

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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 of 5 residents (Resident #1) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #1's Hydrocodone-Acetaminophen, a medication to help with pain. This failure could place residents at risk for not receiving prescribed medications. Findings included: The Minimum Data Set (MDS) dated [DATE] reflected Resident #1 was admitted on [DATE], was a [AGE] year-old male, and his diagnoses in part included Depression, difficulty in walking, phantom limb syndrome with pain (feeling pain in a missing body part after amputation), polyneuropathy (malfunction of many nerves outside of the brain or spinal cord), and chronic pain syndrome. The Care Plan dated 11/07/24 reflected Resident #1 required pain management related to chronic pain syndrome, polyneuropathy, and phantom pain and included the intervention to administer pain medication as per orders. A record review of a written statement obtained by the facility, dated 01/27/25 and signed by LVN B revealed that LVN B reported that she accepted Resident #1's narcotic medication on early Saturday morning of 01/25/25. She reported she placed Resident #1's narcotic in the lock box and placed a narcotic count sheet in the binder. LVN B no longer worked at the facility, could not be contacted by phone (disconnected) and was not available for interview. A record review of the pharmacy manifest reflected that LVN B signed for receipt of Resident #1's Oxycodone 10 mg, 60 count, on 01/25/25 at 12:00 am. In an interview on 02/04/25 at 05:35, LVN A reported that when she returned to work on 01/27/25 she noted that Resident #1's oxycodone was not on the 200 Hall medication cart. She reported she noted this because she had ordered this medication the prior week and she expected it to have been delivered. She reported that she called the pharmacy who verified the medication had been delivered and that she notified the ADON and DON of the missing medication. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/04/25 at 17:30, Resident #1 reported that he did not request or need his oxycodone over the weekend of 01/25/25 to 01/27/25 and that he had wanted to try a trial of remaining only on Tylenol. He reported he only became aware of an issue with the medication missing when the facility notified him on 01/27/25. He reported he had never had an issues with receiving his narcotic as needed and had no idea what might have happened to his medication. In an interview on 02/05/25 at 11:37 am, Nurse Practitioner E, reported he was notified of Resident #1's missing narcotic and that the facility told him they had started an investigation. He reported that Resident #1 did not complain of any unmanaged pain to him, and that Resident #1 was very vocal about any issues. He stated it looked like the Tylenol was effective for Resident #1 and that the Oxycodone was subsequently discontinued. In an interview on 02/05/25 at 09:55 am, the DON reported that Resident #1's oxycodone, 10 mg-60 tabs was delivered by the pharmacy on Friday night (01/25/25) and was placed on the medication cart and the narcotic sheet was put in the narcotic count book by LVN B. She reported she reviewed the cameras and was able to verify this. She reported the cameras did not reach all the way down the hall and were not able to capture what might have occurred after this. She was notified the medication was missing on 01/27/25 when LVN A recognized that they were missing. She reported that LVN A recognized the medications were missing because she was the one who had ordered them. She reported the weekend nurses did not notice they were missing during narcotic count each shift because the weekend nurses did not order them, the medication was ordered as needed and the resident did not request it, and because the narcotic sheet was missing as well as both cards (60 count tablets) of the medication. The DON reported that the facility immediately started the investigation, interviewed all the nurses with access to that narcotic, took written statements, and no one recalled counting that specific medication. She reported a police report was filed and that the facility does not have a policy that allows for drug testing of employees. The DON reported that following the investigation she put into place the procedure that two nurses would sign to receive narcotics from the pharmacy and place them on the medication cart, and that ADONs would check the narcotic book each morning for discrepancies. She reported the facility is also putting into place a procedure in which the narcotic count will include the counting and reconciliation of the total number of narcotic medications cards on the cart. In an interview on 02/05/25 at 08:36 am, Medication Aide A revealed she had not witnessed medication carts being left unlocked or narcotics left unsecured. She did note that if the entire narcotic card as well as that drug's narcotic count sheet were removed, there would be no way for the staff to know that the narcotic was missing. In an interview on 02/05/25 at 08:49 am, LVN D reported that narcotic count was done each shift with the oncoming nurse, and she denied witnessing medication carts being left unlocked or narcotics left unattended. She reported that if the entire card for a medication was removed from the cart as well as the corresponding narcotic count sheet, there would be no way for the nurse to know that the medication was missing. In an interview on 02/05/25, the ADON (LVN F) reported that Resident #1's narcotic was noted as missing with each shift's narcotic count for two days because the entire medication cards as well as the narcotic count sheet for that drug was missing. She reported to minimize the risk of this occurring in the future, the facility was going to implement counting the number of narcotic cards that are supposed to be present on the cart as part of the cart exchange count process each shift. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse Prevention and Prohibition Program with revision date 10-24-22 stated the purpose of the policy was, To ensure the Facility establishes, operationalizes, and maintains an Abuse prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review the facility failed to determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 5 residents (Resident #1) reviewed for accurate reconciliation of controlled medications. The facility failed to have an accurate reconciliation and accounting of all controlled medications for one resident (Resident #1) of five residents reviewed for accurate reconciliation of controlled medications. This failure could place residents receiving controlled medications at risk for a lack of availability of controlled medications or unnecessary interruptions in receiving controlled medication due to possible drug diversion. Findings included: The Minimum Data Set (MDS) dated [DATE] reflected Resident #1 was admitted on [DATE], was a [AGE] year-old male, and his diagnoses in part included Depression, difficulty in walking, phantom limb syndrome with pain (feeling pain in a missing body part after amputation), polyneuropathy (malfunction of many nerves outside of the brain or spinal cord), and chronic pain syndrome. The Care Plan dated 11/07/24 reflected Resident #1 required pain management related to chronic pain syndrome, polyneuropathy, and phantom pain and included the intervention to administer pain medication as per orders. A record review of a written statement obtained by the facility, dated 01/27/25 and signed by LVN B revealed that LVN B reported that she accepted Resident #1's narcotic medication on early Saturday morning of 01/25/25. She reported she placed Resident #1's narcotic in the lock box and placed a narcotic count sheet in the binder. LVN B no longer worked at the facility, could not be contacted by phone (disconnected) and was not available for interview. A record review of the pharmacy manifest reflected that LVN B signed for receipt of Resident #1's Oxycodone 10 mg, 60 count, on 01/25/25 at 12:00 am. In an interview on 02/04/25 at 05:35, LVN A reported that when she returned to work on 01/27/25 she noted that Resident #1's oxycodone was not on the 200 Hall medication cart. She reported she noted this because she had ordered this medication the prior week and she expected it to have been delivered. She reported that she called the pharmacy who verified the medication had been delivered and that she notified the ADON and DON of the missing medication. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/04/25 at 17:30, Resident #1 reported that he did not request or need his oxycodone over the weekend of 01/25/25 to 01/27/25 and that he had wanted to try a trial of remaining only on Tylenol. He reported he only became aware of an issue with the medication missing when the facility notified him on 01/27/25. He reported he had never had an issues with receiving his narcotic as needed and had no idea what might have happened to his medication. In an interview on 02/05/25 at 11:37 am, Nurse Practitioner E, reported he was notified of Resident #1's missing narcotic and that the facility told him they had started an investigation. He reported that Resident #1 did not complain of any unmanaged pain to him, and that Resident #1 was very vocal about any issues. He stated it looked like the Tylenol was effective for Resident #1 and that the Oxycodone was subsequently discontinued. In an interview on 02/05/25 at 09:55 am, the DON reported that Resident #1's oxycodone, 10 mg-60 tabs was delivered by the pharmacy on Friday night (01/25/25) and was placed on the medication cart and the narcotic sheet was put in the narcotic count book by LVN B. She reported she reviewed the cameras and was able to verify this. She reported the cameras did not reach all the way down the hall and were not able to capture what might have occurred after this. She was notified the medication was missing on 01/27/25 when LVN A recognized that they were missing. She reported that LVN A recognized the medications were missing because she was the one who had ordered them. She reported the weekend nurses did not notice they were missing during narcotic count each shift because the weekend nurses did not order them, the medication was ordered as needed and the resident did not request it, and because the narcotic sheet was missing as well as both cards (60 count tablets) of the medication. The DON reported that the facility immediately started the investigation, interviewed all the nurses with access to that narcotic, took written statements, and no one recalled counting that specific medication. She reported a police report was filed and that the facility does not have a policy that allows for drug testing of employees. The DON reported that following the investigation she put into place the procedure that two nurses would sign to receive narcotics from the pharmacy and place them on the medication cart, and that ADONs would check the narcotic book each morning for discrepancies. She reported the facility is also putting into place a procedure in which the narcotic count will include the counting and reconciliation of the total number of narcotic medications cards on the cart. In an interview on 02/05/25 at 08:36 am, Medication Aide A revealed she had not witnessed medication carts being left unlocked or narcotics left unsecured. She did note that if the entire narcotic card as well as that drug's narcotic count sheet were removed, there would be no way for the staff to know that the narcotic was missing. In an interview on 02/05/25 at 08:49 am, LVN D reported that narcotic count was done each shift with the oncoming nurse, and she denied witnessing medication carts being left unlocked or narcotics left unattended. She reported that if the entire card for a medication was removed from the cart as well as the corresponding narcotic count sheet, there would be no way for the nurse to know that the medication was missing. In an interview on 02/05/25, the ADON (LVN F) reported that Resident #1's narcotic was noted as missing with each shift's narcotic count for two days because the entire medication cards as well as the narcotic count sheet for that drug was missing. She reported to minimize the risk of this occurring in the future, the facility was going to implement counting the number of narcotic cards that are supposed to be present on the cart as part of the cart exchange count process each shift. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse Prevention and Prohibition Program with revision date 10-24-22 stated the purpose of the policy was, To ensure the Facility establishes, operationalizes, and maintains an Abuse prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for one (Resident #2) of five residents reviewed for medications errors in that: The facility administered Clonidine to Resident #2 on multiple occasions outside of the ordered blood pressure parameters. This failure could place residents receiving blood pressure medications at risk for low blood pressure. Findings include: Review of Resident #2's Face Sheet and Minimum Data Set (MDS) dated [DATE] reflected Resident #2 was a was a [AGE] year-old male admitted on [DATE] with diagnoses in part including End Stage Renal Disease (final, permanent stage of chronic kidney disease where kidneys no longer function on their own), and Essential Hypertension (high blood pressure not caused by another medical condition). Review of Care Plan dated 10/15/24 reflected Resident #2 had hypertension which included an intervention to give antihypertensive medications as ordered. Review of Physician G's physician order dated 12/30/24 reflected Resident #2 was ordered to receive Clonidine 0.2 milligrams by mouth three times daily if systolic blood pressure was greater than 170, diastolic blood pressure greater than 100. This order was open-ended (had no stop date). Review of Resident #2 Medication Administration Record (MAR) reflected Resident #2 received Clonidine 0.2 mg on two occasions in February 2025, 49 occasions in January 2025, and 68 occasions in December 2024 when Resident #2's blood pressure was less than 170 systolic and less than 100 diastolic. A review of Resident #2's blood pressures for February 2025, January 2025, and December 2024 reflected no episodes of hypotension requiring intervention. In an interview on 02/05/25 at 09:10 am, Medication Aide H stated she had received in-service training on 02/04/25 regarding the need to give blood pressure medications according to ordered parameters. She reported Resident #2 took two blood pressure medications. One medication if the blood pressure was not below 110/60, and an additional medication if blood pressure was above 170/100 and she had been in a routine of taking the blood pressure and giving the medication without necessarily reading the parameters. She stated it was human error and she took responsibility. She reported that giving Clonidine outside of the scheduled parameters could cause the resident to have low blood pressure. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 09:55 am, the DON reported that she was notified on 02/05/25 of Clonidine being given to Resident #2 outside of the ordered blood pressure parameters. She reported the nurse practitioner was notified and the ordered was changed from scheduled to PRN (as needed) so that nurses would give this medication instead of the medication aides. She reported all other medication aide carts were audited and no other orders for scheduled Clonidine with ordered parameters were found. She reported the facility would review all blood pressure medications including ordered parameters during, stand up report in the mornings. The DON reported that Resident #2 did not experience any known adverse effects due to this medication error. The DON reported that if a resident received Clonidine outside of the scheduled blood pressure parameters, they could potentially code (cardiac arrest), pass away, or end up in the emergency room . In an interview on 02/05/25 at 11:37 am, Nurse Practitioner E reported that the facility notified him that Resident #2 had received Clonidine outside of the ordered blood pressure parameters and that he had come to the facility to evaluate Resident #2 on 02/05/25. He reported that Resident #2 had no negative impact that he could find, and that hypotension was the only side effect that could have happened. In an interview on 02/05/25 the Medical Director reported that most dialysis patients including Resident #2 required antihypertensive medications, and that after reviewing Resident #2's chart, it looked like Resident #2 receiving Clonidine 0.2 mg outside of the scheduled blood pressure parameters had actually helped his blood pressure. He reported the risk of giving an antihypertensive medication outside of the ordered parameters is that the resident could have low blood pressure. In an interview on 02/04/25 at 16:30 pm, Resident #2 reported that the medication aides always took his blood pressure, and he had not experienced any issues with his medications or his blood pressure. He reported that his medications were given accurately to the best of his knowledge. He denied any symptoms of hypotension, and none were noted. The facility policy titled, Medication-Administration (Policy no. -NP-310, undated) states, The resident's MAR will be reviewed for allergies and/or special considers for administration including: C. vital sign parameters and lab results as appropriate.		