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	02/21/2026

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 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 review, the facility failed to 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 2 of 2 Residents (Resident #1, and Resident #2) observed for infection control. 1.The facility failed to ensure CNA D and RN A utilized Enhanced Barrier Precautions and performed hand hygiene during wound care for Resident #1 on 02/21/26. 2. The facility failed to ensure RN A handled Resident #1's wound care supplies appropriately to prevent cross contamination during wound care on 02/21/26. 3.The facility failed to ensure LVN B performed hand hygiene during wound care for Resident # 2 and failed to prevent cross contamination of wound care supplies on 02/21/26. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record Review of Resident #1's Face Sheet dated 02/21/26 reflected a [AGE] year-old male with an admission date of 11/11/25. His diagnoses included quadriplegic (partial or total loss of sensation and motor function in all four limbs) and protein malnutrition (deficiency resulting in inadequate intake of protein/and or calories leading to weight loss and muscle wasting). Record review of Resident #1's care plan initiated on 11/13/2 reflected, [Resident #1] is on Enhanced Barrier Precautions.Interventions included. Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care.high-contact activity. Posting at the residents room entrance indicating the resident is on enhanced barrier precautions. In an interview and observation on 02/21/26 at 8:25 a.m. with Resident #1 in his room, resident was observed on a low air loss mattress and pressure relieving boots on both feet. Resident #1 stated he had been in the facility before and had moved closer to his family to another facility but stated it was terrible and came back here November 2025. He stated the wound care doctor comes to see him once a week. He stated they had his wounds closed up but they had opened back up. He stated he had requested his wound care be done only three times a week on Monday, Wednesday, and Friday. He stated he did decline wound yesterday (02/202/26) and stated he would let the nurse do his wound care today. An observation on 02/21/2026 at 8:55 a.m. revealed RN A outside of Resident #1's room preparing his wound care supplies. An EBP sign was posted on the door. RN A pulled several packages of boarder dressings, stack of 4x4 gauze, syringes of normal saline, squeezed some hydrogel into a medication cup and poured collagen powder in another medication cup. RN A and CNA D entered the room and RN A placed the wound care supplies on the resident's bedside without cleaning the table or placing the supplies on a barrier. Both staff then washed their hands and put on gloves, but no gowns. RN A removed the old dressing from Resident #1's left inner knee and discarded the dressing. With the same gloves she picked up a syringe of normal saline and picked up a few 4xr4's from the stack and cleaned with wound. RN A then took her gloved finger and dipped it into the cup containing the hydrogel and rubbed it onto the wound with her finger and did the same with the collagen powder and then covered the wound with a boarder dressing. RN A then removed her gloves and put on clean gloves without performing hand hygiene and removed the outer dressing from the resident's right outer ankle and picked up a syringe of a saline to (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before entering a resident's room and before leaving a resident's room. She stated all residents who were in Enhanced Barrier Precautions had signs posted on their doors and the staff was expected to follow those protocols. She stated they train and do in-services constantly on infection control. She stated that failing to follow those protocol places residents at a higher risk of infections. She stated annual skills checks on the nurse's which included wound care. She stated they were to set up their supplies on a clean field and most definitely were not to apply any wound treatment with their gloved hand. She stated the staff was only to carry in the supplies they needed and anything not used needed to be discarded. She stated she would discard the tube of hydrogel, gauze, and dressing that was brought out of Resident #2's room. She stated they had a treatment nurse during the week but stated the weekend nurses were to be doing the wound care on the weekends. She stated she would be doing skills checks and re-education with the nurses. She stated she and her ADON do spot checks with nurses on their skills. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated on April 2024, reflected, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities.Wounds generally include chronic wounds.pressure ulcers.unhealed surgical wounds.venous stasis ulcers. Record review of the facility undated policy titled, Fundamentals of infection control, reflected, .Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene.When hands are visibly soiled.before and after direct contact resident contact.Before and after isolation precautions.Before and after changing a dressing.after removing gloves. Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.