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	04/02/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systemically organized in accordance with accepted professional standards for 2 of 3 residents (Residents #1 and #2) reviewed for clinical records regarding wound care.1. The facility failed to ensure nursing staff documented that physician ordered wound care was provided to Resident #1 for a skin tear on her left buttocks on 03/06/26, 03/07/26, 03/08/26, 03/14/26, and 03/15/26 and for a post-surgical wound on her abdomen on 03/06/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/20/26, 03/21/26, 03/28/26 and 03/30/26. 2. The facility failed to ensure nursing staff documented that physician ordered wound care was provided to Resident #2 on 03/10/26, 03/20/26, 03/27/26, 03/28/26, 03/29/26. This failure could place residents at risk for incomplete and inaccurately documented medical records that included their progress treatment, services, and interventions. Findings included: 1.Record review of Resident #1's Comprehensive MDS dated [DATE] reflected that the resident was a [AGE] year-old female who was admitted on [DATE]. Her diagnoses included unspecified intestinal obstruction, unspecified as to partial versus complete obstruction (a partial or complete blockage of the small or large intestine that prevents food, fluids, and gas from moving through the digestive tract). The resident #1's BIMS score was 15, indicating her cognition was intact. The MDS reflected that the resident had recent surgery requiring active Skilled Nursing Facility Care and was at risk of developing pressure ulcers/injuries.Record review of Resident #1's care plan dated 02/20/26 reflected the following:* resident had the potential for pressure ulcers (injuries to the skin and underlying tissue caused by prolonged pressure on the skin) development related to decreased mobility and urinary incontinence. Resident #1 had a wound on her sacral area (the triangular bone at the base of the spine). The care plan interventions included following the facility policies and protocols for the prevention and treatment of skin breakdown. * Resident #1 had post-surgical site to abdomen. Goal: - Resident #1 surgical sites will show signs of improving and remain free from signs and symptoms of infection with treatment as ordered over the next 90 days. Interventions Observed for sign and symptoms of pain during treatment and medicate as needed per physician orders.Record review of Resident #1's physician orders for dated 02/27/2026 reflected the following: skin tear of the left buttock: cleanse wound with normal saline/woundCleanser [an isotonic solution that does not interfere with normal wound repair], pat dry with gauze, apply hydrogel w/silver [an antimicrobial silver compound], cover with bordered gauze [an absorptive dressing consisting of three layers: a low-adherent layer protects the wound surface, an absorbent gauze layer absorbs exudate, and a non-woven adhesive tape holds the dressing in place and maintains a moist wound environment]. Daily and as needed .post-surgical wound of the abdomen: cleanse with normal saline/wound cleanser, pat dry with gauze, apply xeroform [a medicated gauze dressing that keeps the wound moist and helps prevent infection] to wound bed, cover with bordered gauze. Daily and as needed. Record review of Resident #1's March 2026 Wound Administration Record reflected that:- there was no documentation showing that the resident was provided with wound care for the skin tear on her (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left buttocks on 03/06/26, 03/07/26, 03/08/26, 03/14/26, and 03/15/26; and - there was no documentation showing that the resident was provided with wound care for the post-surgical wound on her abdomen on 03/06/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/20/26, 03/21/26, 03/28/26 and 03/30/26.Record review of Resident 1's wound care report by the Wound Care Physician for March 2026 reflected the resident was being seen and treated weekly and there was no evidence the wound deteriorated and all wounds were healed.Interview with resident#1 on 04/02/26 at 9:25AM revealed she was receiving wound care, and she stated all the wounds are healed. She denied skin assessment.During an interview on 04/02/26 at 1:35 PM, the Wound Care Nurse revealed she was responsible for Resident #1's wound care Tuesday through Thursday and on the other days, it was done by the charge nurses. The Wound Care Nurse said she was not aware Resident #1's wound care treatment record was being left blank on (03/06/26, 03/07/26, 03/08/26, 03/20/26,03/21/26, 03/28/26 and 03/30/26). She said when she reported on Tuesdays for wound care the dressing were dated with a previous day date and wounds were not getting worse. She stated it would be unknown if the resident had been provided with the wound care or if the charge nurse failed to document the wound care. She stated the wound care report not being completed would indicate the wound care was not done and it would put the wound at risk of becoming infected and taking longer to heal. During an interview on 04/02/26 at 3:05 PM with LVN K, she stated she provided wound care to Resident #1 on the weekends. LVN K said if there were dates that were blank (03/06/26, 03/07/26, 03/08/26, 03/20/26, 03/21/26, and 03/28/26) that probably meant she performed the resident wound care, but she probably forgot to check the box. She stated there were some weekends she performed wound care, and she did not know where to document it. She stated later she was notified to document the wound care on the residents' wound care treatment records. She said she did not go back and document the care she forgot to document, and she did not notify the DON. She stated failure to document care could affect wound management and healing. Attempts to contact LVN F via phone on 04/02/26 at 3:50PM who worked with Resident #1 was unsuccessful. 2. Record review of Resident #2's quarterly MDS assessment, dated 02/06/26, reflected that the resident was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included paraplegia (partial or complete paralysis of the lower half of the body), chronic pain syndrome, muscle weakness, and orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down). Resident #2's BIMS score was 12 which indicated moderate cognitive impairment. The MDS further reflected that Resident #2 had other open lesions on the foot and skin tears. Record review of Resident #2's care plan, revised 02/27/26, reflected * Focus: [Resident #2] has a non- pressure wound to the left ankle. Non pressure wound to left ankle: cleanse with normal saline, pat dry with gauze, apply betadine to the area, [leave open to air] QD and PRN. Goal: [Resident #2] will be free from non-pressure wound to the left ankle through the review date. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. Use lotion on dry scaly skin. * Focus: [Resident #2] has a non- pressure wound to the right ankle. Trauma Injury to right ankle cleanse area with normal saline/wound cleanser, pat dry with gauze, apply collagen powder, secondary dressing: continue gauze island dressing with bdr [an absorbent pad surrounded by a sticky frame]. Record review of Resident #2's physician orders, dated 03/04/25, reflected the following orders: * Non-Pressure trauma injury to right lateral shin: cleanse area with normal saline/wound cleanser, pat dry with gauze, apply collagen powder to wound bed, cover with non-adherent pad, secure with bordered gause QD and PRN one time a day for wound care.* Trauma injury to right ankle: cleanse area with normal saline/wound cleanser, pat dry with gauze, apply collagen powder; cover with bordered gauze one time a day for wound care if saturated, soiled or dislodged.Record review of Resident #2's physician orders, dated 03/18/25, reflected the following orders:* Skin tear wound to right lateral foot: cleanse area with normal saline/wound cleanser, pat dry with gauze, apply collagen powder and cover with gauze island w/bdr; once daily and as needed: if saturated, soiled or dislodged one time a day. * Non pressure wound injury to right (continued on next page)

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