13/25 in the morning Resident #22 was out of Robaxin. She stated she thought she or the nurse had ordered it the previous week and was not sure why it hadn't arrived. She stated, if they were running low or near the blue area on a medication card, she informed the nurse a medication needed to be reordered. She stated she was not absolutely sure whether the medication had been reordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 10:25 AM, Resident #22 stated she had received other medication for her muscle spasms and was pleased with the outcome. She stated her main concern was ensuring her medications were available when she needed them. During an interview on 5/14/25 at 5:06 PM, the Administrator stated he had been made aware of the concerns related to medication ordering. He stated the risk for failure to timely order a resident's medication was missing doses and depended upon the type of medication missed. During an interview on 5/14/25 at 2:43 PM, the DON stated she was unable to locate a written policy related to ordering and re-ordering medications from the facility's contracted pharmacy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28637 Based on observation, interview, and record review the facility failed to properly secure medications in a locked compartment for 1 of 2 medication carts (Unit 2) reviewed for drug storage. On 05/13/2025, LVN D left the Unit 2 medication cart unlocked and unattended for an unknown amount of time. These failures placed residents at risk for unauthorized access to the medication cart and consumption of harmful medications. Findings included: An observation and interview on 5/13/25 at 7:46 AM revealed an unlocked medication cart was situated in a hallway across from the Unit 2 nurses' station. There was no nurse or medication aide seen in the vicinity of the cart. RN C approached from around a corner and stated she did not know why the medication cart had been left unlocked and believed that MA E had the keys. RN C was observed locking the cart. During an observation and interview on 5/13/25 at 7:50 AM, MA E was passing medications on the 100 Hall and stated she did not have the keys to the 200 Hall at that time and believed the nurse had them. During an interview on 5/13/25 at 8:47 AM, LVN D stated she had counted the cart and received the keys from the night shift. LVN D stated she had briefly handed the keys to RN C who needed to check something in the cart but was standing with her the entire time. LVN D stated she did not know how she left the cart unlocked. LVN D stated leaving a cart unlocked placed residents at risk of theft. During an interview on 5/13/25 at 11:25 AM, RN C stated she did not know how the Unit 2 cart had been left unlocked and that medication carts should remain locked at all times when not in use. RN C stated the risk of unlocked carts was that residents could potentially take medications from the cart resulting a overdoses or other negative effects from the medications. During an interview on 5/13/25 at 1:05 PM, the DON stated she had been made aware of the medication cart found unlocked. DON stated the staff had been trained and knew better. The DON stated the risk of unlocked medication carts included medication theft and resident access to medications potentially causing harm. DON stated she had initiated additional in-service training related to medication security. During an interview on 5/14/25 at 5:06 PM, the Administrator stated the risk of unlocked and unattended medication carts was residents could access the carts and get at the medications causing potential harm. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Medication Storage in the Facility dated 2025 reflected the following: Policy Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access .