

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Fair Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #19, Resident #22) of 8 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #19 had her fingernails cleaned and trimmed. 2- Resident #22 had his fingernails cleaned and trimmed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1. Record review of Resident #19's Quarterly MDS assessment dated [DATE] reflected Resident #19 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses included hemiplegia (paralysis of one side of the body) affecting left side, lack of coordination, and contracture of the left elbow. Resident #19 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #19 required maximal assistance with dressing and personal hygiene. Record review of Resident #19's Comprehensive Care Plan, revised 11/02/22, reflected the following: Focus: Resident #19 had an ADL self-care performance deficit related to contractures and hemiplegia. Goal: Resident #19 will improve current level of function through the review date. Intervention: . personal hygiene/oral care - Extensive assistance . In an observation and interview on 04/03/24 at 10:03 AM revealed Resident #19 was sitting in her wheelchair. The nails on the right hand were approximately 0.2cm in length extending from the tip of her fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #19 stated she did not like her fingernails dirty. She stated sometime CNAs clean her nails, but she did not remember when was the last time they were cleaned. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #22's Quarterly MDS assessment, dated 03/17/24, reflected Resident #22 was a [AGE] year-old male admitted to the facility on [DATE] with readmitted [DATE]. Diagnoses included hemiplegia (paralysis of one side of the body), lack of coordination, and type 2 diabetes mellitus. Resident #22 had a BIMS score of 9, which indicated her cognition was moderately impaired. Resident #22 required maximal assistance with dressing, and personal hygiene. Record review of Resident #22's Comprehensive Care Plan initiated 05/05/21, reflected the following: Focus: [Resident #22] has an ADL self-care performance deficit. Goal: [Resident #22 will maintain current level of function in ADLs Interventions: Personal hygiene - support provided one person physical assist . In an observation and interview on 04/03/24 at 10:14 AM revealed Resident #22 was sitting in the wheelchair in his room. The nails on the right hand were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored yellow, and the underside had dark brown colored residue. Resident #22 stated he could not do his nails himself and he did not tell anybody about it. In an interview on 04/03/24 at 10:45 AM, CNA D stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA D stated he did not get to do the nail care for residents yet. He stated he would do it right then. In an Interview on 04/04/24 at 11:41 AM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated residents having long and dirty could be an infection control issue.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one (Residents #25) of one resident reviewed for feeding tubes in that: LVN B failed to check placement of Resident #25's G-Tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) by checking for gastric residual (quantity remaining) prior to administering the resident medications. This failure could affect residents by placing them at risk of obstruction of the G-tube, nausea, vomiting and potential for aspiration and discomfort. Findings included: Record review of Resident #25's Quarterly MDS assessment, dated 04/03/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including dysphagia (swallowing difficulties), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and diabetes mellitus. The assessment reflected BIMS was not assessed. Resident #25 received 51% or more of total calories through tube feeding (G-tube - tube inserted through the abdomen that delivers nutrition directly to the stomach.). Record review of Resident #25's Care Plan, initiated on 01/11/24, reflected, . The resident requires tube feeding .Goal .The resident will remain free of side effects or complications related to tube feeding . Interventions .Check for tube placement and gastric contents/residual volume per facility protocol and record. Record review of Resident #25's Physicians Order Report dated 04/05/24 reflected, .Enteral Feed Order every shift related to Gastrostomy Status Check residual before medications and feedings: return contents after each check (hold feeding residual greater than 100 ml and notify MD/NP . with a start date of 01/29/24. Record review of Resident #25's MAR for March 2024 reflected, .Enteral Feed Order every shift Check residual before medications and feedings: return contents after each check . An observation on 03/03/24 at 12:00 PM revealed LVN B at the medication cart pulling the following medication for G-tube administration and for Resident #25: Acetaminophen 500 mg tablet (for pain) (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN B donned gloves and placed the tablet into a plastic sleeve and crushed it and placed the medication into a plastic cup. LVN B gathered a plastic water cup filled with warm water and entered the resident's room. LVN B poured approximately 10 to 15 ml of water into the pill cup and placed the continuous feeding pump on hold. LVN B retrieved a 60-ml piston syringe and drew back to approximately 30 ml of air, disconnected the G-tube line from the feeding pump and placed the syringe onto the end of the g-tube and pushed the 30 ml of air into the resident's stomach and listened with his stethoscope. LVN B then removed the plunger from the piston syringe and flushed the G-tube with approximately 30ml of water he administered the medication. LVN B flushed the G-tube with approximately 30 ml after the medication. In an interview with LVN B on 04/03/24 at 12:15 PM he revealed he checked placement of Resident #25's feeding tube by using air auscultation. He stated he inserted at least 30 cc of air and listened to determine the G-tube was in place. LVN B stated he should have checked for residual but failed to do that. When asked how much residual the resident had to have before he would hold medications, he stated 60 to 100 ml. He stated he failed to check the orders for the residual check before administering the medication to Resident #25. Review of LVN B's in-service records dated 12/13/23 reflected he had been in serviced on Administering medications through an enteral feeding tube. In an interview with the DON on 04/04/24 at 11:41 AM, she stated the staff were always to check the placement of the G-Tube prior to medication administration by checking for gastric residual. She stated any resident who had 60 ml or more of gastric residual would require them to hold the medication and notify the physician for further instructions. She stated she would re-educate the staff to ensure they were following the proper standard of care. Review of the facility's policy, Enteral Medication Administration, revised 01/25/13, reflected, .Check the placement of feeding tube by aspiration of contents or auscultation .		

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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** 48560 Based on observation, interview and record review the facility failed to ensure that a Resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 (Resident #23) reviewed for respiratory care, in that: The facility failed to ensure Resident #23 Oxygen humidity bottle were labeled or dated. These failures could place the resident at risk for respiratory infection and not having their respiratory needs met. The findings were: Review of Resident # 23s Quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female readmitted to the facility on [DATE]. Relevant diagnoses include Chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing- related problems), Congestive heart failure (compromised blood supply from heart to meet body's needs), Hyperlipidemia (high blood lipid level), Schizophrenia (severe mental disorder) and was on oxygen therapy in the facility. Review of Resident #23's care plan dated 9/6/2022 reflected Resident #23 has Oxygen Therapy related to Congestive heart failure and one of the interventions included OXYGEN SETTINGS: Oxygen as needed via Nasal cannula between 2-5 Liter per minute to maintain oxygen saturation more than 90%. Review of Resident #23's Physician order dated 2/16/2024 Oxygen via Nasal cannula between 2-5 Liter per minute to maintain oxygen saturation more than 90% every shift. Review of Resident #23's Physician order dated 6/6/2022 Change Oxygen tubing/water every week on SUNDAY and as needed every night shift every Sunday for Oxygen Usage. Observation on 04/03/24 at 10:46 AM revealed that Resident #23 was not in the room. Oxygen concentrator was running and there was no date or label on oxygen humidifier bottle. In an interview with LVN B on 04/03/24 at 11:06 AM revealed that Resident #23 was on continuous oxygen , however resident was noncompliant with physician orders and often took off oxygen when she went on smoke breaks. He stated that Nurses were responsible for changing and dating humidifier bottle and was done on weekly basis. He stated if Oxygen supplies were not dated , it could lead to risk of infection to the residents. LVN B confirmed there was no date or label on the humidifier bottle and stated that he will change the humidifier bottle. In an interview with the DON on 4/4/24 12:54 PM, it was revealed that her expectation was that all oxygen equipment be dated and labeled. she stated that Nighttime nursing staff was responsible for changing and dating oxygen supplies every Sunday every week. The DON stated risk to residents for not changing Oxygen supplies was lapses in infection control. The DON added that she checked on nursing practices at least weekly in the facility. She also stated that facility did not have specific policy for labeling Oxygen equipment and was a part of nursing routine care. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Facility Oxygen administration policy , revised March 21, 2023, reflected . Goals. 3. Resident will be free from infection .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed to ensure refrigerator items were dated and labeled. 2. The facility failed to ensure ice scoop was left outside of ice bin. 3. The facility failed to ensure Cook A performed hand hygiene during lunch meal service on 4/4/24. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed, and food contamination. Findings included: Observation in the kitchen on 04/03/24 at 9:43 AM revealed a box of celery in the walk-in refrigerator that was not dated and labeled. Observation in the kitchen on 04/03/24 at 9:50 AM revealed a box of tomatoes in reach-in refrigerator that was not dated and labeled. Observation on 04/03/24 at 09:52 AM revealed that ice scoop was left inside the ice bin touching the ice cubes within the ice machine. Observation of lunch meal service on 4/4/24 at 11:30 AM revealed that Cook A was serving food to residents in the kitchen. Cook A went to the walk-in refrigerator to get lettuce and, sliced tomatoes to put on the hamburger. Cook A came out of the walk-in refrigerator and proceeded to assemble the hamburger without performing hand hygiene or changing her gloves. In an interview with Cook A on 4/4/24 at 11:46 AM revealed that she did not change her gloves or wash hands when she came out of the refrigerator. She stated that she realized she should have performed hand hygiene and changed gloves after coming out before proceeding to handle food. She stated she knew she needed to wash hands every time she goes in and out of tasks. She stated that risk of not changing gloves and washing hands was poor sanitation and risk of food borne illness. She also stated everyone in the kitchen , including herself , were responsible for dating and labeling items in the kitchen . She stated it was important to date all food items in the kitchen; so that older items can be used first and decrease the risk of any food borne illness. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietary manager on 4/4/24 at 11:51 AM revealed that celery and tomato had arrived on 4/1/24 and the kitchen workers may have forgotten to date and label them. She stated that it was important to date and label all items in the kitchen to prevent food borne illness. She stated the ice machine was new and had a place to keep the spoon inside the ice bin. She stated that she knew that scoops should always be placed outside the ice bin and had corrected it at the time of this interview. She stated that it was an expectation to perform hand hygiene after every task in the kitchen and especially while handling food items. She stated that not performing adequate hand hygiene can increase the risk of food borne illness for residents. Record Review of the Facility's Food Storage and supplies policy, undated, reflected all facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety Review of FDA food code dated 2022 reflected 3-304.12 In-Use Utensils, Between-Use Storage 43. In-use utensils; properly stored Based on the type of operation, there are a number of methods available for storage of in-use utensils during pauses in food preparation or dispensing, such as in the food, clean and protected, or under running water to prevent bacterial growth. If stored in a container of water, the water temperature must be at least 135 F. In-use utensils may not be stored in chemical sanitizer or ice between uses. Ice scoops may be stored handles up in an ice bin except for an ice machine .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 resident (Resident #10) of 8 observed for infection control. The facility failed to ensure RN C performed hand hygiene and changed gloves during wound care for Resident #10. This failure could place residents at risk for infection and cross contamination. Findings include: Record review of resident #10's Quarterly MDS assessment, dated 03/20/24, reflected a [AGE] year-old male with an admitted [DATE] with diagnoses included peripheral vascular disease, chronic ulcer of unspecified part of left lower leg, and non-pressure chronic ulcer of other part of unspecified foot. Resident #10 had a BIMS of 12 which indicated Resident #10's cognition was moderately impaired. Resident #10 required moderate assistance of one-person physical assistance with dressing, and toileting hygiene. The resident was occasionally incontinent of urine bowel. Review of Resident #10's care plan, initiated on 02/04/24, reflected .[Resident #10] has venous stasis ulcers to the left lower leg and left dorsal foot .Interventions .Administer treatments to venous ulcers as ordered by MD . In an observation and interview of wound care on Resident #10 by RN C on 04/03/24 at 01:45 PM, revealed her at the treatment cart. RN C placed gauze, a pair of scissors, a calcium alginate dressing (a soft conformable, highly absorbent dressing), an abdominal pad, gauze roll, and a cohesive bandage in a clean disposable chuck. RN C entered the resident's room and placed the chuck of supplies onto the bed and then washed her hands and put on gloves. RN C removed the resident's left sock. She changed her gloves without any kind of hand hygiene. It revealed the dressing on Resident #10's left lower leg and foot with a date of 04/02/24. RN C removed the old dressing slowly since it had dried and was stuck to the wound bed of the venous ulcer located on dorsal left foot and on the left lower leg. RN C reached into the chuck and retrieved a container of normal saline and wet the old dressing to help facilitate the removal. Once the dressing was removed, the wound bed had some slough present with moderate drainage. RN C then removed her gloves and put on clean gloves without performing hand hygiene and again reached into the chuck of supplies and pulled out more vials of normal saline and gauze and cleaned the wound bed. With the same gloves on, she patted the wound bed dry with the gauze. With the same gloves on, she reached back into the chuck of supplies and retrieved the calcium alginate dressing and the abdominal pad. She covered the wound with the calcium alginate dressing and covered it with the abdominal pad. RN C then removed her gloves and put on clean gloves without performing hand hygiene and again reached into the chuck of supplies and retrieved the gauze roll and the cohesive bandage. She covered the abdominal pad with the gauze roll and then the cohesive bandage. RN C then dated the dressing with a date of 04/03/24. RN C then removed her gloves and washed her hands. (continued on next page)		

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