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	05/29/2024

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 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** 42214 Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for one (Resident #1) of five residents reviewed for privacy. The facility failed to ensure RN A locked the computer, which showed Resident #1's medication and personal information, after he walked away and left the computer unattended. This failure could place residents at risk of having medical information exposed to others. This failure could cause residents to feel uncomfortable and disrespected. The findings included: Record review of Resident #1's face sheet. printed on 05/29/24, revealed a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses of fracture of lower left tibia (fracture in the lower leg), type 2 diabetes (high blood sugars), and hyperlipidemia (in excess of lipids or fats in the blood). Record review of Resident #1's quarterly MDS assessment, dated 05/16/24, reflected Resident #1 had a BIMS score of 15, which indicated she was cognitively intact. Record review of the physician orders tab of Resident #1's electronic record revealed the following active orders: Anticoagulant Monitoring Place letter of symptoms of excess bleeding in square. Complete for all blood thinners including but not limited to Plavix, Coumadin, Aspirin, Lovenox, and Heparin. Start date of 01/04/24. Admelog Solostar 100UNIT/ML Solution pen-injector, inject 25 unit subcutaneously, start date of 04/12/24. In an observation of the second-floor nurses' station on 05/29/24 at 11:40 a.m., revealed a laptop computer left opened with Resident #1's personal information, insulin and anticoagulant monitoring tasks visible. In an attempted interview on 05/29/24 at 11:52 a.m., Resident #1 stated she was well, but declined to speak with the surveyor. (continued on next page)

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 - Few	In an interview on 05/29/24 at 12:46 p.m., RN A states he was the nurse assigned to the laptop that was left opened at the second-floor nurse's station. RN A stated he did not realize he did not lock the computer before he stepped away. RN A stated he was trained to lock any computer screen when facility staff were away from any work computers. RN A stated leaving a residents health information unsecured could potentially allow other residents or other individuals to access to their HIPAA protected information. In an interview on 05/29/24 at 4:03 p.m., the DON stated it was expected for facility staff to log out, lock or engage the electronic systems privacy screen whenever staff were away from their computers. The DON stated all facility staff who accessed resident electronic health records had the responsibility to ensure the records were secured. The DON stated residents would risk having their personal information stolen or their health information would be exposed by leaving their records opened and left unattended. The DON stated she would start a HIPAA Inservice for all facility staff, and she would conduct random computer checks to ensure they were locked. In an interview on 05/29/24 at 4:30 p.m., The ADMIN stated the facility took HIPAA seriously and by no means should residents health records be left opened for all to access. The ADMIN stated it was all facility staff's responsibility to ensure records were secured at all times. The ADMIN stated residents' records that were left unsecured could lead to a leak in health information, which would be a violation of the residents' rights. The ADMIN stated he would conduct a one-on-one Inservice with RN A as well as a facility wide Inservice on HIPAA. Record review of the facility's policy entitled Resident Rights, revised in 08/2020, read in part: Resident Rights - Operational Manual - Resident Rights - Policy No. - RR - 01 Purpose: To promote and protect the rights of all residents at the Facility . Procedure: . VI. The unauthorized release, access, or disclosure of resident information is prohibited. A. Release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues .

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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** 42214 Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for one (Resident #2) of five residents reviewed for ADL care. The facility failed to ensure Resident #1 received bath/showers three times a week as per their shower schedule. This failure could place residents at risk of skin breakdown, infection and loss of self-esteem. The findings include: Record review of Resident #2's face sheet, printed on 05/29/24, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of acute osteomyelitis of the left ankle and foot(bone infection), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), major depressive disorder, type II diabetes (increase blood sugar levels) and acute infective endocarditis (inflammation of the inner lining of the heart and heart valves). Record review of Resident #2's quarterly MDS assessment, dated 05/06/24, reflected Resident #2 had a BIMS score of 10, which indicated he had a moderate cognitive impairment. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #2 was dependent on facility staff for ADLs of toileting, showers, and dressing. Record review of Resident #2's care plan revised on 05/06/24, reflected the following: FOCUS: [Resident #2] has an ADL Self Care Performance Deficit r/t wounds, Musculoskeletal impairment . INTERVENTIONS: BATHING: Provide the resident with a sponge bath when a full bath or shower cannot be tolerated. BATHING: The resident requires extensive staff participation with bathing. PERSONAL HYGIENE/ORAL CARE: the resident requires extensive staff participation with personal hygiene and oral care. PERSONAL HYGIENE: the resident requires extensive assistance with personal hygiene care . Record review of Resident #2's electronic health record, showering/bathing task indicated Resident #2's last documented shower or bed bath was 5/22/24. Record review of the facility's shower sheet binder from 03/01/24 to 05/29/24, revealed Resident #2's last documented shower was 05/18/24. In an interview on 05/28/24 at 12:36 p.m., Resident #2 stated he did not get his showers or bed baths as often as he would like. Resident #2 stated he spoke with facility staff about his showers but could not recall who he spoke to. Resident #2 stated his last shower was about a week ago. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/29/24 at 12:46 p.m., RN A stated he was Resident #2's assigned nurse. RN A stated residents showers were provided to even rooms on Monday, Wednesdays and Fridays, odd rooms were Tuesdays, Thursdays, and Saturdays. RN A stated a beds were showered by the 6:00 a.m. to 2:00 p.m. aide and b beds were showered by the 2:00 p.m. to 10:00 p.m. aide. RN A stated aides were responsible for providing residents showers and he as the nurse was responsible for signing the shower sheet to confirm the shower was provided. RN A stated he was not aware that Resident #2's last documented shower was 05/22/24. He stated he had not received any complaints from residents who had not received their showers. RN A stated residents could risk infections if they were not showered regularly. RN A states Resident #2 resided in an even numbered room, in the b-bed, so his assigned shower days were Mondays, Wednesdays, and Fridays and he should receive showers from the 2:00 p.m. to 10:00 p.m. aide. In an interview on 05/29/23 at 2:29 p.m., CNA B stated he was Resident #2's 2:00 p.m. to 10:00 p.m. aide. CNA B stated he provided showers to the b-bed residents in even rooms on Mondays, Wednesdays and Fridays and he provided showers to the b-bed residents in odd rooms on Tuesdays, Thursdays and Saturdays, if the resident allowed. CNA B stated A bed residents were showered by the 6:00 a.m. to 2:00 p.m. aide. CNA B stated he had not received any complaints about residents not receiving their showers. CNA B stated he last provided Resident #2 a bed bath roughly 8-10 days ago. CNA B stated the facility rotated staff throughout the facility and he believed CNA C was Resident #2's aide for the previous week. In an interview on 05/29/24 at 2:52 p.m., CNA C stated she last worked with Resident #2 on Monday, 05/27/24, CNA C stated she continuously asked Resident #2 if he needed anything throughout her shift and he stated no. CNA C stated she did not specifically ask Resident #2 if he wanted to take a shower, but that he normally would say what he needed. CNA C stated Resident #2 had not reported to her that he had not received his showers regularly. In an interview on 05/29/24 at 4:03 p.m., the DON stated ADL care, including showers should be provided to residents according to the schedule and upon request. The DON stated it was all nursing staff responsibility to ensure showers where provided and documented accordingly. The DON stated residents could risk infections by not being showered regularly. The DON stated she would conduct an Inservice on ADL care, the shower schedule and documentation and conduct shower sheet audits to ensure showers were offered, provided and documented regularly. In an interview on 05/29/24 at 4:30 p.m., the ADMIN stated showers should be given on schedule and upon request. The ADMIN stated the responsibility of the showers fell on all nursing staff, because the aides conduct the shower and shower sheet documentation, and the nurse signed the shower sheets to confirm the shower was given. The ADMIN states the biggest issue with resident not receiving regular showers would be the risk of skin breakdown and it could be a dignity issue. The ADMIN stated he would Inservice staff on ADL care and he and facility management would conduct shower sheet audits to ensure showers were provided. Record review of the facility's policy entitled Care and Services, revised in 06/2020, read in part: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process. Policy: Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth .