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	04/08/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #1) of 5 residents reviewed for pressure ulcer treatment. The facility failed to ensure Resident #1 received wound care according to physician orders. This failure could place the resident at risk of worsening wounds. Findings included: Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included paralysis following a motor vehicle crash, chronic non-pressure ulcers, and bone infection to lower back. Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 15, indicating she was cognitively intact. Her Functional Status revealed she required extensive assistance with all of her ADLs. Her Skin Conditions indicated she had three Stage 4 pressure ulcers. Review of Resident #1's care plan, dated 11/29/23, indicated she had skin impairment related to fragile skin, incontinence, and poor mobility. She was care planned for behavior issues including refusing medications and wound care. Resident #1 had Stage 4 pressure ulcers to both hips and to tailbone, Stage 3 of the right elbow, and Stage 2 to the left elbow. A care plan meeting on 11/21/23 reflected the resident agreed to wound care at a certain time of the day. Review of Resident #1's physician orders revealed the following wound care orders, dated 01/24/24: STAGE 4 ULCER TO RIGHT ISCHIUM cleanse wound with dakins solutions, pat dry, apply gentamicin 1% ointment and silver alginate to wound bed, cover with dry dressing.every day shift AND as needed for soiled or dislodged STAGE 4 ULCER TO LEFT ISCHIUM cleanse wound with ns, pat dry, apply gentamicin 1% ointment and silver alginate to wound bed, cover with dry dressing every day shift AND as needed for soiled or dislodged (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	STAGE 3 ULCER TO LEFT BUTTOCKS cleanse wound with ns, pat dry, apply gentamicin 1% ointment and silver alginate to wound bed, cover with dry dressing every day shift AND as needed for soiled or dislodged STAGE 4 ULCER TO SACRUM cleanse wound with dakins, pat dry, apply gentamicin 1% ointment and silver alginate to wound bed, cover with dry dressing every day shift AND as needed for soiled or dislodged Review of Resident #1's Treatment Record for April 2024 indicated no wound care was provided on 04/03/24, 04/04/24, and 04/06/24. Review of Resident #1's Wound Care physician notes indicated on 12/13/23 the resident refused care, and subsequent notes indicated: the patient's visit has been rescheduled. Pt refused. Interview on 04/08/24 at 10:52 AM with Resident #1 revealed her wound care was supposed to be done daily, but it was frequently not done. Resident #1 stated her last wound care was done on 04/02/24. Resident #1 stated she had not seen the Wound Care Physician in several months. Resident #1 stated she did not realize refusing to see the Wound Care Physician once meant she would not be seen again. Resident #1 stated she used to refuse wound care when staff wanted to put her back to bed to do her care, and now they did wound care before she got out of bed and started her day. Observation and interview on 04/08/24 at 2:15 PM of wound care for Resident #1 provided by ADON A revealed she provided appropriate care using clean technique. ADON A stated Resident #1's wounds were slow to heal due to her physical condition and mobility issues making it difficult to offload pressure to the affected area. Resident #1's dressings were dated 4/2 [04/02/24]. Interview on 04/08/24 at 3:00 PM with ADON B revealed the nursing staff knew they had to follow physician orders as they were written. If there was any confusion, the doctor was contacted for clarification. ADON B stated the facility had a Wound Care Nurse, but she was out frequently for a medical condition. Staff nurses were responsible for wound care when the Wound Care Nurse was not available. The other ADON was helping out with wound care as well. Interview on 04/08/24 at 3:00 PM with the Regional Nurse Consultant revealed she would speak with the Wound Care Physician about seeing Resident #1 again. She agreed that one refusal should not mean the resident did not want to see the physician every week. She agreed that the lack of documentation of wound care on 04/03/24, 04/04/24, and 04/06/24 indicated the wound care was not provided due to a lack of documentation by the nurse to indicate the resident had refused care on those dates. Review of the facility's current, undated Wound Management policy reflected: .A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent non-pressure injuries from developing. Documentation: The IDT will document discussion and recommendations for: .C. v. Resident refusing care