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	12/12/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, easy to use, clean and comfortable environment for 4 of 10 resident rooms on the 100 - hall (Resident rooms #1, #2, #3, and #4). The facility failed to ensure Resident rooms #1, #2, #3, and #4, were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.Findings include: An observation on 9/23/25 at 8:26 AM of resident room [ROOM NUMBER] reflected trash on the floor and white milk spilled on the floor, near the resident's bed. An observation on 9/23/25 at 8:27 AM of resident room [ROOM NUMBER] reflected large patches of brown and black stains on the floor, under the resident's bed. An observation on 9/23/25 at 8:28 AM of resident room [ROOM NUMBER] reflected large brownish stains on the floor, under the resident's bed. An observation on 9/23/25 at 8:28 AM of resident room [ROOM NUMBER] reflected large brownish dirt stains on the floor, under the resident's bed. Near the resident's bed was a large reddish fluid stain. The bedside table in the room was heavily stained on the bottom portion of the frame. In an interview on 09/23/25 at 01:38 PM, the Housekeeping Assistant Supervisor stated she had been at the facility for 7 seven years. She stated she cleaned the rooms on the 100-hall daily. She stated she cleaned the entire room, which included the bathrooms, under the beds, floors, and bedside tables. She stated she had not been at the facility for two days and someone else was responsible for cleaning the rooms. She stated all the concerns observed in Resident #1, #2, #3, and #4 rooms should have been cleaned. She stated the resident's family could have seen the dirty rooms and someone could have fallen from the spilled milk. In an interview on 09/23/25 at 01:49 PM, the Housekeeping Supervisor stated he had been at the facility for 20 years. He stated staff was to clean the entire rooms. He was advised and shown pictures of Resident room [ROOM NUMBER], #2, #3, and #4. He stated his cleaning staff was responsible for cleaning the areas observed. He stated the areas were unsanitary and not a good living environment for the residents. He stated he was responsible for checking to ensure the rooms were thoroughly cleaned but had not been checking them like he should have. In an interview on 09/23/25 at 2:16 PM, the Administrator was advised and shown pictures of concerns observed in Resident room [ROOM NUMBER], #2, #3, and #4. He stated he expected his housekeeping staff to thoroughly clean the resident rooms daily. He stated it was a sanitary and resident rights concern. Record review of the facility's policy on For Housekeeping Cleaning & Disinfecting, 2021, reflected In a quality program, its essential for all employees doing the same type of work to perform procedures in the same manner. To keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each resident is being watched and has assistance devices, when needed, to prevent accidents for six of nine residents (Resident #4, #5, #6, #7, #8, and #9) reviewed for accident hazards. The facility failed to ensure Resident #4, #5, #6, #7, #8, and #9 were properly supervised while smoking in the smoking area of the facility. This failure could place the residents at risk of harm and serious injuries. Findings include: 1 Record review of Resident #4's Face Sheet, dated 09/23/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Asthma (inflamed airways) and COPD (lung disease). Record review of Resident #4's Quarterly MDS assessment, dated 8/22/25, reflected she had a BIMS score of 15 (intact cognitive response). For active diagnosis it reflected a stroke. Record review of Resident #4's Comprehensive Care Plan, dated 9/23/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #4's Smoking assessment, dated 8/18/25, reflected the resident required supervision while smoking. 2. Record review of Resident #5's Face Sheet, dated 09/23/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included stroke syndrome (neurological disorder) and lack of coordination. Record review of Resident #5's Quarterly MDS assessment, dated 6/25/25, reflected she had a BIMS score of 9 (moderate cognitive impairment). For active diagnosis it reflected contracted hand (tightening of tendons). Record review of Resident #5's Comprehensive Care Plan, dated 9/05/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #5's Smoking assessment, dated 9/15/25, reflected the resident required supervision while smoking. 3. Record review of Resident #6's Face Sheet, dated 09/23/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination. Record review of Resident #6's Quarterly MDS assessment, dated 9/05/25, reflected she had a BIMS score of 1 (severe cognitive impairment). For active diagnosis it reflected a stroke. Record review of Resident #6's Comprehensive Care Plan, dated 9/05/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #6's Smoking assessment, dated 8/23/25, reflected the resident required supervision while smoking. 4. Record review of Resident #7's Face Sheet, dated 09/23/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and COPD (lung disease). Record review of Resident #7's Quarterly MDS assessment, dated 9/01/25, reflected he had a BIMS score of 11 (moderate cognitive impairment). For active diagnosis it reflected COPD and tremors. Record review of Resident #7's Comprehensive Care Plan, dated 9/23/25, reflected the resident was a smoker, and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #7's Smoking assessment, reflected the resident did not have a smoking assessment completed. 5. Record review of Resident #8's Face Sheet, dated 09/23/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included schizoaffective disorder (mood disorder) and lack of coordination. Record review of Resident #8's Quarterly MDS assessment, dated 7/01/25, reflected she had a BIMS score of 10 (moderate cognitive impairment). For active diagnosis it reflected schizophrenia and muscle weakness. Record review of Resident #8's Comprehensive Care Plan, dated 8/22/25, reflected the resident was a smoker and an intervention was for the resident to be supervised while smoking for safety. Record review of Resident #8's Smoking assessment, dated 8/23/25, reflected the resident required supervision while smoking. 6. Record review of Resident #9's Face Sheet, dated 09/11/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included stroke syndrome and lack of coordination. Record review of Resident #9's Quarterly MDS assessment, dated 8/15/25, reflected he had a BIMS score of 6 (severe cognitive impairment). For active diagnosis it reflected lack of coordination. Record review of Resident #9's Comprehensive Care Plan, dated 9/05/25, reflected no care plan for the resident being a smoker. Record review of Resident #9's Smoking assessment, reflected the resident did not have a smoking assessment completed. In an observation on 09/23/25 from 9:30 AM to 9:35 AM, Resident #4, #5, #6, #7, #8, and #9 were observed outside smoking in the smoking area. CNA G was observed sitting down and looking down at her phone and not observing the residents. In an interview on 09/23/25 at 10:52 AM, CNA G, stated she was responsible for monitoring Resident #4, #5, #6, #7, #8, and #9 when they were

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for one of three residents (Resident #2) reviewed for respiratory care. The facility failed to ensure Resident #2's nasal canula was properly stored in a bag when not in use on 09/23/25. This failure could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings include: Record review of Resident #2's Face Sheet, dated 09/23/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Chronic Respiratory Failure (lack of oxygen) and Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #2's Quarterly MDS assessment, dated 8/08/25, reflected he had a BIMS score of 15 (intact cognitive response). For ADL care, it reflected the resident required total assistance and it reflected an active diagnosis of cardiorespiratory failure and COPD. Record review of Resident #2's Comprehensive Care Plan, dated 9/05/25, reflected the resident requiring oxygen therapy and one of the interventions was to provide oxygen therapy through a moveable oxygen apparatus. Record Review of Resident #2's Physician Orders, dated 9/23/25, reflected Oxygen LPM 2-5 Via nasal canula In an observation on 09/23/25 at 08:29 AM, Resident #2 was not seen in his room. The resident had an oxygen tank connected to his wheelchair and his nasal canula was observed under a pile of clothes on his wheelchair. In an interview on 09/23/25 at 11:23 AM, LVN S was advised of Resident #2 not having his nasal canula bagged on his oxygen device attached to his wheelchair. She stated the resident usually removes the bag off his nasal canula. She was advised to observe the nasal canula on top of his wheelchair, under a pile of clothes. She started her shift at 6:00 AM but did not check to ensure the nasal canula was bagged when she checked on him this morning. She stated CNAs were responsible for checking to ensure the nasal cannulas were bagged. She stated it could cause an infection if the nasal canula was not bagged when not in use. In an interview on 09/23/25 at 1:16 PM, the DON was advised of Resident #2 nasal canula being observed on top of his wheelchair, under a pile of clothes, and unbagged. She stated nasal cannulas should be bagged when not in use to avoid transmission of germs. She stated primarily the nurses check for this when they make their rounds. Review of the facility's policy Oxygen Administration, 02/07/21, reflected Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed or concentrator. All sources require humidification to prevent drying of mucous membranes and thickening of respiratory secretions if used routinely. Goals 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. 2. The residents will maintain an effective breathing pattern with administration of oxygen. 3. The resident will be free from infection.

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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, interview and record review the facility failed to ensure the call system was accessible to residents while in their bed or other sleeping accommodations within the resident's room for two of five residents (Resident #1, and #3) reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Resident #1, and #3's room was in a position that was accessible to the residents on 09/23/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: 1. Record review of Resident #1's Face Sheet, dated 09/23/25, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included stroke and lack of coordination. Record review of Resident #1's Quarterly MDS assessment, dated 9/05/25, reflected he had a BIMS score of 9 (moderate cognitive impairment). For ADL care, it reflected the resident required total assistance. Record review of Resident #1's Comprehensive Care Plan, dated 9/05/2025, reflected no care plan involving the resident's use of the call light. In an observation and interview on 09/23/25 at 08:25 AM Resident #1 was observed lying in bed. His call light pull cord was hanging from the wall behind him and out of reach. He was asked if he could reach his call light and he stated he did not know where it was at. 2. Record review of Resident #3's Face Sheet, dated 09/23/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 8/21/25, reflected he had a BIMS score of 12 (moderate cognitive impairment). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #3's Comprehensive Care Plan, dated 09/05/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 09/23/25 at 8:31 AM, Resident #3 was observed lying in bed and his call light was located approximately 3 feet away from his bed, out of reach from the resident. In an observation and interview on 09/23/25 at 08:35 AM Resident #3 was observed lying in bed. His call light pull cord was hanging from the wall behind him and out of reach. He was asked if he could reach his call light and he stated he did not know where it was and asked the surveyor to pull it for him because he needed assistance. In an interview on 09/23/25 at 8:35 AM, LVN C was advised of the call lights for Resident #1 and Resident #3 not being within reach of the residents. She stated staff checked the resident rooms at least every 2 hours to ensure call lights were within reach of the resident. She stated if the resident's call light were not within reach, they could not contact anyone if they needed help. She stated Resident #1 and Resident #3 were fall risk. In an interview on 09/23/25 at 11:06 AM, LVN P stated she had been at the facility for 15 years. She stated call lights should be close to the residents, and within their reach so they could call for assistance when they need it. She was shown pictures of the call light pull cord for Resident #1 and Resident #3 and where the cords were positioned. She stated it was the responsibility of all staff to ensure the call light was within the resident's reach. She stated they did have clips on them to ensure they stayed in place, but sometimes the clips fall off. In an interview on 09/23/25 at 11:23 AM, LVN S stated she had been at the facility since May 2025. She stated call lights should generally be within reach of the residents so they could notify staff if they need something. She stated they checked for this at least two times during her shift. She stated the call lights had a clip on them, but it may have fallen off. She was shown pictures of the call light pull cord for Resident #1 and Resident #3 and where the cords were positioned. She stated staff may have moved the call light when they brought in the residents' breakfast. She stated the risk of the call light not being within reach would be the resident would not be able to notify anyone if anything happened. In an interview on 09/23/25 at 11:51 AM, CNA L stated the call lights were to be clipped to the resident's bed and within reach. She was advised of Resident #1 and Resident #3 call light not being within reach. She stated she normally checked for this at the start of the shift, but it slipped her mind this morning. She stated the residents would not be able to contact anyone if they were in distress if the call lights were not within reach. In an interview on 09/23/25 at 1:16 PM, the DON was shown pictures of the call light pull cord for Resident #1 and Resident #3 and where the cords were positioned. She stated her expectation was for call lights to be in the resident's reach. She stated staff should check to ensure that they observe for call lights being within reach of the residents when making their rounds. She stated they need the call light within reach in case they need anything. Record review of the facility's policy on Resident Rights (11/28/16), revealed The resident has a right to a dignified existence