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	05/06/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident was free from abuse, neglect and corporal punishment of any type by anyone one of four residents (Resident #1) reviewed for abuse. PTA M reported and observed Resident #2 hitting Resident #1 while in the smoking area on 04/09/26. This failure could place residents at risk of sustaining serious harm and not being free from abuse.Findings included:Record review of Resident #1's Face Sheet, dated 05/06/26, reflected a [AGE] year-old female admitted [DATE]. Resident #1 had a diagnosis of COPD (obstructed airflow).Record review of Resident #1's Quarterly MDS Assessment, dated 03/20/26, reflected BIMS score of 12 indicating moderate cognitive impairment. The MDS assessment reflected the resident had active diagnoses of COPD and bi-polar.Record review of Resident #2's Face Sheet, dated 05/07/26, reflected a [AGE] year-old male admitted [DATE]. Resident #2 had a diagnosis of schizophrenia (severe brain disorder).Record review of Resident #2's Quarterly MDS Assessment, dated 03/01/26, reflected a BIMS score of 4, indicating severe cognitive impairment. The MDS assessment reflected the resident had an active diagnoses of schizophrenia. Record review of the facility's incident logs on 05/06/26 for the past four months reflected no incidents between the two residents. During an interview on 05/06/25 at 10:35 a.m., Resident #2 stated he was trying to get to a wedding today. He stated he did not know if he was involved in an incident with another resident. Resident #2 did not respond when asked if he hit another resident. During an interview on 05/06/25 at 10:50 a.m., Resident #1 stated she felt safe at the facility. She stated Resident #2 was talking trash to her and she told him to do something and Resident #2 punched her in the heart twice. She stated it did not bruise her, but it did hurt at the time. She stated there was no other incident since then. She stated she had a pacemaker, but records and DON confirmed she did not have one. She stated the Physical Therapist was present during the incident and separated them. During an interview on 05/06/25 at 12:15 p.m., the DON stated she was notified by PT M that Resident #2 hit Resident #1 twice in the chest area. She stated she immediately assessed Resident #2 at the time of the incident. She stated she completed a head-to-toe assessment, and she observed no marks or bruises. She stated the incident was observed by PT M. She stated they placed Resident #2 on 1:1 monitoring, completed a urinalysis test to check for any infections, and contacted psych services. She stated the resident had a history of being aggressive with staff and this was the first time he was aggressive with another resident. During an interview on 05/06/25 at 12:30 p.m., PTA M stated he was supervising residents in the smoking area and witnessed the incident between Resident 1 and #2. He stated Resident #2 stated Resident #1 had bumped his foot. He stated they started arguing and Resident #2 struck Resident #1 in the chest when he was sitting in his wheelchair and then Resident #2 stood up and struck her again in the chest. He stated Resident #2 struck Resident #1 quite hard. He stated he separated the residents. He stated he was not sure if the resident had a history of hitting other residents. He stated he notified the Administrator and DON, and they arrived within minutes. During an interview on 05/06/26 at 12:45 p.m., the Administrator stated he was informed by staff of Resident #2 striking Resident #1. He stated Resident #2 was placed on 1:1 monitoring, he was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	referred to psychiatric services, and they completed a urinalysis test to check for an infection, but it was negative. He stated the resident sees a therapist from Psych services weekly to address his behaviors. He stated he completed a safe survey with all residents in the facility and there were no concerns. He stated he in-serviced the staff on reporting abuse and neglect on 04/09/26.Record review of the facility's policy titled, Abuse and Neglect, dated 3/29/18, revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.Definitions1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.