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	03/15/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on observation, interview, and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #1) reviewed for ADLs. The facility failed to ensure Resident #1 received incontinent care on 03/15/24. This failure could place residents at risk of impaired skin integrity, and decreased feelings of self-worth and dignity. Findings Include: Record review of Resident #1's electronic face sheet, dated 03/15/24, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included obesity (excessive fat deposits), osteomyelitis (infection of the bone), Encephalopathy (change in brain function), Cellulitis (bacterial skin infection), Difficulty in Walking, Muscle Weakness, Lack of Coordination, Schizophrenia (chronic brain disorder), Acute Congestive Heart Failure (heart does not pump blood efficiently), Chronic Obstructive Pulmonary Disease (airflow blockage and breathing problems), Peripheral Vascular Disease (narrowing, blockage, or spasms of blood vessels), Non-pressure Chronic Ulcer of other part of Right Lower Leg with Unspecified Severity, and Dyspnea (labored breathing). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1's BIMS score was 11, which indicated his cognition was moderately impaired. Record review of Resident #1's Care Plan, dated 03/07/24, reflected Resident #1 was incontinent of the bowel. The goal noted on the care plan was for Resident #1 to be free of skin breakdown by being checked every 2 hours and to assist with toileting. Resident #1 had an ADL self-care deficit and needed assistance from staff for toileting, transferring, repositioning, turning, and bathing. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 03/15/24, at 10:50 AM revealed, Resident #1's room had a strong smell of urine and feces, which could be smelled at the doorway. Resident #1's bedsheet was observed to e be wet right under the resident's bottom, but darker dried stains around his thigh area. Resident #1 was laying in the bed on his back, with a brief on, no pants, with a blue blanket covering up his private area. The blue blanket was observed with a brown dried matter in circular spots. [NAME] matter was also observed on Resident #1's fingers on both hands and on the upper left thigh. Resident #1 stated he needed to be changed and he was not feeling well. Resident #1 stated he told a staff member, but he could not remember who he told and how long he had been soiled. He stated he last was moved out of the bed last night. Resident #1 stated he was not able to get to the bathroom alone. Resident #1 stated he did not feel well, because he was laying in poop and pee. In a follow up observation on 03/15/24 at 10:56 AM, Regional Director of Operations A asked Resident #1 what was the brown substance on his fingers and Resident #1 stated it was bowel movement. Regional Director of Operations stated he would have staff assist the resident as soon as possible. In an observation on 03/15/24 at 11:45 AM, Resident #1 was observed well groomed and clean as he exited the front door of the facility. In an interview on 3/15/24 at 1:07 PM, CNA B stated she arrived to work at 6:00 AM. She stated Resident #1 was one of the residents she checked on when she arrived to work. She stated she noticed Resident #1 was a little wet, but she did not change him immediately. She stated she went to get some other residents ready for dialysis. CNA B stated she returned back to Resident #1 and changed him and his bedsheet, but she could not remember what time she went back to Resident #1 to change him. She stated she changed his brief, his sheet, and cleaned him up. CNA B stated Resident #1 told her he had diarrhea. She stated she did not recall if she told a nurse Resident #1 said he had diarrhea. CNA B stated she checked on all her residents every 15-20 minutes. CNA B stated she knew the importance of changing a resident's bed sheets and brief, and that was to prevent infection and skin issues. In an interview on 03/15/24 at 2:37 PM, Administrator C stated care should be provided to all residents in a dignified and safe way. He stated the expectation was for ADL care to be given timely or when a resident needed it. Administrator C stated the bowel movement on Resident #1 appeared to be dried up, so he did not think it was a recent bowel movement. Administrator C stated Resident #1 was usually up and out of his room by that time of morning, because he's a smoker. Administrator C stated the risk of Resident #1 being left in feces and urine was a dignity issue and risked some kind of skin breakdown. Record review of the facility's policy titled, Incontinent Care/Perineal Care with or without a Catheter, dated 05/2017, reflected the following: Policy It is the policy of this home to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination. Record review of the facility's policy titled, Resident Rights-Quality of Life, dated 08/2020, reflected the following: Purpose (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	To ensure that all residents are treated with the level of dignity they are entitled to while residing in the facility. Policy Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality. XI. Facility staff provides care and services that ensure that resident's abilities in activities of daily living, including: hygiene, mobility, elimination, dining, communication, speech, language and other methods of communication do not diminish while in the care of the facility, except when unavoidable as evidenced by clinical condition.