STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676293	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing & Rehabilitation	6825 Harry Hines Blvd Dallas, TX 75235

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on interview and record review the facility failed to ensure the resident had the right to participate in the development and implementation of his person-centered plan of care for one (Resident #1) of one resident reviewed for person-centered plans of care. The facility failed to include Resident #1 in his Care Plan Conference. This failure could affect residents and place them at-risk by contributing to inadequate care. The findings included: Record review of Resident #1's face sheet, printed 01/26/2024, revealed Resident #1 was a [AGE] year-old male who was admitted to the facility initially on 08/03/2023 and re admitted on [DATE]. The resident had diagnoses which included osteomyelitis (a serious infection of the bone that can be either acute or chronic), type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), hypertension(high blood pressure) Record review of Resident #1's initial MDS dated [DATE] revealed a BIMS score of 10 which indicated Resident #1 was mildly cognitively intact. Review of Resident #1's care plan with review date of 11/10/023 revealed Resident #1 was resistive to care and refused wound care. Resident #1's care plan stated to allow the resident to make decisions about treatment regime to provide a sense of control. Record review of Resident #1's Care Conference meeting notes completed 09/25/2023 revealed the resident was not present at the care plan conference due to being at dialysis. During an interview on 01/25/2024 at 2:00PM Resident #1 stated he had not participated in a care plan conference and was not aware of what goals or services were being provided to reach of goal being discharged . Resident #1 stated he wanted to be apart of his care plan conference however no one had contacted him regarding attending the conference. (continued on next page)

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/26/2024 at 1:30 PM with the Social Worker, she revealed Resident #1 had not been involved in the previous care plan conference due to him being at dialysis. The Social Worker stated said they had scheduled the next care plan conference for Monday 01/29/2024 however would reschedule to allow Resident #1 to be involved. The Social worker stated she was responsible for scheduling the care plan conferences. The Social Worker stated Resident #1 was asked to attend the care plan conference on 09/25 however he stated to move forward without him. The social Worker stated she did not document her attempt to allow Resident #1 to be a part of the care plan conference. Interview on 01/26/2024 at 3:00 PM with the Administrator and Director of nursing revealed the care conference should have been scheduled at a time to allow for Resident #1 to be apart of the conference. The Administrator and Director of Nursing stated it was the responsibility of the interdisciplinary team to ensure Resident #1 was able to attend the care conference. The Administrator and Director of Nursing revealed the risk of not allowing the resident to be involved in the care conference would be that the resident may feel they were not able to make decisions regarding their care. Review of the facility policy titled Care planning revised October 24,2022 revealed, The Facility will invite the resident, if capable, and their family to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident and family.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268 Based on observation, interview, and record review the facility failed to ensure residents had a right to personal privacy for one of three residents (Resident #2) reviewed for personal privacy in that: Caregiver A failed to ensure the door to Resident #2's room was closed while she assisted in dressing Resident #2. This failure could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to a lack of privacy during their care. Findings included: Review of Resident #2's face sheet, printed 01/16/2024, reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included respiratory failure with hypercapnia (impairment of neuromuscular transmission, mechanical defect of the ribcage and fatigue of the respiratory muscles), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident #2's most recent quarterly MDS assessment, dated 10/02/2024, reflected he had a BIMS score of 15 which indicated Resident #2 was cognitively intact. Review of Section E titled Behaviors indicated the resident had no behaviors present. Review of the care plan with a review date of 01/26/2024 revealed Resident #2 tended to undress himself and leave his room. (This was created after surveyor intervention). Resident #2's care plan indicated he was 1 person assist for ADL's Interview and observation on 01/26/2024 at 10:46 AM revealed Resident #2 in the hall in his wheelchair with no pants or underwear on. Resident #2 had small blanket in his lap. Resident #2 stated he was going to a game room downstairs, and he was covered due to the small blanket in his lap. Resident #2 stated he would need help to go back to his room to put his clothes on. Interview and observation on 01/26/2024 at 11:00 AM with Caregiver A revealed she had worked in the facility for 6 months as a CNA pushed Resident #2 back to his room and assisted with putting on clothes. Caregiver A did not completely close the door to Resident #2's room or pull the privacy curtain which left Resident #2's bottom exposed to those in the hallway. Maintenance staff and housekeeping passed by the door while Resident #2 was getting dressed. Caregiver A stated the privacy curtain was not pulled due to the roommate not being present. Caregiver A revealed the risk of not closing the door completely or not closing the privacy curtain would be that the resident right could be violated. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/26/2024 at 3:00 PM with the Administrator and Director of nursing revealed the privacy curtain should be pulled and the door to the room should be closed when staff were providing resident care. The Administrator stated all staff were being in serviced today 01/26/2024 regarding privacy and resident rights. The Administrator stated the risk of not closing the door during care would be resident rights could be violated. Review of the facility policy titled Resident rights- quality of life revised 08/2020 revealed, Facility Staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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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 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** 45268 Based on interviews and record reviews 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 three residents (Resident #2) reviewed for accuracy of assessment . The facility failed to ensure Resident #2's care plan was revised to include his tendency to undress himself and leave his room undressed. This failure could place residents at risk of receiving care that did not fully address the resident's needs. The findings include: Review of Resident #2's face sheet, printed 01/16/2024, reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included respiratory failure with hypercapnia (impairment of neuromuscular transmission, mechanical defect of the ribcage and fatigue of the respiratory muscles), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident #2's most recent quarterly MDS assessment, dated 10/02/2024, reflected he had a BIMS score of 15 which indicated Resident #2 was cognitively intact. Review of Section E titled Behaviors indicated the resident had no behaviors present. Review of the care plan with a review date of 01/26/2024 revealed Resident #2 tended to undress himself and leave his room. (This was done after surveyor intervention) Interview and observation on 01/26/2024 at 10:46 AM revealed Resident #2 in the hall in his wheelchair with no pants or underwear on. Resident #2 had a small blanket in his lap. Resident #2 stated he was going to a game room downstairs, and he was covered due to the small blanket in his lap. Resident #2 stated he would need help to go back to his room to put his clothes on. Interview on 01/26/2024 at 11:00 AM with Caregiver A revealed had worked in the facility for 6 months. She stated she was not working the hall the Resident #2 was on however was aware of Resident #2 taking his clothes off but stated he would not typically leave his room. She stated since she had been working in the facility, she had known Resident #1 to not want to keep his clothes on. She stated when Resident #2 would take his clothes off he was redirected, and staff would attempt to redress him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/26/2024 at 2:15 PM with the MDS regional nurse revealed she had worked in the facility for the past 2 days due to the facility not currently having a MDS coordinator. She stated she updated Resident #2's care plan today (01/26/2024) to address his tendency to undress himself after she was informed of the incident in which the surveyor found the resident in his wheelchair undressed from waist down. The MDS coordinator stated she spoke with other staff and was informed that Resident #2 had a history of undressing and leaving his room. The MDS Regional Nurse revealed that due to this behavior being known to have occurred previously, then it should have already been addressed on the care plan. The MDS Regional Nurse stated she was not sure how long Resident #2 had been displaying this behavior. The MDS Regional Nurse stated the risk of not updating the care plan to reflect accurate information would be that the resident would not receive the appropriate care. Interview on 01/26/2024at 3:00PM with the Administrator and Director of Nursing revealed they each had only been working in the facility for 2 days and was not sure how long Resident #2 had been taking off his clothes and leaving the room. The Administrator and Director of Nursing stated after speaking with staff it was determined that Resident #2 had been displaying this behavior and that the care plan should have reflected the behavior. The Administrator stated the MDS Regional Nurse updated the care plan and once a new MDS nurse was hired they would be responsible for ensure the accuracy of the care plan. The Administrator and Director of Nursing stated the risk of the care plan not being updated would be care would not be properly provided to the resident. Review of the facility policy titled Care planning revised 10/24/2023 revealed, The IDT will revise the Comprehensive Care Plan as needed at the following intervals: Per RAI schedules, as dictated by changes in the resident's condition, in preparation for discharge, to address changes in behavior and care, Other times as appropriate or necessary.

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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** 45268 Based on interviews and record reviews, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, which included both the comprehensive and quarterly review assessments for one of three residents (Resident #2) reviewed for accuracy of assessment . The facility failed to ensure Resident #2's care plan was revised to include his tendency to undress himself and leave his room undressed. This failure could place residents at risk of receiving care that did not fully address the resident's needs. The findings include: Review of Resident #2's face sheet, printed 01/16/2024, reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included respiratory failure with hypercapnia (impairment of neuromuscular transmission, mechanical defect of the ribcage and fatigue of the respiratory muscles), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident #2's most recent quarterly MDS assessment, dated 10/02/2024, reflected he had a BIMS score of 15 which indicated Resident #2 was cognitively intact. Review of Section E titled Behaviors indicated the resident had no behaviors present. Review of the care plan with a review date of 01/26/2024 revealed Resident #2 tended to undress himself and leave his room. (This was done after surveyor intervention) Record review of Resident #1's Care Conference meeting notes completed 09/25/2023 revealed the resident was not present at the care plan conference due to being at dialysis. Interview and observation on 01/26/2024 at 10:46 AM revealed Resident #2 in the hall in his wheelchair with no pants or underwear on. Resident #2 had a small blanket in his lap. Resident #2 stated he was going to a game room downstairs, and he was covered due to the small blanket in his lap. Resident #2 stated he would need help to go back to his room to put his clothes on. Interview on 01/26/2024 at 11:00 AM with Caregiver A revealed had worked in the facility for 6 months. She stated she was not working the hall the Resident #2 was on however was aware of Resident #2 taking his clothes off but stated he would not typically leave his room. She stated since she had been working in the facility, she had known Resident #1 to not want to keep his clothes on. She stated when Resident #2 would take his clothes off he was redirected, and staff would attempt to redress him. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/26/2024 at 1:30PM with the Social Worker, she revealed Resident #1 had not been involved in the previous care plan conference due to him being at dialysis. The Social Worker stated was had scheduled the next care plan conference for Monday 01/29/2024 however would reschedule to allow Resident #1 to be involved. The Social Worker stated the care plan conference should be held quarterly. The Social worker stated since the last care plan conference was done in September, she thought the next one would be due in January. Interview on 01/26/2024 at 2:15 PM with the MDS regional nurse revealed she had worked in the facility for the past 2 days due to the facility not currently having a MDS coordinator. She stated she updated Resident #2's care plan today (01/26/2024) to address his tendency to undress himself after she was informed of the incident in which the surveyor found the resident in his wheelchair undressed from waist down. The MDS coordinator stated she spoke with other staff and was informed that Resident #2 had a history of undressing and leaving his room. The MDS Regional Nurse revealed that due to this behavior being known to have occurred previously, then it should have already been addressed on the care plan. The MDS Regional Nurse stated she was not sure how long Resident #2 had been displaying this behavior. The MDS Regional Nurse stated the risk of not updating the care plan to reflect accurate information would be that the resident would not receive the appropriate care. Interview on 01/26/2024at 3:00PM with the Administrator and Director of Nursing revealed they each had only been working in the facility for 2 days and was not sure how long Resident #2 had been taking off his clothes and leaving the room. The Administrator and Director of Nursing stated after speaking with staff it was determined that Resident #2 had been displaying this behavior and that the care plan should have reflected the behavior. The Administrator stated the MDS Regional Nurse updated the care plan and once a new MDS nurse was hired they would be responsible for ensure the accuracy of the care plan. The Administrator and Director of Nursing stated the risk of the care plan not being updated would be care would not be properly provided to the resident. Administrator and Director of nursing revealed the care plan conferences were held quarterly and was scheduled by the Social Worker. The Administrator and Director of Nursing stated they were not aware of why the care plan had not been completed quarterly due to them both only working in the facility for 2 days. The Administrator and Director of Nursing stated the risk of not completing the care plan conference timely would be residents may not receive the most accurate care needed. Review of the facility policy titled Care planning revised 10/24/2023 revealed, The IDT will revise the Comprehensive Care Plan as needed at the following intervals: Per RAI schedules, as dictated by changes in the resident's condition, in preparation for discharge, to address changes in behavior and care, Other times as appropriate or necessary. Review of the policy titled Care planning revised 10/24/2022 revealed, The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive Admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments.