

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
NAME OF PROVIDER OR SUPPLIER Fair Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2815 Martin Luther King Jr Boulevard 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for four of eighteen residents (Residents #2, #19, #30, and #35) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident Residents #2, #19, #30, and #35's rooms were in a position that was accessible to the residents on 07/08/2026. 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 included: Resident #19 Record review of Resident 19's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body), hemiparesis (weakness on one side of the body), and history of falling. Record review of Resident #19's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 06/24/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS (screening tool used to assess cognitive status) score of 05. The Comprehensive MDS Assessment indicated the resident was dependent on staff for transfer, bed mobility, toileting, hygiene, shower, and dressing. Record review of Resident #19's Comprehensive Care Plan, dated 05/10/2026, reflected the resident had a history of having actual falls and interventions included be sure the resident's call light was within reach. During an observation and interview on 07/08/2026 at 9:08 a.m., Resident #19 was in his bed, awake. It was observed that his call light was hanging by the wall and was not within reach. It was also observed that there was a sign inside the room that indicated Call, don't fall. The resident stated his call light was nowhere to be found. Resident #35 Record review of Resident #35's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Resident diagnoses included muscle weakness, muscle wasting (loss of muscle leading to its shrinking and weakening), and repeated falls. Record review of Resident #35's Comprehensive MDS Assessment, dated 05/31/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was dependent on staff for transfer, bed mobility, toileting, hygiene, shower, and dressing. Record review of Resident #35's Comprehensive Care Plan, dated 05/10/2026, reflected the resident had an actual fall and one of the interventions was to be sure the resident's call light was within reach. During an observation on 07/08/2026 at 9:11 a.m., Resident #35 was on her bed with eyes closed. It was observed that her call light was hanging by the wall and was not within reach. During an interview on 07/08/2026 at 9:56 a.m., LVN A said he did not notice that the Resident #19 and Resident #35's call lights were not withing reach. He said staff should always make sure the call lights were with the residents before leaving the room so that they could call the staff if they needed anything. He said he would check if the call lights on his hall were with the (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during medical treatment and personal care and confidentiality of personal and medical records for five of twenty residents (Residents #2, #6, #12, #21, and #49) reviewed for privacy and confidentiality. 1.The facility failed to ensure Residents #12, #21, and #49's personal medical information was secured on 07/09/2026. 2.The facility failed to ensure LVN B closed the door or pulled the privacy curtain while checking Resident #2's blood sugar and administering his insulin on 07/09/2026. 3.The facility failed to ensure LVN B closed the door or pulled the privacy curtain while checking Resident #6's blood sugar on 07/09/2026. These failures could place the residents at risk of not having their personal privacy maintained while treatments were provided, which could result in the residents feeling uncomfortable during care, and having their personal and medical record exposed to unauthorized individuals.Findings included: 1.Record review of Resident #12's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The Face Sheet indicated the resident's primary payer. Record review of Resident #21's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The Face Sheet indicated the resident's primary payer. Record review of Resident #49's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The Face Sheet indicated the resident's primary payer. During an observation on 07/08/2026 at 9:07 a.m. revealed a piece of paper, titled Midnight Census Report, was on top of the ledge of the nurses' station. On the piece of paper were Residents #12, #21, and #49's names and their respective type of healthcare delivery system that coordinated and managed the healthcare services, the type of insurance plan where healthcare services were prepaid, the Medicare payment used, and the name of the insurance company that provided the health insurance. It was observed that the piece of paper was in plain view and there were no staff in the station. During an interview on 07/08/2026 at 9:56 a.m., LVN A said he did not notice that the paper had PHI on them. He said if he noticed it, he would flip it or secure it somewhere because the information on the paper was confidential. 2.Record review of Resident #2's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #2's Comprehensive MDS Assessment, dated 04/27/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin. Record review of Resident #2's Comprehensive Care Plan, dated 04/07/2026, reflected the resident had diabetes mellitus and the interventions included to check the blood sugar and administer insulin as ordered. Record review of Resident #2's Physician Order, dated 07/02/2026, reflected Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject subcutaneously (administer under the skin) before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (high blood sugar in the blood stream) . BEFORE MEALS NOTIFY FOR BLOOD SUGARS > 400. During an observation on 07/09/2026 at 10:37 a.m., LVN B prepared to check Resident #2's blood sugar. She sanitized her hands, put on a pair of gloves, and prepared her glucometer, test strips, alcohol wipes, and a push button safety lancet. She went inside the resident's room and positioned herself at the side of the resident, who was sitting in his wheelchair in front of his door, and checked the resident's blood sugar. She told the resident that he needed some insulin. She went back to her cart and prepared the resident's insulin. She then lifted the resident's shirt and administered the insulin to the resident's right upper abdomen. She did not (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	close the door while she was checking the resident's blood sugar and when she administered the resident's insulin. The treatment could be seen from the hallway. 3. Record review of Resident #6's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #6's Comprehensive MDS Assessment, dated 05/21/2026, reflected that the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin. Record review of Resident #6's Comprehensive Care Plan, dated 05/28/2026, reflected that the resident had diabetes mellitus and one of the interventions was to administer diabetes medication as ordered. Record review of Resident #6's Physician Order, dated 05/11/2026, reflected NovoLog Solution 100 UNIT/ML (Insulin Aspart) Inject subcutaneously threetimes a day for DIABETES. During an observation on 07/09/2026 at 11:15 a.m., LVN B prepared to check Resident #6's blood sugar. She sanitized her hands, put on a pair of gloves, and prepared her glucometer, test strips, alcohol wipes, and a push button safety lancet. She went inside the resident's room and positioned herself at the side of the resident, who was lying in her bed, and checked the resident's blood sugar. She told the resident that she did not need any insulin. She did not close the door while she was checking the resident's blood sugar, and the treatment could be seen from the hallway. During an interview on 07/09/2026 at 11:32 a.m., LVN B said she forgot to close the door when she checked Resident #2 and Resident #6's blood sugars and when she administered resident #2's insulin. She said the door should be closed, or the privacy curtain should have been pulled to provide privacy during treatment or care. She said the resident might get embarrassed that other people could see what their treatments were. She said it did not matter if the resident minded it or not, but the staff had the responsibility to provide privacy. During an interview on 07/10/2026 at 9:26 a.m., the ADON said staff should close the door or pull the privacy curtain when they were providing treatments to the residents. She said the staff needed to get used to providing privacy during treatment so that individuals that did not have anything to do with the residents' care would not see it. She said it did not matter if the residents minded or not, but the expectation was the staff should be sensible enough that if they were in the residents' position, they might want their door closed during treatment. She said the piece of paper had some personal medical information that was supposed to be confidential. She said the paper should not have been left unattended in the nurses' station or should have been flipped over. She said the expectation was that information that was confidential was secured, and residents were provided with privacy during treatment. She said she would coordinate with the DON to do an in-service about privacy and confidentiality. During an interview on 07/10/2026 at 9:47 a.m., the DON said the door should be closed every time the staff provided treatment to give privacy and prevent improper exposure of any body part. She said privacy should be given so others, like non-clinical personnel, visitors, and other residents, would not see the treatments being done. She said the door should be closed, or the privacy curtain pulled to avoid embarrassment and so that the residents would be more comfortable during treatment. She said the paper should have been turned over. She said she did not know why the census report was on the ledge of the nurses' station. She said the resident's insurance was PHI and could be a HIPAA (law protecting health information aimed to ensure confidentiality) violation. She said she would start an in-service about privacy and confidentiality as soon as the interview was over. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the piece of paper that had the resident's name, and their insurances should have been turned over or was placed in a folder because it could be a HIPAA violation. She said the staff must make sure that the residents were provided privacy when treatment was being done so they would be (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comfortable and would not be embarrassed. She said the expectation was for the staff to be mindful about providing privacy and securing confidential records. She said she would collaborate with the DON about the issue. She said they would in-service the staff about privacy and confidentiality and would monitor closely if the staff understood the in-service. Record review of the facility's policy Resident Rights undated, reflected Privacy and confidentiality . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . 1. Personal privacy includes . medical treatment . 3. The resident has a right to secure and confidential personal and medical records.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the residents' environment remained free of hazards as was possible for three of eight residents (Residents # 6, #38, #45) and two direct care staff (LVN A and WCN E) reviewed for accident hazard. 1.The facility failed to ensure there was no razor inside Resident #6's room on 07/08/2026. 2.The facility failed to ensure there was no cleaner disinfectant inside Resident #45's room on 07/08/2026. 3.The facility failed to ensure WCN E did not leave her scissors, unattended, inside Resident #38's room on 07/09/2026. 4.The facility failed to ensure there was no germicidal wipes on top of a cart parked in the hallway, unattended, on 07/08/2026. 5.The facility failed to ensure a container of germicidal wipes was not left at the nurse station unattended on 07/09/2026. These failures could place residents at risk of injuries and exposure to toxic chemicals.Findings included: 1.Record review of Resident #6's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #6's Comprehensive MDS Assessment, dated 05/21/2026, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident required substantial assistance for personal hygiene. Record review of Resident #6's Comprehensive Care Plan, dated 05/28/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to assist with personal hygiene as required: e.g. shaving. During an observation and interview on 07/08/2026 at 9:39 a.m. revealed Resident #6 was in her bed, awake. It was observed that an uncovered razor was at the resident's sink. The resident said she did not know who left the razor in her room but the staff would use it to shave the hairs on her chin. 2.Record review of Resident #45's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male, admitted [DATE]. The resident was diagnosed with depression and delusion (brain disorder of an individual who has delusional thoughts). Record review of Resident #45's Comprehensive MDS Assessment, dated 05/22/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was diagnosed with depression and delusion. Record review of Resident #45's Comprehensive Care Plan, dated 06/28/2026, reflected the resident had delirium and one of the interventions was to monitor new onset of signs and symptoms of delirium. During an observation and interview on 07/08/2026 at 9:33 a.m. revealed Resident #45 was in his bed, awake. It was observed that a container of liquid disinfectant (chemical substance used to kill microorganisms) was on top of the resident's side table, in a tray along with the resident's mouthwash. The resident said the solution was used to clean his room and was left by a staff member. He said he could not remember who left the solution inside his room. During an observation and interview on 07/08/2026 at 9:59 a.m., LVN B said there should be no sharp objects or disinfecting solutions inside the rooms of the residents. She went inside Resident #6's room, saw the razor in the resident's sink, and said it should not be left where residents could get it because they might use it to cut themselves. She took the razor and said she would remind the aides not to leave the razors after they were done using it. She then went to Resident #45's room and saw the disinfecting solution on top of the resident's side table. She took the container of solution and said it should not be inside the room because confused residents might consume it. She said the solution had harmful chemicals and had a warning on the back of the container that said, Keep out of reach of children. During an interview on 07/08/2026 at 11:29 a.m., HK F said housekeeping used the disinfecting solution to clean the residents' rooms. She said the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution should not be inside the rooms of the residents because it had chemicals in it that could cause irritation to the skin. She said it would be harmful for the residents if they accidentally drank it. 3.Record review of Resident #38's Face Sheet, dated 07/09/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cellulitis (bacterial infection of the skin and the tissues beneath it). Record review of Resident #38's Comprehensive MDS Assessment, dated 06/05/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident had arterial ulcers present (wound caused by poor blood circulation). Record review of Resident #38's Comprehensive Care Plan, dated 04/23/2026, reflected the resident had a non-pressure ulcer to the scalp and a venous ulcer to the right leg and the intervention for both was to treat wound as ordered. Record review of Resident #38's Physician Order, dated 06/03/2026, reflected, WOUND: Cleanse scalp with normal saline/wound cleanser, pat dry with 4 x 4 gauze, apply mupirocin ointment, and cover with dry dressing daily and PRN, if soiled or dislodgment, as needed for wound care. Record review of Resident #38's Physician Order, dated 06/24/2026, reflected, WOUND CARE: Cleanse skin tear to right medial ankle with normal saline/wound cleanser, pat dry with 4 x 4 gauze, apply Mupirocin . to open areas and wrap with a kerlix daily and PRN if soiled or dislodged. one time a day for WOUND CARE. During an observation on 07/09/2026 at 8:31 a.m., WCN E was about to clean Resident #38's wounds to his scalp and right leg. She prepared the things needed for wound care, including scissors, and placed them on top of the resident's overbed table. When she was about to start her wound care, another staff member called her for assistance. She left Resident #38's room and assisted the other staff member. She left her scissors on top of the overbed table and within reach of the resident. During an interview on 07/09/2026 at 8:47 a.m., WCN E said she should have taken the scissors when she stepped out of the room or told the other staff to call someone else for assistance because the resident might take the scissors and use them to harm himself. 4.During an observation on 07/08/2026 at 9:26 a.m. revealed a container of germicidal wipes (substance that destroys germs and microorganism) was left on top of a cart, unattended. The lid of the container was open, and a portion of a germicidal wipe was peeping out of the lid. It was observed that several residents were passing the cart. 5.During an observation on 07/09/2026 at 6:38 a.m., LVN A was sitting at the nurses' station. He stood up and left the station leaving a container of germicidal wipes at the edge of the nurses' station, unattended and was within reach of the residents passing the station. On the back of the container was a warning that said, Keep out of reach of children. During an interview on 07/09/2026 at 12:06 p.m., LVN A said the germicidal wipes were used to sanitize the tables, the carts, and the bp cuff. She said the container should be inside the drawers of the cart and not within reach of the residents because they might use it in their face or private area and cause irritations. He said he did not know who left the germicidal wipes on top of the cart. He took the germicidal wipes from the nurses' station and put them inside a cart. During an interview on 07/10/2026 at 9:26 a.m., the ADON said the container of disinfecting wipes, closed or opened, should have been placed inside the cart when staff were leaving their cart unattended. She said residents could get them and use them on their face and body. She said the wipes could cause irritation, that was why the staff used gloves when using them. She said the disinfecting wipes should not be left at the edge of the nurses' station for the same reason. She said the disinfecting solution should not be left in the rooms of the residents because they might mistakenly drink the solution, which had hazardous chemicals in it. She said the razor and the scissors should not be left inside the residents' rooms because they could use it to harm themselves. She said the expectation was for the staff not to leave the germicidal wipes, the razor, and the scissors within reach of the residents. She said would coordinate with the DON (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding the germicidal wipes, razors, and scissors. During an interview on 07/10/2026 at 9:47 a.m., the DON said the germicidal wipes, the disinfecting solution, the razor, and the scissors should not be left unattended because the residents might get them. She said the residents might use the wipes to clean their faces or their private parts and might drink the disinfecting solution. She said the residents might get hold of the razor and scissors and use them to harm themselves. She said the expectation was for all the staff to not leave the germicidal wipes and sharps objects, unattended. She said she would start an in-service about the issues as soon as the interview was over. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the germicidal wipes, the disinfecting solution, the razor, and the scissors could all cause harm to the residents if used inappropriately. She said the expectation was for the staff to store the germicidal wipes accordingly before walking away from their carts and before leaving the nurses' station to ensure that the residents would not be able to get any wipes. She said another expectation was for the solution; the razor, and the scissors would not be left inside the rooms of the residents because they could also harm the residents if used improperly. She said she would collaborate with the DON about the issue. She said they would in-service the staff about storage of disinfectants and sharp objects and would monitor them closely if the staff understood the in-service. Record review of the facility policy, Medication Storage in the Facility, revised March 2025, reflected, Policy: Medications and biologicals are stored safely, securely, and properly . 8. Potentially harmful substances (e.g. urine test reagent tablets, household poisons, cleaning supplies, and disinfectants) are clearly identified and stored in a locked area. During an interview on 07/10/2026 at 11:05 a.m. via e-mail, the policy about storage of sharp objects was requested from the Administrator. The Administrator said the facility did not have a policy for storage of sharp objects.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for five of eighteen residents (Residents #8, #15, #38, #45, and #47) reviewed for medication storage. 1.The facility failed to ensure that there was no medication for hemorrhoids inside Resident #8's room on 07/08/2026. 2.The facility failed to ensure that there was no laxative solution inside Resident #15's room on 07/08/2026. 3.The facility failed to ensure that there was no nasal spray inside Resident #47's room on 07/08/2026. 4.The facility failed to ensure that there were no eye drops, calcium alginate powder, and wound cleanser inside Resident #45's room on 07/08/2026. 5.The facility failed to ensure WCN E did not leave a cup of topical antibiotic on top of Resident #38's overbed table on 07/09/2026. These failures could place the residents at risk of misuse of medications and possible adverse reactions.Findings included: 1.Record review of Resident #8's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with a psychotic disorder with delusion (mental health condition with loss of contact to reality, hallucinations, and delusions). Record review of Resident #8's Comprehensive MDS Assessment, dated 04/06/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a psychotic disorder with delusion. Record review of Resident #8's Comprehensive Care Plan, dated 05/13/2026, reflected the resident required anti-psychotic medications and the intervention for both was to monitor for constipation (problem with passing stool). Record review on 07/08/2026 of Resident #8' list of Physician Orders, reflected the resident did not have an order for hemorrhoids (swollen veins in the anus) medication. Record review on 07/08/2026 of Resident #8's Clinical Assessment List, reflected the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation on 07/08/2026 at 9:17 a.m., revealed the resident was not inside his room. It was observed that a tube of ointment used for hemorrhoids was on top of the resident's side table and was in plain view. 2.Record review of Resident #15's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with cognitive impairment and depression. Record review of Resident #15's Comprehensive MDS Assessment, dated 06/02/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had cognitive impairment (decline in mental abilities) and depression. Record review of Resident #15's Comprehensive Care Plan, dated 05/28/2026, reflected the resident required antidepressant and one of the interventions was to administer medications as ordered. Record review on 07/08/2026 of Resident #15' Physician Orders reflected that the resident did not have an order for laxative (substance that loosens the bowels) solution. Record review on 07/08/2026 of Resident #15's Clinical Assessment List, reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 07/08/2026 at 9:23 a.m. revealed Resident #15 was sitting in his wheelchair. It was observed that a bottle of laxative was inside the resident's opened drawer. When asked who left the laxative solution, the resident shrugged his shoulder. The laxative solution was in plain view and was within reach. 3.Record review of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #47's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with acute upper respiratory infection. Record review of Resident #47's Comprehensive MDS Assessment, dated 06/12/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had acute upper respiratory infection. Record review of Resident #47's Comprehensive Care Plan, dated 06/22/2026, reflected the resident did not have a care plan for acute upper respiratory infection, chronic cough, or SOB. Record review on 07/08/2026 of Resident #47' Physician Orders reflected the resident did not have an order for nasal spray. Record review on 07/08/2026 of Resident #47's Clinical Assessment List, reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 07/08/2026 at 9:18 a.m., Resident #47 was sitting in her wheelchair. It was observed that a nasal spray was on top of her side table. The resident said it was her nasal spray, and she would use it sometimes. The nasal spray was in plain view and was within reach. During an observation and interview on 07/08/2026 at 9:56 a.m., LVN A said medications were not supposed to be inside the room of the residents because first, the staff should be the ones administering the medications; second, the staff would not be able to monitor how frequent and how much the residents were administering the medications that could eventually lead to overdosing or underdosing; third, the staff would not know if the medications were needed; fourth, the staff would not know if the resident was allergic to the medications.; and lastly, other residents might get the medications and use them inappropriately. He went inside the rooms of Residents #8, #15, and #47, and removed them. She said she was not aware that there were medications inside the rooms of the residents. 4. Record review of Resident #45's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with depression and delusion. Record review of Resident #45's Comprehensive MDS Assessment, dated 05/22/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had depression and delusion. Record review of Resident #45's Comprehensive Care Plan, dated 06/28/2026, reflected that the resident had a non-pressure ulcer to the scalp and a venous ulcer to the right leg and the intervention for both was to treat wounds as ordered. Record review of Resident #45's Physician Order, dated 06/03/2026, reflected, WOUND: Cleanse scalp with normal saline/wound cleanser, pat dry with 4x4 gauze, apply mupirocin ointment, and cover with dry dressing daily and PRN if soiled or dislodgment as needed for wound care. Record review on 07/08/2026 of Resident #45's Clinical Assessment List, reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 07/08/2026 at 9:33 a.m., Resident #45 was in his bed, awake. It was observed that containers of wound cleanser and collagen powder were on top of the resident's side table, in a tray along with the resident's mouthwash. The resident said the wound cleanser and the powder were used for his wounds. He said he did not know who left the wound cleanser and powder on his table. During an observation and interview on 07/08/2026 at 9:56 a.m., LVN B said she was not aware there were wound cleaning materials inside Resident #45's room and she did not know who left them. She said those should be inside the treatment cart. She said confused residents might get them and use them inappropriately. She took the containers of wound cleanser and collagen powder and said she would place them inside the treatment cart. 5. Record review of Resident #38's Face Sheet, dated 07/09/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cellulitis. Record review of Resident #38's Comprehensive MDS Assessment, dated (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/05/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated that the resident had venous and arterial ulcers present. Record review of Resident #38's Comprehensive Care Plan, dated 04/23/2026, reflected that the resident had a non-pressure ulcer to the scalp and a venous ulcer to the right leg and the intervention for both was to treat wounds as ordered. Record review of Resident #38's Physician Order, dated 06/03/2026, reflected, WOUND: Cleanse scalp with normal saline/wound cleanser, pat dry with 4 x 4 gauze, apply mupirocin ointment (antibiotic used to treat skin infection), and cover with dry dressing daily and PRN if soiled or dislodgment as needed for wound care. Record review of Resident #38's Physician Order, dated 06/24/2026, reflected, WOUND CARE: Cleanse skin tear to right medial ankle with normal saline/wound cleanser, pat dry with 4 x 4 gauze, apply Mupirocin and adaptic (an absorbent dressing) to open areas and wrap with a kerlix daily and PRN if soiled or dislodged one time a day for WOUND CARE. During an observation on 07/09/2026 at 8:31 a.m., WCN E was about to clean Resident #38's wounds to his scalp and right leg. She prepared the things needed for wound care, including the antibiotic ointment, and placed them on top of the resident's overbed table. When she was about to start her wound care, another staff member called her for assistance. She left Resident #38's room and assisted the other staff member. She left her antibiotic ointment, along with the other wound care supplies, on top of the overbed table and within reach of the resident. During an interview on 07/09/2026 at 8:47 a.m., WCN E said she should have told the other staff to call someone else for assistance because she already prepared everything needed for wound care. She said the ointment was a topical medication and should not be left inside the room because confused residents might consume them or put it in their eyes. She said she did not know who left the wound cleanser and the collagen powder inside Resident #45's room should be inside the treatment cart. During an interview on 07/10/2026 at 9:26 a.m., the ADON said there should be no medications inside the rooms of the residents because confused residents might mistakenly consume them or use them inappropriately. She said the antibiotic ointment should not have been left with the resident. She said she was not sure why there were wound cleansers, collagen powder, and laxative solutions inside the rooms but will try to find out who left them, so they would be reminded why they were not supposed to be inside the rooms of the residents. She said the expectation was for the staff to be diligent enough to scan the rooms of the residents for any medication. She said she would also talk to the residents and assess them if they needed the medications so she could request orders for the said medications. She they would include other staff in the in-service so they could notify the nurses if they saw any medications inside the rooms of the residents. During an interview on 07/10/2026 at 9:47 a.m., the DON said medications, whether oral, nasal, optical, or topical, should not be inside the residents' rooms or left inside the rooms because the residents might use them inappropriately and that could result in adverse reactions. She said the expectation was for the staff to be vigilant when they entered the residents' room to check for any medications and for staff not to leave the wound cleanser, collagen powder, the antibiotic ointment, and the laxative solution inside the rooms of the residents. She said she would start an in-service about medications storage. She said she would also remind the residents that they could not keep any medications inside their rooms. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the expectation was for the staff to make sure there were no medications inside the rooms of the residents because the residents might consume them or use them on their eyes causing irritation. She said she would coordinate with the DON about the issue. She said she would collaborate with the DON about the issue regarding the medications inside the rooms of the residents. She said they would in-service the staff about medications inside the rooms of the residents and monitor closely if the staff understood the in-service. Record review of (continued on next page)		

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Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility policy, Medication Storage in the Facility, revised March 2025, reflected, Policy: Medications and biologicals are stored safely, securely, and properly . The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.		

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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. Based on observation, interview 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 kitchen reviewed for food and nutrition services. The facility failed to ensure all food items in kitchen was dated and discarded prior to their use-by date and were properly sealed. This failure could place residents at risk for food contamination and food-borne illness. During an observation on 07/08/2026 between 9:05 AM and 9:39 AM in the facility's kitchen revealed: One gallon bag containing Cookie pieces dated 05/01/2025 expiration date 09/01/2025. One gallon bag of cake mix dated 04/07/2026 with an expiration date of 05/07/2026. One large plastic bag containing ketchup with no visible dates. One container of all-vegetable shortening 02/14/2022 best buy date of 12/25/2023. One ready pie crust with no visible dates, not properly sealed and exposed to air contaminants. One 6lb 15 oz can Garbanzo beans dated 01/09/2023 with an expiration date of 07/12/2025. One 5lb 13oz can of leaf spinach dated 05/04/2021 with an expiration date of 01/12/2024. One plastic bin containing squash dated 06/22/2026 with no visible expiration date. During an interview on 07/09/26 at 11:14 AM, the DM stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. DM confirmed the surveyor observations and stated the listed items would be corrected. DM stated once items were opened, they should be properly sealed and dated. DM stated he was responsible for ensuring policy was followed. DM stated the risk to residents if policy was not followed was a health risk to the residents. DM stated the items should be labeled, and the risk of the concerns not being addressed could result in food-borne illnesses. DM stated if food items were not dated when opened, then they would not know how long the item would remain fresh. DM stated the risk of serving foods that were past the use-by date, or serving food that was not labeled or dated, could cause food borne illness. During an interview on 07/10/2026 at 12:55 PM, Admin stated she oversaw all departments, and ensured residents were taken care of. Admin stated the expired items could cause food contamination. She stated if items were expired, they should not serve them to residents. ADMIN stated the risk of all those concerns observed in the kitchen could result in residents getting sick. Admin stated she expected DM to ensure the kitchen staff followed all guidelines, including ensuring the food items were labeled properly in the kitchen. She said the risk to residents if policy was not followed, was residents could get sick from food borne illnesses. Admin stated she expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. Record review of the facility's, Food Storage and Supplies Dietary Services Policy & Procedure Manual, dated ??2012, indicated, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry, and protected from vermin, and insects. Procedure: 6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it, so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires, and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes.		

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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 observation, interview, and record review, the facility failed to establish and 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 four of eighteen residents (Residents #11, #19, #31, and #33) reviewed for infection control. 1.The facility failed to ensure CNA C performed hand hygiene during Resident #31's incontinent care on 07/08/2026. 2.The facility failed to ensure MA G performed hand hygiene when preparing medications for Residents #11, #19, and #33 on 07/09/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1.Record review of Resident #31's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #31's Comprehensive MDS Assessment, dated 04/24/2026, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was incontinent (unable to control) for bladder and bowel. Record review of Resident #31's Comprehensive Care Plan, dated 05/03/2026, reflected the resident had an ADL self-care performance deficit and one of the interventions was to assist with toilet use. During an observation on 07/08/2026 at 12:59 p.m., CNA C was about to do Resident #31's incontinent care. She went inside the room, washed her hands, and put on a pair of gloves. It was observed that on top of the resident's overbed table were a box of gloves, wipes, plastic bags, a brief, and a container of hand sanitizer. She pulled the resident's pants down and unfastened her brief. She pulled some wipes and cleaned the sides of the resident's perineal area (area between the legs) using the front to back technique. After cleaning the sides, she took off her gloves and put on a new pair of gloves and cleaned the middle portion of the perineal area. She took off her gloves and put on a new pair of gloves. She assisted the resident to roll towards the wall and started to clean the resident's bottom. After cleaning the resident's bottom, she took off her gloves and put on a new pair of gloves, took the brief from the overbed table, and fixed it under the resident's bottom. She did not perform hand hygiene every time she changed gloves. During an interview on 07/08/2026 at 1:18 p.m., CNA C said she should have sanitized her hands when she changed gloves to prevent contamination. She said there was sanitizer on top of the table, and she also had one in her pocket but forgot to use it. 2.Resident #11 Record review of Resident #11's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with cerebral infarction (blockage in the blood vessels of the brain), hypertension (high blood pressure), and diabetes mellitus (high blood sugar). Record review of Resident #11's Comprehensive MDS Assessment, dated 06/10/2026, reflected the resident had severe impairment in cognition with a BIMS score of 04. The Comprehensive MDS Assessment indicated the resident had debility (weakness) and cardiorespiratory (relating to the heart and the lungs) conditions. Record review of Resident #11's Comprehensive Care Plan, dated 04/16/2026, reflected that the resident had cerebral infarction, hypertension, and diabetes mellitus, and the intervention for all the above was to administer medications as ordered. Resident #19 Record review of Resident #19's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with hypertension, diabetes mellitus, chronic pain, and atrioventricular block (disruption of the electrical signals in the heart). Record review of Resident #19's Comprehensive MDS Assessment, dated 06/24/2026, reflected the resident had severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident had medically complex conditions (multiple (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Fair Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2815 Martin Luther King Jr Boulevard 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health conditions affecting the body. Record review of Resident #19's Comprehensive Care Plan, dated 05/10/2026, reflected that the resident had hypertension, diabetes mellitus, chronic pain, and AV block, and the intervention for all of the above was to administer medications as ordered. Resident #33 Record review of Resident #33's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and schizophrenia (a mental condition characterized by abnormal thought processes and unstable mood). Record review of Resident #33's Comprehensive MDS Assessment, dated 04/30/2026, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had medically complex conditions. Record review of Resident #33's Comprehensive Care Plan, dated 05/10/2026, reflected the resident had altered neurological status and impaired cognitive function and the intervention for both was to administer medications as ordered. During an observation on 07/09/2026 starting at 6:29 a.m. revealed MA G was about to prepare Resident #11's medications. He took a small cup and started to place Resident #11's medications. He then went inside Resident #11's room and administered the resident's medications. He did not perform hand hygiene before preparing and after administering Resident #11's medications. He then went to Resident #19's room and started to prepare Resident #19's medication. After preparing Resident #19's medication, he went inside Resident #19's room and administered his medications. MA G did not perform hand hygiene before preparing and after administering Resident #19's medication. He then went to Resident #33's room, prepared his medications, and then administered his medications. He did not perform hand hygiene before he prepared and after he administered Resident #33's medications. During an interview on 07/10/2026 at 9:26 a.m., the ADON said the staff should always perform hand hygiene before, during, and after each care. She said the staff should have sanitized or washed their hands when they changed their gloves and before preparing the residents' medications to prevent cross contamination or spread of infection if there was any. She said the expectation was for the staff to practice what they were taught. She said they would do an in-service again about infection control. During an interview on 07/10/2026 at 9:47 a.m., the DON said hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should perform hand hygiene every time they changed their gloves and before they prepared the medications. She said she just did an in-service about infection control and, not following the policies and procedures of infection control, could contribute to cross contamination, development of infection, and spread of infection. She said the expectation was for the staff to adhere to the policies and procedures of infection control. She said she would start another in-service about infection control. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the expectation was for the staff to practice the proper procedure for hand hygiene to prevent cross contamination. She said she would collaborate with the DON about the issue regarding not doing hand hygiene. She said they would in-service the staff about infection control and would monitor closely if the staff understood the in-service. She said she would also ensure proper training was done. Record review of the facility's policy, Fundamentals of Infection Control Precautions, undated, reflected, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions . 1. 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 . Before and after direct resident contact . Before and after assisting a resident with personal care . Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident) . After contact with a resident's mucous membranes and body fluids or excretions . After removing gloves.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to one of eight residents (Resident #47) reviewed for baseline care plan. The facility failed to ensure Resident #47 had a baseline care plan for atelectasis after admission to the facility on [DATE]. This failure could place the resident at risk of not receiving necessary care, treatment, and services upon admission that could result in worsening conditions. Findings included: Record review of Resident #47's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Upon admission, the resident diagnosis included atelectasis (collapse of the lungs that could result in SOB and coughing). Record review of Resident #47's Comprehensive MDS Assessment, dated 05/09/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated that the resident had atelectasis. Record review of Resident #47's Baseline Care Plan, dated 05/11/2026, reflected that the resident did not have a care plan for atelectasis, cough, or shortness of breath. Record review of Resident #47's Physician Order, dated 05/10/2026, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB OR WHEEZING. Record review of Resident #47's admission Note, dated 05/09/2026, reflected Cough: Occasional, non-productive cough (dry cough). During an observation and interview on 07/08/2026 at 9:19 a.m., Resident #47 was observed with occasional coughing. The resident said her cough was on and off, but she had medications for her cough. During an observation and interview on 07/08/2026 at 9:56 a.m., LVN A said Resident #47 had a chronic cough but was non-compliant with her treatment. He said the resident had respiratory issues when she was admitted to the facility. During an observation and interview on 07/10/2026 at 8:59 a.m., the RRM said if a resident had a pertinent condition when admitted to the facility, then there should be a baseline care plan for that condition. The RRM logged on to a computer, reviewed Resident #47's profile, and saw the resident did not have a care plan for a cough when she was admitted. She said there should have been a care plan for her cough or any respiratory issues. She said she would let the MDS Coordinator know about the issue so she could audit the care plans accordingly. During an interview on 07/10/2026 at 9:26 a.m., the ADON said if a resident was admitted to the facility with respiratory issues, it should have been included in the baseline care plan to plan for the immediate treatment of the issues. During an interview on 07/10/2026 at 9:47 a.m., the DON said the baseline care plans were important because it would give the providers the minimum healthcare information about the resident that needed to be addressed immediately or upon admission. She said without the baseline care plan, the immediate needs of the resident would not be met. She said she would start an in-service about baseline care plan as soon as the interview was over. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said all the residents must have a baseline care so that the care staff would know how to take care of the residents. She said the expectation was for the staff to initiate the baseline care plan immediately after admission. She said she would collaborate with the DON about the issue would monitor closely if the staff understood the in-service. Policy for baseline care plan requested on 07/10/2026 at 11:00 a.m. but was not provided prior to exit. Record review of the facility's policy Comprehensive Care Planning Nursing Policy & Procedure Manual, undated reflected The facility will develop and (continued on next page)		

Department of Health & Human Services
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Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement a comprehensive person-centered care plan for each resident . The resident's care plan will be reviewed after each Admission.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one of eight residents (Resident #47) reviewed for care plans. The facility failed to ensure that Resident #47 had a care plan for her acute upper respiratory infection on 07/09/2026. This failure could place the residents at risk of not receiving the necessary care and services. Findings included: Record review of Resident #47's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with acute upper respiratory infection (infection that could affect the nose, throat, and voice box) eleven days after admission. Record review of Resident #47's Comprehensive MDS Assessment, dated 06/12/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated that the resident acute upper respiratory infection. Record review of Resident #47's Comprehensive Care Plan, dated 06/22/2026, reflected that the resident did not have a care plan for acute upper respiratory infection, chronic cough, or SOB. Record review of Resident #47's Physician Order, dated 05/10/2026, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB OR WHEEZING. Record review of Resident #47's Physician Order, dated 05/20/2026, reflected AZITHROMYCIN 500 mg 1 tab PO QD x 3 days for URI. Record review of Resident #47's Progress Note, dated 05/20/2026, reflected resident is being treated for URI . Negative Findings: Nasal Congestion, Productive cough. Sputum is Clear . Respirations: SOB on Exertion, Observed SOB While Lying . Interventions: Antibiotic treatment: AZITHROMYCIN 500 mg 1 tab PO QD x 3 days. Record review of Resident #47's Progress Note, dated 05/28/2026, reflected N/O received from . NP of Medrol dose pak and Tessalon for cough RT residual cough/ congestion . Treatment Plan: Nebulizer treatments according to physician orders delivered by handheld device. Record review on Resident #47's Progress Note, dated 05/30/2026, reflected resident is being treated for URI . Negative Findings: Productive cough . Antibiotic treatment: LEVAQUIN 500 MG QD X 7 DAYS. Record review on Resident #47's Progress Note, dated 06/03/2026, reflected This resident is being treated for URI. Record review on Resident #47's Progress Note, dated 06/05/2026, reflected This resident is being treated for Pneumonia . Productive cough. Record review on Resident #47's Progress Note, dated 06/09/2026, reflected NP contacted nurse to give the following orders . 1. DuoNeb 3 ml via neb QD Dx: SOB/Cough. Record review on Resident #47's Progress Note, dated 06/26/2026, reflected NP notified nurse of the following orders . 1. Guaifenesin 600 mg 1 tab PO BID x 7days Dx: Cough. Record review on Resident #47's Progress Note, dated 06/27/2026, reflected Note Text: XRAY RESULTS SENT TO . FOR REVIEW. NEW ORDER PREDNISONE 20 MG 1 TAB PO DAILY X 3 DAYS, REPEAT CHEST XRAY ON 7/1/26. ENCOURAGE USE OF INCENTIVE SPIROMETER, N/O IS Q 2 HRS WHILE AWAKE X 72 HRS. During an observation and interview on 07/08/2026 at 9:19 a.m., Resident #47 was in her wheelchair and was observed with occasional coughing. The resident said her cough was on and off, but she had medications for her cough. She said she also had an infection last month, and she was given antibiotics for it. During an observation and interview on 07/08/2026 at 9:56 a.m., LVN A said Resident #47 had a chronic cough but was non-compliant to her treatment. He said the resident had on and off respiratory issues like (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the respiratory infection and cough. During an observation and interview on 07/10/2026 at 8:59 a.m., the RRM said if a resident had a change in condition like respiratory infection, then it should be reflected on her care plan. The RRM logged on to a computer, reviewed Resident #47's profile, and saw the resident was diagnosed with upper respiratory infection. She then checked the resident's current and discontinued physician orders and saw the resident had orders, during her stay, for breathing treatment, cough syrup, prednisone, and antibiotics for respiratory issues. She said there should be a care plan for her respiratory issues, especially if she was prone to have one. She said the care plans should be in place so that everybody taking care of the resident would be aware of how to manage it. She said the care plan should reflect the potential issues of the residents and provide interventions for such issues. She said she should let the MDS Coordinator know about the issue so she could make a care plan for the resident's respiratory issues. During an interview on 07/10/2026 at 9:26 a.m., the ADON said care plans should reflect the needs of the residents that needed to be addressed. She said the care plan served as the facility's agreement with the resident in terms of the care and services that the facility would be providing. She said another purpose of the care plan was that the individuals taking care of the residents would be on the same page. During an interview on 07/10/2026 at 9:47 a.m., the DON said the MDS Nurse was responsible for making the care plans of the residents. She said care plans should be in place to reflect the realistic goals, reflect the needed interventions, to gauge if the expectations were being met, so that the staff could provide the best care needed. She said the expectation was for all the issues of the residents were care planned appropriately. She said the change in the resident's condition should be planned. She said she would coordinate with the MDS Coordinator with regards to Resident #47's care plan for respiratory issues. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the expectation was that all the residents were care planned specific to their needs so the staff taking care of the residents could provide the care and services needed. She said care plans should be in place so that the individuals providing care for the residents would be on the same page. She said she would coordinate with the MDS Nurse and the DON regarding the care plans of the residents. Record review of the facility's policy Comprehensive Care Planning Nursing Policy & Procedure Manual, undated reflected The facility will develop and implement a comprehensive person-centered care plan for each resident . Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs . The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team for two of twelve residents (Residents #12 and Resident #29) reviewed for care plans revision. The facility failed to ensure the care plans for Residents #12 and Resident #29 were reviewed and revised after each comprehensive and quarterly assessment. This failure could place the residents at risk of care and needs not being met. Findings included: Resident #12 Record review of Resident #12's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #12's Quarterly MDS Assessment reflected that the last MDS completed for the residents was on 06/09/2026. Record review of Resident #12's Quarterly Care Plan reflected the last care plan completed for the resident on 03/24/2026. Resident #29 Record review of Resident #29's Face Sheet, dated 07/09/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #29's Comprehensive MDS Assessment reflected that the last MDS completed was on 06/24/2026. Record review of Resident #29's Comprehensive Care Plan reflected the last care plan completed for the resident was 03/06/2026. During an observation and interview on 07/09/2026 at 1:39 PM, the MDS Coordinator said care plans were updated or revised quarterly or if there was a change in condition. She said she was responsible for updating the care plans of the residents. She said the care plan should be updated quarterly or if the resident had a change in condition, had a fall, or had an infection. She logged onto her computer and checked the residents in question and saw that the residents' care plans were not updated. She said the residents had their quarterly assessments, and the quarterly care plans should have followed. She said both Resident #12 and Resident #29's last care plans were both done last March 2026, and the next care plans should have been done last June and not July. During an interview on 07/10/2026 at 9:26 a.m., the ADON said care plans were done during admission and updated quarterly. She said care plans were also updated if there was a change in condition like the resident had a new wound or had a fall. She said care plans should be updated so the staff would know if there were new interventions that needed to be done and to monitor the resident's response to the new interventions. During an interview on 07/10/2026 at 9:47 a.m., the DON said every resident needed a detailed care plan to ensure the residents received the care they needed. She said the care plans should be updated because the resident might have new issues that needed attention or previous issues that needed more extensive interventions. She said the care plan should be done quarterly or if there was a change in condition. She said the expectation was for the care plans to be updated. She said she would coordinate with MDS Nurses to audit the care plans of the residents. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said care plans were supposed to be updated quarterly to make sure that the care being given was still appropriate. She said the expectation was for all the residents to be care planned and that the care plans were updated quarterly and when needed. She said she would coordinate with the MDS Nurse and the DON regarding the care plans of the residents. Record review of the facility's policy Comprehensive Care Planning Nursing Policy & Procedure Manual, undated reflected The facility will develop and implement a comprehensive person-centered care plan for each resident . Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs . The (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change . and revised based on changing goals, preferences and needs of the resident and in response to current interventions.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of five residents (Resident #45) reviewed for catheter care. The facility failed to ensure Resident #45's catheter bag was off the floor on 07/08/2026. This failure could place the residents at risk of urinary tract infection. Findings included: Record review of Resident #45's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #45's Comprehensive MDS Assessment, dated 05/22/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag). Record review of Resident #45's Comprehensive Care Plan, dated 06/28/2026, reflected the resident had a suprapubic catheter (device inserted into the stomach to the bladder to drain urine) and one of the interventions was to maintain the drainage bag (catheter bag: (collects urine from the urinary bladder) off the floor. Record review of Resident #45's Physician Order, dated 03/28/2026, reflected MAY HAVE SUPRAPUBIC INDWELLING CATHETER: 22-24 F (French: unit of measurement for catheter sizes) WITH 30 ML BULB (a soft tube with a balloon at the tip). CHANGE FOR OCCLUSION, LEAKING, CLOSED SYSTEM WAS COMPROMISED. every shift related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED . AND as needed for CATHETER CHANGE INDICATED. During an observation and interview on 07/08/2026 at 9:33 a.m., Resident #45 was in his bed, awake. It was observed that the resident had a catheter bag hanging at the side of his bed. The resident said he had the catheter for almost ten years. During an observation on 07/08/2026 at 11:53 a.m., Resident #45's catheter bag was touching the floor. During an observation and interview on 07/08/2026 at 11:56 a.m., LVN B said the catheter bag should be off the floor because it could result in urinary tract infection (infection in any part of the urinary system). She went inside Resident #45's room and saw that the resident's catheter bag was touching the floor. She said, maybe, somebody changed the resident and put the bed in the lowest position but did not notice that the bag was touching the floor. She raised the resident's bed until the catheter bag was off the floor. She said she would remind the CNAs that catheter bags should not be touching the floor. She said she would also change the resident's catheter bag. During an interview on 07/10/2026 at 9:26 a.m., the ADON said catheter bags should always be off the floor because it could cause UTI. She said the expectation was catheter bags would always be off the floor. She said she would coordinate with the DON on what to do about the issue regarding the catheter. During an interview on 07/10/2026 at 9:47 a.m., the DON said the catheter bags should not be touching the floor to keep it clean and prevent UTI. She said she would start an in-service about catheter care. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the expectation was that the catheter bag would be off the floor to prevent infection. She said she would collaborate with the DON about the issue regarding the catheter. She said they would in-service the staff about catheter care and would monitor closely if the staff understood the in-service. Record review of the facility's policy, Catheter Care Nursing Policy and Procedure Manual, undated reflected General Guidelines . 10. Be sure the catheter tubing and drainage bag are kept off the floor.		

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 07/10/2026
NAME OF PROVIDER OR SUPPLIER Fair Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2815 Martin Luther King Jr Boulevard 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 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 observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of ten residents (Residents #47) reviewed for respiratory care. The facility failed to ensure Resident #47's breathing mask was properly stored when not in use on 07/08/2026. This failure could place residents at risk of respiratory infection and not having their respiratory needs met. Findings included: Record review of Resident #47's Face Sheet, dated 07/09/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with acute upper respiratory infection. Record review of Resident #47's Comprehensive MDS Assessment, dated 06/12/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had acute upper respiratory infection. Record review of Resident #47's Comprehensive Care Plan, dated 06/22/2026, reflected the resident did not have a care plan for acute upper respiratory infection, chronic cough, or SOB. Record review of Resident #47's Physician's Order, dated 05/10/2026, reflected, Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB OR WHEEZING. Record review of Resident #47's eMAR, dated July 2026, reflected the last time the resident used her breathing mask (a medical device used to deliver medication in the form of mist directly to the lungs) was 07/06/2026. During an observation and interview on 07/08/2026 at 9:19 a.m., Resident #47 was in her wheelchair, awake. It was observed that the resident's breathing mask was on top of the resident's side table and was unbagged. She said the staff would put her mask on and would take it off when the treatment was done. During an observation and interview on 07/08/2026 at 9:56 a.m., LVN A said the breathing mask should be inside a plastic bag when not in use to keep it clean and prevent any respiratory infection. He said he had already placed the breathing mask inside a bag. During an interview on 07/10/2026 at 9:26 a.m., the ADON said the breathing mask should be inside a plastic bag when not in use to maintain its cleanliness as well as its patency (opened, unobstructed, or unblocked). She said bagging the mask was important to prevent cross contamination and development of any respiratory infections. She said the staff administering the breathing treatment was responsible for bagging the breathing mask once the treatment was done. She said she would coordinate with the DON about the issue. During an interview on 07/10/2026 at 9:47 a.m., the DON said the staff were responsible in bagging the breathing mask to prevent any respiratory infection. She said she would start an in-service about respiratory care. During an interview on 07/10/2026 at 10:12 a.m., the Administrator said the expectation was all the masks be bagged when the residents were not using them to keep them clean. She said the resident already had respiratory issues and using dirty masks, nasal cannula, and suction tip could add to their medical issues. She said she would collaborate with the DON about the issue regarding the breathing mask. She said they would in-service the staff about respiratory care and would monitor closely if the staff understood the in-service. Record review of the facility's policy, Respiratory Muscle Trainer (RMT) Respiratory Policies and Procedures, revised June 01, 2006, reflected, POLICY: Respiratory muscle training is performed by a respiratory therapist with a physician's order . Process . 8. If using a nebulizer . 18 . Store in treatment bag labeled with patient's name.		