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	07/08/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 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 to be free from abuse, neglect, misappropriation of resident property, and exploitation for two (Resident #1 and Resident #2) of two reviewed for abuse and neglect.The facility failed to ensure Resident #2 was free from abuse, on 6/27/25, when Resident #1 struck her in the forehead with a cane, which resulted in a laceration.This failure could place residents at risk of abuse and emotional stress. Findings include: 1. Record review of Resident #1's face sheet dated 02/26/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: dementia of unspecified severity without behavioral disturbance (a decline in memory or other cognitive function not accompanied by aggression), psychotic disturbance (delusions or hallucinations), delirium due to psychological condition (acute confusion linked to psychiatric causes), cognitive communication deficit (difficulty understanding or using language), unsteadiness on feet, gait abnormalities, muscle weakness, and a history of lack of coordination.Record review of Resident #1's Quarterly MDS dated [DATE] , reflected a BIMS score of 10, which indicated she was moderately cognitively impaired. Resident #1 used a cane when off the facility premises but did not typically use it inside the facility. Record review of Resident #1's June 27, 2025 care plan reflected interventions related to behavioral health and safety, including redirection, increased monitoring, and staff awareness of behaviors that could place others at risk. The care plan specifically indicated that the resident had exhibited physical behaviors toward others and outlined interventions such as staff immediately intervening to protect involved residents, calling for assistance, and attempting to de-escalate situations by removing the resident from the source of distress and engaging them calmly. If the resident's response was aggressive, staff were directed to calmly walk away. These interventions reflected a history of agitation and physical aggression toward others.Record review of progress notes dated 06/26/25, entered at 11:50 p.m. indicated Resident #1 had returned to the facility and was involved in an altercation with Resident #2. The progress note did not include a detailed or verbatim account of the incident, but did outline the facility's response following the event. According to the documentation, the residents were separated, first aid was provided to both individuals, and both a skin assessment and pain assessment were completed. Urinalysis samples were obtained from both residents, the abuse coordinator was notified, and the facility's abuse protocol was followed. The progress note also stated that one-on-one supervision was initiated for Resident #1 and that the facility would continue to monitor the situation.2. Record review of Resident #2's face sheet dated 10/02/ 24 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: spinal stenosis (narrowing of the spine that can cause pain or mobility issues), muscle weakness, chronic low back pain, major depressive disorder (recurrent, severe feelings of sadness and loss of interest), generalized anxiety disorder(intense , excessive or persistent worry or fear), and essential hypertension(high blood pressure).Record review of Resident #2's Quarterly MDS dated [DATE] , reflected a BIMS score of 13, which indicated she was cognitively intact.Record review of Resident #2's June 27, 2025 care plan reflected interventions addressing safety, mood, and behavior. The care plan noted Resident #2 preferred to eat in her room and had minimal peer interaction. No history of aggressive behaviors was documented. Record review of progress notes dated 06/26/25 relevant to the incident were reviewed. The progress notes reflected that Resident #2 was involved in an altercation with another resident. Resident #2 was assessed both physically and emotionally afterward. The progress notes reflect that first aid was administered, a skin assessment and pain assessment were completed, and that Resident #2 received support following the incident. The progress notes reflected appropriate post-incident procedures were followed, but did not include an in-depth description of the resident's behavior or emotional state beyond confirming that interventions were provided. Record review of Resident #2's progress notes 06/26/25 reflected law enforcement was dispatched to the facility following the altercation. Resident #2 initially requested to be sent to the hospital when officers arrived but later refused treatment upon ambulance arrival, and stated she felt fine. A small laceration approximately 2 cm in length was noted on her forehead. The wound did not require stitches or advanced intervention. Record review treatment orders for Resident #2's forehead laceration were discontinued on , 07/08/25 which indicated the wound had resolve. Record review of documentation by social services dated 06/27/25 reflected Resident #2 was alert, oriented, and stated she was feeling better. She accepted supportive counseling and was encouraged to avoid contact with Resident #1 and to report any further concerns