

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

Printed: 06/26/2025
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 03/07/2025
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #1) of five residents reviewed for injury of unknown origin reporting. The facility failed to ensure on 02/02/25 Resident #1's injury of unknown origin was reported to HHSC when the staff did not know why she had a swollen left wrist that was later diagnosed as fractured (broken). This failure could place fall risk residents of getting more injuries, bruises, and pain which could result in emotional turmoil and cause decreased health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed by MDS Coordinator R on 02/06/25 revealed, a [AGE] year-old female who admitted on [DATE] with a BIMS score of 02 (Severe cognitive impairment). She was admitted to the 100 hall (memory care unit). She had disorganized thinking and inattention that fluctuated and no assistance for mobility needed and did not have any mood or behaviors. She needed partial to moderate assistance with toileting, bathing, upper and lower body dressing, personal hygiene and partial to moderate assistance with transfers. She was always continent with urine and bowel and she had other neurological conditions. She had diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection and damage), hyperlipidemia (high level of fat particles), thyroid disorder (gland dysfunction), non -Alzheimer's - Dementia (cognitive loss), malnutrition (nutritional deficit), encephalopathy (brain disease) , insomnia (poor sleep habit), muscle weakness (weak muscles), difficulty walking, other lack of coordination, cognitive communication deficit. She had a history of falling with no injury and for the past seven days took antipsychotic and antidepressant medications. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated 01/30/25 revealed, Impaired cognitive function/dementia or impaired thought processes related to dementia. On 01/23/25 At risk for elopement related to elopement evaluation risk score and requires a secured unit environment for safety and at risk for falls related to decreased safety awareness, impaired cognition, wandering, will often lay on the floor. On 01/25/25 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. On 02/02/25 had an actual fall with major injury (wrist fracture). On 02/05/25 alteration in musculoskeletal status related to fracture of the left wrist. Record review of Resident #1's Incident Report by LVN A dated 02/02/25 at 4:41 pm revealed, Incident Description Nursing Description: observed swelling to left wrist. Incident was unwitnessed. Resident Description: Resident was unable to specify. Was this incident witnessed: No. Immediate Action Taken: Description: Attempted to do ROM exercises. Resident stated it is too painful. Picture taken and sent to NP G. STAT X-RAY was ordered. Ice applied to the Left wrist/hand. PRN Tylenol given for the pain. Resident Taken to Hospital? No. Mental status: oriented to person, lack of safety awareness, forgetful, Predisposing physiological factors: confused, gait imbalanced, Administrator, [Weekend Supervisor E] and the [FM] notified. Record review of Resident #1's left wrist and hand 2 D (dimensional) X-ray results, dated 02/03/25, revealed, Final Reason for Study: R22.32 LOCALIZED SWELLING, MASS, AND LUMP, LEFT UPPER LIMB - WRIST 2V (view), LEFT See Note FINDINGS: There is a dorsal impaction fracture (wrist bone break)involving the distal radius (broken wrist) with modest callus (bone cartilage) and mild displacement. There is associated soft tissue swelling. Diffuse osseous demineralization (decreased bone density) is noted. Moderate degenerative changes are seen. See Note CONCLUSION: Impacted wrist fracture (wrist bone driven into another bone, compression damage) as described. Correlation is needed with history, symptomatology, and physical exam to determine precise acuity. CT or MRI examination follow-up is advised if clinical ambiguity remains. Record review on Resident #1's Nurses note dated 02/03/25 by LVN B revealed, [NP G]n/o to send resident to ER for evaluation, FM requests that resident be sent to Hospital ER. Record review of Resident #1's Hospital Discharge Record dated 02/03/25 revealed, Diagnosis: wrist Mildly displaced intra-articular fracture of the distal radius (break in wrist bone) with mild apex volar angulation (small degree tilt or bending of fracture point). Surrounding soft tissue swelling. The carpal arcs are preserved (wrist bones were intact): Ortho clinic 2 weeks. Record review of Resident #1's Nurses Note dated 02/03/25 by RN H revealed, Returned from the ER Hospital. Was sent there for left wrist fx. Returned with dx closed fx of distal end of left radius (broken bone at the wrist), unspecified fx morphology(shape/form). A splint immobilizer was applied, wrapped with ace wrap. Plan is for surgical procedure - closed reduction (realign of fracture without surgery) or the wrist at surgical center. The center will call for further information. The [FM] aware. Assessed for pain continuing. Denied pain on arrival to reassess. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 02/13/25 at 7:10 pm at the hospital revealed Resident #1 had 1:1 hospital sitter in the room with her and she was watching TV. Resident #1 had a beige elastic bandage wrapped around her left wrist and forearm and cotton was underneath the bandage. She stated she had not fallen that she knew of and that her arm was broken because she was always picking up something too heavy. Resident #1 said she had no pain of her mouth or left wrist and said she could not remember where she lived prior to coming to the hospital. She stated she could not remember if anyone had been abusive to her, and the people should know if they were abusive because she did not have time for that. She stated the IV port and hospital ID band on her right arm got on her nerves more so than the elastic bandage around her left arm. Interview on 02/14/25 at 10:39 am, LVN A stated she worked double weekends. She stated Resident #1 admitted about three weeks ago and she was very familiar with Resident #1. Resident #1 normally walked but had an unsteady gait and they always made sure her bed was in the lowest position. She stated they also increased monitoring of Resident #1 and anticipated her needs and that she was A/o x1 (person). She stated Resident #1 was doing well walking without assist but once or twice she was sent to the hospital. She stated she worked Saturday 02/01/25 and Resident #1 did not have any falls, unusual occurrences or wrist swelling but she did have generalized and hip pain. She stated she called Resident #1's doctor and her Tylenol 300 mg was increased to 650 mg which was effective. She stated the FM said she did not want Resident #1 on narcotics and the hip pain was probably due to a fall she had at home. She stated she did not remember Resident #1 having a fall the weekend of Saturday 02/01/25 or Sunday 02/02/25. She stated on Sunday 02/02/25 Resident #1 was not a morning person and they would let her sleep in. She stated Resident #1 woke up around 9:00 am or 10:00 am on 02/02/25 and she had no swelling of her left wrist but later that afternoon the FM visited and reported Resident #1's left wrist was swollen. She stated when she assessed Resident #1, she saw the swelling of her left wrist and the FM said her left wrist was not swollen the previous day. She stated she took a picture of Resident #1's left wrist to show the DON and ADON F and to her doctor. She stated she asked Resident #1 to flex her arm and Resident #1 said it hurt and her doctor ordered a STAT x-ray. She stated she was confused as to how Resident #1's left wrist got swollen even though Resident #1 said she fell a couple of days ago. She stated the FM said Resident #1 could be saying she fell but she could have fallen the night prior 02/01/25 or that day 02/02/25. She stated Resident #1 was fine on 02/02/25 and few hours later her left wrist was swollen then she did Resident #1's full body assessment. She stated Resident #1's left kneecap and left elbow had STs and Resident #1 said she fell but could not say how. She stated if she had a fall who could have helped her off the floor, because she did not have a lot of strength. She stated they could not say if Resident #1 was able to get up without assist after falling, and they did not know what caused Resident #1's swollen broken left wrist. She stated on 02/02/25 Resident #1's left wrist x-ray was done and LVN B sent her to the hospital on 02/03/25. Interview on 02/24/25 at 3:02 pm, the Administrator stated she was manager on duty on 02/02/25 and heard Resident #1 had fallen. She stated she was making rounds on 02/02/25 around 10:30 am and talked to Resident #1 who was sitting in a chair in the dining room and she was fine. She stated later seeing Resident #1's wrist was swollen and she asked LVN A to let her know when the FM came to the facility. She stated she spoke to the staff from the night before and who were on duty on 02/02/25 and no one said she had fallen. She stated even though Resident #1's BIMS score was low they went by what Resident #1 said that she had fallen, which was why she did not report the incident to HHSC. She stated she believed Resident #1 had fallen and the nurses did their incident and reporting process. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse and Neglect policy date revised 10/24/24 revealed, Purpose: To ensure the facility establishes, operationalizes, and maintains an Abuse prevention and prohibition program designed to screen and train employee, protect residents and to ensure a standardized methodology for the prevention, identification, investigation and reporting of abuse in accordance with federal and state requirements. Policy: Each resident has the right to be free from mistreatment, abuse .The facility has zero tolerance for abuse .Procedure: IX. Reporting/Response: D. The facility will report allegations of injuries of unknown source i. Immediately, but no later than 2 hours after forming the suspicion if the alleged violation results in serious bodily injury to the state survey agency .		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record reviews the facility failed to ensure In response to allegations of abuse, neglect, or mistreatment, have evidence that all alleged violations were thoroughly investigated to prevent further potential abuse, neglect, or mistreatment while the investigation was in progress. And report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for one (Resident #1) of five residents reviewed for Abuse and Neglect. The facility failed to ensure on 02/02/25 Resident #1's injury of unknown origin was investigated and report sent to HHSC when the staff did know why she had a swollen left wrist that was later diagnosed as fractured (broken). This failure could place residents at risk of getting more injuries, bruises, and pain which could result in emotional turmoil and cause decreased health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed by MDS Coordinator R on 02/06/25 revealed, a [AGE] year-old female who admitted on [DATE] with a BIMS score of 02 (Severe cognitive impairment). She was admitted to the 100 hall (memory care unit). She had disorganized thinking and inattention that fluctuated and no assistance for mobility needed and did not have any mood or behaviors. She needed partial to moderate assistance with toileting, bathing, upper and lower body dressing, personal hygiene and partial to moderate assistance with transfers. She was always continent with urine and bowel and she had other neurological conditions. She had diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection and damage), hyperlipidemia (high level of fat particles), thyroid disorder (gland dysfunction), non -Alzheimer's - Dementia (cognitive loss), malnutrition (nutritional deficit), encephalopathy (brain disease) , insomnia (poor sleep habit), muscle weakness (weak muscles), difficulty walking, other lack of coordination, cognitive communication deficit. She had a history of falling with no injury and for the past seven days took antipsychotic and antidepressant medications. Record review of Resident #1's Care Plan dated 01/30/25 revealed, Impaired cognitive function/dementia or impaired thought processes related to dementia. On 01/23/25 At risk for elopement related to elopement evaluation risk score and requires a secured unit environment for safety and at risk for falls related to decreased safety awareness, impaired cognition, wandering, will often lay on the floor. On 01/25/25 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. On 02/02/25 had an actual fall with major injury (wrist fracture). On 02/05/25 alteration in musculoskeletal status related to fracture of the left wrist. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/14/25 at 10:39 am, LVN A stated she worked double weekends. She stated Resident #1 admitted about three weeks ago and she was very familiar with Resident #1. Resident #1 normally walked but had an unsteady gait and they always made sure her bed was in the lowest position. She stated they also increased monitoring of Resident #1 and anticipated her needs and that she was A/o x1 (person). She stated Resident #1 was doing well walking without assist but once or twice she was sent to the hospital. She stated she worked Saturday 02/01/25 and Resident #1 did not have any falls, unusual occurrences or wrist swelling but she did have generalized and hip pain. She stated she called Resident #1's doctor and her Tylenol 300 mg was increased to 650 mg which was effective. She stated the FM said she did not want Resident #1 on narcotics and the hip pain was probably due to a fall she had at home. She stated she did not remember Resident #1 having a fall the weekend of Saturday 02/01/25 or Sunday 02/02/25. She stated on Sunday 02/02/25 Resident #1 was not a morning person and they would let her sleep in. She stated Resident #1 woke up around 9:00 am or 10:00 am on 02/02/25 and she had no swelling of her left wrist but later that afternoon the FM visited and reported Resident #1's left wrist was swollen. She stated when she assessed Resident #1, she saw the swelling of her left wrist and the FM said her left wrist was not swollen the previous day. She stated she took a picture of Resident #1's left wrist to show the DON and ADON F and to her doctor. She stated she asked Resident #1 to flex her arm and Resident #1 said it hurt and her doctor ordered a STAT x-ray. She stated she was confused as to how Resident #1's left wrist got swollen even though Resident #1 said she fell a couple of days ago. She stated the FM said Resident #1 could be saying she fell but she could have fallen the night prior 02/01/25 or that day 02/02/25. She stated Resident #1 was fine on 02/02/25 and few hours later her left wrist was swollen then she did Resident #1's full body assessment. She stated Resident #1's left kneecap and left elbow had STs and Resident #1 said she fell but could not say how. She stated if she had a fall who could have helped her off the floor, because she did not have a lot of strength. She stated they could not say if Resident #1 was able to get up without assist after falling, and they did not know what caused Resident #1's swollen broken left wrist. She stated on 02/02/25 Resident #1's left wrist x-ray was done and LVN B sent her to the hospital on 02/03/25. Interview on 02/24/25 at 3:02 pm, the Administrator stated she was manager on duty on 02/02/25 and heard Resident #1 had fallen. She stated she was making rounds on 02/02/25 around 10:30 am and talked to Resident #1 who was sitting in a chair in the dining room and she was fine. She stated later seeing Resident #1's wrist was swollen and she asked LVN A to let her know when the FM came to the facility. She stated she spoke to the staff from the night before and who were on duty on 02/02/25 and no one said she had fallen. She stated even though Resident #1's BIMS score was low they went by what Resident #1 said that she had fallen, which was why she did not investigate this 02/02/25 incident to HHSC. She stated she believed Resident #1 had fallen and the nurses did their incident and reporting process. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse and Neglect policy date revised 10/24/24 revealed, Purpose: To ensure the facility establishes, operationalizes, and maintains an Abuse prevention and prohibition program designed to screen and train employee, protect residents and to ensure a standardized methodology for the prevention, identification, investigation and reporting of abuse in accordance with federal and state requirements. Policy: Each resident has the right to be free from mistreatment, abuse .The facility has zero tolerance for abuse .Procedure: VI. Investigation: A. The facility promptly and thoroughly investigates reports of .injuries of unknown source. B. The Administrator receives the report of an incident or suspected incident of resident .injuries of unknown source. VII. Special consideration for investigation of injuries of unknown origin (unexplained injuries): A. Unexplained injuries are promptly and thoroughly investigated by the Director of Nursing Services and/or other staff person designated by the Administrator, to ensure that resident safety is not compromised and action is taken whenever possible, to avoid future occurrences.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32581 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents reviewed for care plans. The facility failed to ensure Resident #1's care plan addressed her combative behavior (aggressive and eager to fight or argue) as documented by RN Q on 01/26/25 and ADON F on 01/27/25. Subsequently, on 02/06/25 at 10:22 pm, LVN D and CNA I said Resident #1 was about to fall and as they tried to stop her from falling, Resident #1 became combative and hit her lip which caused her lip to bleed. And on 02/08/25, Resident #1 hit the Weekend Supervisor E's face when she was trying to reposition Resident #1. This failure could place all residents with aggressive and combative behaviors, at risk of their individual needs not being met, which could cause falls and injuries and result in a decline in the resident's health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed by MDS Coordinator R on 02/06/25 revealed, a [AGE] year-old female who admitted on [DATE] with a BIMS score of 02 (Severe cognitive impairment). She was admitted to the 100 hall (memory care unit). She had disorganized thinking and inattention that fluctuated and no assistance for mobility needed and did not have any mood or behaviors. She needed partial to moderate assistance with toileting, bathing, upper and lower body dressing, personal hygiene and partial to moderate assistance with transfers. She was always continent with urine and bowel and she had other neurological conditions. She had diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection and damage), hyperlipidemia (high level of fat particles), thyroid disorder (gland dysfunction), non -Alzheimer's - Dementia (cognitive loss), malnutrition (nutritional deficit), encephalopathy (brain disease) , insomnia (poor sleep habit), muscle weakness (weak muscles), difficulty walking, other lack of coordination, cognitive communication deficit. She had a history of falling with no injury and for the past seven days took antipsychotic and antidepressant medications. (The MDS did not address her combative behaviors) (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Care Plan dated 01/30/25 revealed, the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. On 01/23/25 she was at risk for elopement related to elopement evaluation risk score and required a secured unit environment for safety and at risk for falls related to decreased safety awareness, impaired cognition, wandering and will often lay on the floor. With interventions: Anticipate and meet the resident's needs and to be sure the resident's call light was within reach and encouraged the resident to use it for assistance as needed. Educated the resident/family/caregivers about safety reminders and what to do if a fall occurred. Encouraged the resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. Ensured that the resident was wearing appropriate footwear examples included nonskid socks, closed footed shoes and other safe footed coverings when ambulating or mobilizing in w/c. On 01/25/25 she was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. Interventions: Introduced the resident to residents with similar background, interests, and encourage/facilitate interaction. Invited the resident to scheduled activities and provided the resident with materials for individual activities as desired the resident liked the following independent activities and to Provide with activities calendar. Notify resident of any changes to the calendar of activities. The resident needed 1 to 1 bedside/in-room visits and activities if unable to attend out of room events On 02/04/25 had an actual fall with major injury (wrist fracture) with Interventions: For no apparent acute injury, determine and address causative factors of the fall. And to monitor/document /report PRN x 72 hours to Medical Doctor for signs/symptoms: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Provided activities that promoted exercise and strength building where possible. And to Provide 1:1 activities if bedbound On 02/05/25 alteration in musculoskeletal status related to fracture of the left wrist. (The Care plans did not address her combative behaviors). Record review of Resident #1's Progress Note dated 01/26/2025 at 4:57 pm Type: Skilled Evaluation by RN Q revealed, .Teaching and Training;,, assessed behavior, assess for pain, assess for anxiety , provided redirection, Neurological: Resident is Alert: Oriented to Person; Oriented to Place; Resident has Impaired decision making ability; Resident is Confused; Resident has Delusions: Difficulty understanding others, Skin/Skin Conditions: No changes in skin integrity, Cardiovascular .Muscular: Resident has an unsteady gait requiring supervision; Resident has had a change in ADL functional ability, Resident is Ambulatory, Walks Independently, Mood/Behavior: Changes noted in behavior, Resident intentionally lay herself to the floor; uncooperative to be provided assistance to her safety, or to be redirected, and combative to the staff. Record review of Resident #1's Progress Note dated 01/27/2025 at 11:33 a.m., by ADON F revealed, Type: Skilled Evaluation LATE ENTRY Teaching and Training; assessed behavior, assess for pain, assess for anxiety , provided redirection, Neurological: Resident is Alert; Oriented to Person; Oriented to Place; Resident has Impaired decision-making ability; Resident is Confused; Resident has Delusions. Difficulty understanding others; Skin/Skin Conditions: No changes in skin integrity, Gastrointestinal: .Continent of Bowel, Bowel Sounds: Present; Gastro-urinary: Continent of Bladder, Urine Color: Amber, Urine Clarity Clear, No foul odor noted . Muscular: Resident has an unsteady gait requiring supervision; Resident has had a change in ADL functional ability, Resident is Ambulatory, Walks Independently; Mood/Behavior: Changes noted in behavior, Resident intentionally lay herself to the floor; uncooperative to be provided assistance to her safety, or to be redirected, and combative to the staff. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Incident report dated 02/06/25 at 10:22 p.m., by LVN D revealed, Resident was seen walking slumped over when she tripped over her socks, this nurse and on shift CNA attempted to assist Resident to floor when she became combative and physically aggressive with staff, hitting herself in the mouth with her splinted left wrist. Resident was eased to the floor by staff and allowed to rest before being helped back to her feet and assisted to her room. Full head to toe assessment was completed resulting vital signs within normal limits, no apparent bruising, no s/s of respiratory distress. Resident had a complaint of pain in her lip where she hit her mouth with wrist. PRN pain medication administered, and pain has since subsided upon recheck. Resident seen lying in bed resting. Hydration and call light are within reach, bed is in lowest position possible. Care continues. Resident Description: She lost her footing because her socks were too slippery and did not need help getting up. Resident was eased to the floor by staff and allowed to rest before being helped back to her feet and assisted to her room. Full head to toe assessment was completed resulting vital signs within normal limits, no apparent bruising, no s/s of respiratory distress. Res had a complaint of pain in her lip where she hit her mouth with wrist. PRN pain medication administered, and pain has since subsided upon recheck. MD notified, DON/ADON notified. RP notified. Resident seen lying in bed resting. Hydration and call light are within reach, bed is in lowest position possible. Care continues. Resident taken to hospital: No. Injury location: face. Pain level 5 (moderate pain level), Alert, ambulatory with assistance. Mental status: Oriented to person, impulsiveness, lack of safety awareness, forgetful. Res the inside of her lip, Resident taken to rest room to rinse her mouth, given PRN pain med which was effective at recheck. Res resting in bed with eyes closed at this time. Confused, impaired memory, sundowning. Record review of Resident #1's Provider Investigation Report incident dated 02/08/25 at 2:30 p.m., revealed the [FM] alleged that the nurse supervisor (Weekend Supervisor E) had hit Resident #1 in her mouth. There was a bruise on the right side of her chin and redness inside her mouth on the bottom gums. The resident denied any pain or discomfort. Treatment was provided and the resident was taken to the hospital. Statements, interviews, and resident safe surveys were completed and determined the facial bruising and swelling was from her fall 02/07/25. Findings: Unfounded. Interview on 02/13/25 at 5:30 p.m., LVN D stated Resident #1 used to say she worked at the hospital and was the typical dementia resident with behaviors. She stated she was verbally and physically aggressive to the staff and her mindset was that she was always working and she required a lot of redirecting. She stated Resident #1 had a splint with an ace bandage to keep it in place since 02/03/25. She stated Thursday 02/06/25 around 10:00 p.m. or 11:00 p.m., Resident #1 was walking down the hallways by the dining room. She stated she and CNA C saw Resident #1 looking like she was about to fall but Resident #1 said no she did not want any help. She stated they tried to lower Resident #1 to the floor and in the process Resident #1 hit the right side of her mouth (lip) with her cast. She stated Resident #1 had minimum bleeding from her lip and after she assessed Resident #1 she had a skin tear on her lip. She stated she gave her PRN Tylenol and called her Doctor and the FM. She stated she was pending an x-ray of right chin and a skull series as a precaution. She stated she went to check on Resident #1 and she was fine and had no bleeding. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/14/25 at 10:39 am, LVN A stated she worked double weekends. She stated Resident #1 admitted about three weeks ago, and she was very familiar with Resident #1. She stated Resident #1 normally walked but had an unsteady gait and they always made sure her bed was in the lowest position. She stated they also increased monitoring of Resident #1 and anticipated her needs and that she was A/O x1 (person). She stated Resident #1 was doing well walking without assist, but once or twice she was sent to the hospital (for the swollen wrist and bruised and swollen face). She stated she worked Saturday 02/01/25, and Resident #1 did not have any falls, unusual occurrences ,or wrist swelling, but she did have generalized and hip pain. She stated she called Resident #1's doctor and her Tylenol 300 mg was increased to 650 mg which was effective. She stated the FM said she did not want Resident #1 on narcotics and the hip pain was probably due to a fall she had at home. She stated she did not remember Resident #1 having a fall the weekend of Saturday 02/01/25 or Sunday 02/02/25. She stated on Sunday 02/02/25, Resident #1 was not a morning person and they would let her sleep in. She stated Resident #1 woke up around 9:00 am or 10:00 am on 02/02/25 and she had no swelling of her left wrist, but later that afternoon the FM visited and reported Resident #1's left wrist was swollen. She stated when she assessed Resident #1, she saw the swelling of her left wrist, but the FM said her left wrist was not swollen the previous day. She stated she took a picture of Resident #1's left wrist to show the DON and ADON F and to her doctor. She stated she asked Resident #1 to flex her arm, Resident #1 said it hurt, and her doctor ordered a STAT x-ray. She stated she was confused as to how Resident #1's left wrist got swollen even though Resident #1 said she fell a couple of days of ago. She stated the FM said Resident #1 could be saying she fell , but she could have fallen the night prior 02/01/25 or that day 02/02/25. She stated Resident #1 was fine on 02/02/25 and few hours later her left wrist was swollen then she did Resident #1's full body assessment. She stated Resident #1's left kneecap and left elbow had STs and Resident #1 said she fell but could not say how. She stated if she had a fall who could have helped her off the floor, because she did not have a lot of strength. She stated they could not say if Resident #1 was able to get up without assist after falling, and they did not know what caused Resident #1's swollen broken left wrist. She stated on 02/02/25, Resident #1's left wrist x-ray was done showing it was fractured, and LVN B sent her to the hospital on 02/03/25. She stated when she returned to work Saturday 02/08/25, she noticed Resident #1 had a soft wrap bandage across Resident #1's left middle fingers up to her middle arm. On Saturday 02/08/25, Resident #1 was lying horizontally off the bed. She said she asked Weekend Supervisor E to help reposition the resident. She stated Resident #1 swung at and hit Weekend Supervisor E's head and they both stepped back and stopped trying to reposition Resident #1. She stated Resident #1 did not have any bruises or swelling to her face. She stated she called the FM about the incident regarding trying to turn her and that noticed she was taking the cast wrapping around her arm apart and picking at the cotton underneath it. She stated the FM came to the facility around 1:00 pm and said, she was just frustrated and Resident #1 was sitting on the floor and calm in her room. She stated the FM said she would get Resident #1 off of the floor, cleaned her up, and did not want the staff to assist her. She stated 30 to 45 minutes later, the FM asked her to go to Resident #1's room, said Resident #1's face and chin were swollen and Resident #1 was in pain. She stated that was when she noticed Resident #1 had slight swelling and a bruise on the right side of her chin. She stated Resident #1 was assessed and her vitals were checked. They were within normal limits, and she had no pain. She stated she was not sure but thought maybe the bruises were due to the fall she had 02/06/25. She stated she sent pictures of the bruise and video of the inside of her mouth to Resident #1's doctor, the ADON, and DON. She stated she received a doctor's order to send Resident #1 to the hospital, per the family's request. She stated, on 02/08/25, she spoke to the Administrator about Resident #1's dark purple and reddish-purple chin bruises and dark red gums. She stated she told the Administrator she was not sure if Resident #1 had new injuries or delayed bruises from a previous fall. She stated the Administrator said how unfortunate things keep happening to [Resident #1] then she went to talk to the FM. She stated the Administrator and the FM spoke to one another prior to the resident going to the hospital. She stated Resident #1 was picked up by the EMT on 02/08/25 with no signs or symptoms of distress. She stated she charted Resident #1's information in the nurse's notes and did an incident report. She stated if residents continued to have injuries of unknown origin that could cause new medical conditions or bleeding internally. She stated they had to be especially watchful of the memory care residents which could turn into neglect. She stated if the facility was not able to stop a resident		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/14/25 at 12:49 pm, Weekend Supervisor E stated on 02/08/25, LVN A asked her to assist with repositioning Resident #1 because she was laying crooked in bed. She stated during the process of trying to reposition her, Resident #1 swung out and hit her right eye. She stated she then stepped back and did not move her, then the FM was called. Interview on 03/04/25 at 2:46 pm, the DON stated their last fall prevention training was 01/25/25, and they had not had a behavioral management training recently. She stated the last customer service, which was similar to behavioral management, training was 01/24/25. She stated the therapy department did verbal trainings with the nursing staff about how to care for Resident #1 after she had the wrist fracture. She stated she was not sure which staff received the training and would have to talk to the therapist about who she trained. (The DON was not able to provide documentation of the therapy trainings with the staff). Interview on 03/06/25 at 9:42 a.m., MDS Coordinator R stated Resident #1 was resistive to care and bathing and remembered hearing the FM helped with her care. She stated she was not sure how many falls Resident #1 has had but stated as a team they reviewed the residents falls. She stated Resident #1 had a wrist fracture and she believed she had a care plan and could not remember off the top of her head if Resident #1 had a fall on 02/06/25. She stated the care plan was the POC the staff went by to take care of the residents. She stated Resident #1 was still a one person assist and ambulated without assistance and able to help with her own ADL care. She stated she was in charge of completing the comprehensive care plans and the two ADON's did the Care plan revisions. She stated the IDT reviewed the resident's falls daily and stated she would check to see if Resident #1 had a care plan for combativeness. She stated the IDT team consisted of all the department heads. Interview on 03/06/25 at 10:32 a.m., MDS Coordinator R stated she reviewed Resident #1's progress notes and saw that she was resistant to medications and pocketed meds and resisted care. She stated she was not aware Resident #1 was combative and ADON F was responsible for revising Resident #1's Care plan. Interview on 03/06/25 at 10:57 a.m., ADON F stated Resident #1 was resistant to care and her protectiveness of her receiving care she became combative. She stated Resident #1 was not combative all the time and it was associated when the staff provided care to her. Interview on 03/06/25 at 3:50 p.m., ADON F stated Resident #1 had no care plan for combativeness or for her behavior lying in bed sideways. She stated they had no thoughts to move her closer to the nurses station and was not sure why. Interview on 03/07/25 at 12:12 pm, MDS Coordinator R stated she had trainings yesterday 03/06/25 and today 03/07/25. She stated they trained about the Kardex being used for plan of care, behaviors and understanding residents with dementia. She stated the staff needed to let the supervisor know if a resident had behaviors and how to redirect to try get the residents to comply. She stated also stepping back and giving the resident time calm down. She stated they were trained on making sure the residents had on appropriate foot ware like nonskid socks when they were up ambulating. She stated she was not delegated to make sure the care plans were accurate but the IDT team was responsible for ensuring care plans were accurate for high risk fall residents. She stated combativeness was physical aggression and if the care plans were not right could cause the staff to not know how to care for the residents and the residents could fall or get hurt. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/07/25 at 1:43 p.m., ADON F stated she had trainings on dementia care and behavioral management and customer service. She stated they trained the aides on how to use the Kardex for how to care for the residents. She stated the training covered combativeness with dementia residents and how to redirect the behavior, remove self from the behavior and if that failed report going by the chain of command. She stated she did not need to add combative to Resident #1's care plan because she already had a resistance to care, care plan. She stated the education with the staff was ongoing with spot checks for knowledge comprehension. She stated she was trained on the IDT needed to ensure care plan accuracy by updating the resident's care plan during the meeting. She stated the Care plan was related to the Kardex the CNA's used to provide the resident's care. Interview on 03/07/25 at 5:14 p.m., the Administrator stated yesterday 03/06/25, they educated the IDT staff about making sure they reviewed the resident's falls, times of the falls and incidents. She stated during the IDT meeting the IDT were responsible for making changes to the residents care plans during that time of the meeting. She stated the two ADON's and MDS Coordinator R were responsible for ensuring the care plans were accurate and updated. Record review of the Facility's Care Plan policy dated 06/2020 revealed, Purpose: To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. Policy The Facility will provide the highest quality care in the safest environment for the residents residing in the Facility. Policy I. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MOS guidelines. II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/NDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an ass [sic] needed bases. V. The IDT will revise the Comprehensive Care Plan as needed at the following intervals: A. Per RAI schedules; B. As dictated by changes in the resident's condition; C. In preparation for discharge; D. To address changes in behavior and care; and E. Other times as appropriate or necessary. Record review of the facility's Behavioral Management Policy dated 06/2020 revealed, Behavioral Management: Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. Policy: The concept of behavioral management is an interdisciplinary process. The key components of this process are: Identifying residents whose behaviors pose a risk to self and others; Developing individual and practical care strategies based on assessment needs; Implementing the behavior management program; and ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of the psychoactive drugs.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record reviews the facility failed to ensure the resident's environment remained as free of accident hazards as is possible and received adequate supervision and assistance for one (Resident #1) of five residents reviewed for Incident and accidents. 1. The facility failed to provide adequate supervision for Resident #1 to prevent her from having injuries and falls from 02/02/25 to 02/08/25; subsequently Resident #1 sustained a left wrist fracture of unknown origin on 02/02/25, fell on [DATE] sustained a lip bleed, found on the floor next to her bed on 02/07/25 and on 02/08/25 she had left sided facial bruising, a swollen chin, and dark reddish gums. She was later diagnosed at the hospital on 02/08/25 with a hematoma of her jaw and previously diagnosed left wrist fracture. 2. The facility failed to provide supervision in the B Hall Memory Care unit when 2 CNA's were discovered asleep in the unit at the nurses station with the light off on 03/05/25. 3. The facility failed to ensure the staff worked their complete 8-hour shifts (not including 30-minute lunch breaks), did not clocked in to work late or clocked out early and there was no evidence to show who worked in their places if staff called out, which resulted in a lack of supervision of the residents as evidenced by: a. Employees either clocked in late or clocked out early during their shifts for halls A and halls B (Memory Care Unit) on 01/31/25, 02/01/25, 02/02/25, 02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25 and 02/08/25. b. There was no second staff scheduled to work Sunday 02/02/25 from 6:00 am to 2:00 pm that cared for the Memory Care residents where Resident #1 resided. And after the DON reviewed it she said MA P worked from 9:33 am to 2:00 pm, but MA P said she only cleaned the resident's rooms in the Memory Care unit. c. The facility failed to ensure the nursing department employees worked their 8 hours shift (minus 30 minutes for lunch) for dates: 03/02/25, 03/03/25, 03/04/25, 03/05/25, 03/06/25. An IJ (Immediate Jeopardy) was identified on 03/05/25. The IJ template was provided to the facility on [DATE] at 2:34 pm. While the IJ was removed on 03/07/25 at 5:43 pm, the facility remained out of compliance at a scope of no actual harm and a severity level of pattern because all staff had not been trained on their plan to prevent re-occurrences and due to the facility's continued monitoring the implementation and effectiveness of their plan of removal. These failures could place fall risk residents in the memory care unit, at risk of continued falls or possible abuse, which could result in more injuries and pain and cause the residents to experience a health decline and decreased psycho-social well-being. The findings included: (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A) Record review of Resident #1's Admission MDS Assessment completed by MDS Coordinator R on 02/06/25 revealed, a [AGE] year-old female who admitted on [DATE] with a BIMS score of 02 (Severe cognitive impairment). She was admitted to the 100 hall (memory care unit). She had disorganized thinking and inattention that fluctuated and no assistance for mobility needed and did not have any mood or behaviors. She needed partial to moderate assistance with toileting, bathing, upper and lower body dressing, personal hygiene and partial to moderate assistance with transfers. She was always continent with urine and bowel and she had other neurological conditions. She had diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection and damage), hyperlipidemia (high level of fat particles), thyroid disorder (gland dysfunction), non -Alzheimer's - Dementia (cognitive loss), malnutrition (nutritional deficit), encephalopathy (brain disease) , insomnia (poor sleep habit), muscle weakness (weak muscles), difficulty walking, other lack of coordination, cognitive communication deficit. She had a history of falling with no injury and for the past seven days took antipsychotic and antidepressant medications. (The MDS did not address her combative behaviors) Record review of Resident #1's Care Plan dated 01/30/25 revealed, the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. On 01/23/25 she was at risk for elopement related to elopement evaluation risk score and required a secured unit environment for safety and at risk for falls related to decreased safety awareness, impaired cognition, wandering and will often lay on the floor. With interventions: Anticipate and meet the resident's needs and to be sure the resident's call light was within reach and encouraged the resident to use it for assistance as needed. Educated the resident/family/caregivers about safety reminders and what to do if a fall occurred. Encouraged the resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. Ensured that the resident was wearing appropriate footwear examples included nonskid socks, closed footed shoes and other safe footed coverings when ambulating or mobilizing in w/c. On 01/25/25 she was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits. Interventions: Introduced the resident to residents with similar background, interests, and encourage/facilitate interaction. Invited the resident to scheduled activities and provided the resident with materials for individual activities as desired the resident liked the following independent activities and to Provide with activities calendar. Notify resident of any changes to the calendar of activities. The resident needed 1 to 1 bedside/in-room visits and activities if unable to attend out of room events On 02/04/25 had an actual fall with major injury (wrist fracture) with Interventions: For no apparent acute injury, determine and address causative factors of the fall. And to monitor/document /report PRN x 72 hours to Medical Doctor for signs/symptoms: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Provided activities that promoted exercise and strength building where possible. And to Provide 1:1 activities if bedbound On 02/05/25 alteration in musculoskeletal status related to fracture of the left wrist. (The Care plans did not address her combative behaviors). Record review of all of Resident #1's Incidents by incident type printed 02/14/24 revealed: Falls with no injury incidents: 02/02/25 at 8:23 pm, 02/06/25 at 10:22 pm, 02/07/25 at 11:30 pm. Skin tear incidents: 02/02/25 at 8:23 pm and 8:36 pm. Other incidents (observed swelling to left wrist): 02/02/25 at 8:58 pm. Record review of Resident #1's Fall Assessments since she admitted revealed: (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/23/25 score was 2 Low risk 02/03/25 score was 7 Moderate risk 02/06/25 score was 13 High risk 02/08/25 score was 26 High risk Record review of Resident #1's Progress Note dated 01/26/2025 at 4:57 pm Type: Skilled Evaluation by RN Q revealed, .Teaching and Training;,, assessed behavior, assess for pain, assess for anxiety , provided redirection, Neurological: Resident is Alert: Oriented to Person; Oriented to Place; Resident has Impaired decision making ability; Resident is Confused; Resident has Delusions: Difficulty understanding others, Skin/Skin Conditions: No changes in skin integrity, Cardiovascular .Muscular: Resident has an unsteady gait requiring supervision; Resident has had a change in ADL functional ability, Resident is Ambulatory, Walks Independently, Mood/Behavior: Changes noted in behavior, Resident intentionally lay herself to the floor; uncooperative to be provided assistance to her safety, or to be redirected, and combative to the staff. Record review of Resident #1's Progress Note dated 01/27/2025 at 11:33 a.m., by ADON F revealed, Type: Skilled Evaluation LATE ENTRY Teaching and Training; assessed behavior, assess for pain, assess for anxiety , provided redirection, Neurological: Resident is Alert; Oriented to Person; Oriented to Place; Resident has Impaired decision-making ability; Resident is Confused; Resident has Delusions. Difficulty understanding others; Skin/Skin Conditions: No changes in skin integrity, Gastrointestinal: ,Continent of Bowel, Bowel Sounds: Present; Gastro-urinary: Continent of Bladder, Urine Color: Amber, Urine Clarity Clear, No foul odor noted . Muscular: Resident has an unsteady gait requiring supervision; Resident has had a change in ADL functional ability, Resident is Ambulatory, Walks Independently; Mood/Behavior: Changes noted in behavior, Resident intentionally lay herself to the floor; uncooperative to be provided assistance to her safety, or to be redirected, and combative to the staff. Record review of Resident #1's Progress note: Skilled Nursing documentation dated 01/31/25 at 11:35 am by ADON F revealed, Receiving both Skilled Nursing and Skilled Therapy Services with skilled diagnosis: ENCEPHALOPATHY (brain disease), Mood/Behavior: Changes noted in behavior, Res continues to refuse medications, this nurse explained to Res that it is important to adhere to medication regimen as prescribed by her MD, nurse attempted reproach, Res refused. Res has no s/s of distress. Record review of Resident #1's Progress note: Alert note dated 02/01/25 at 5:30 pm, Resident c/o hip pain while the FM was present. requests the nurse to ask NP G to increase the Tylenol 500 to the Tylenol Arthritis 650mg. NP G approve the request. Record review of Resident #1's Progress note: Change of condition dated 02/02/25 at 7:57 pm by LVN A revealed, Observed resident L wrist/hand swollen. Resident stated it hurts during assessment. Ice pack applied. The FM was present during the assessment. NP G notified. STAT X-ray ordered for the L wrist/hand. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Forest Park Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 Harry Hines Blvd Dallas, TX 75235	
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Incident Report by LVN A dated 02/02/25 at 4:41 pm revealed, Incident Description Nursing Description: observed swelling to left wrist. Incident was unwitnessed. Resident Description: Resident was unable to specify. Was this incident witnessed: No. Immediate Action Taken: Description: Attempted to do ROM exercises. Resident stated it is too painful. Picture taken and sent to NP G. STAT X-RAY was ordered. Ice applied to the Left wrist/hand. PRN Tylenol given for the pain. Resident Taken to Hospital? No. Mental status: oriented to person, lack of safety awareness, forgetful, Predisposing physiological factors: confused, gait imbalanced, Administrator, [Weekend Supervisor E] and the [FM] notified. Record review of Resident #1's left wrist and hand 2 D (dimensional) X-ray results, dated 02/03/25, revealed, Final Reason for Study: R22.32 LOCALIZED SWELLING, MASS, AND LUMP, LEFT UPPER LIMB - WRIST 2V (view), LEFT See Note FINDINGS: There is a dorsal impaction fracture (wrist bone break)involving the distal radius (broken wrist) with modest callus (bone cartilage) and mild displacement. There is associated soft tissue swelling. Diffuse osseous demineralization (decreased bone density) is noted. Moderate degenerative changes are seen. See Note CONCLUSION: Impacted wrist fracture (wrist bone driven into another bone, compression damage) as described. Correlation is needed with history, symptomatology, and physical exam to determine precise acuity. CT or MRI examination follow-up is advised if clinical ambiguity remains. Record review on Resident #1's Nurses note dated 02/03/25 by LVN B revealed, [NP G] n/o to send resident to ER for evaluation, the FM requests that resident be sent to Hospital ER. Record review of Resident #1's Hospital Discharge Record dated 02/03/25 revealed, Diagnosis: wrist Mildly displaced intra-articular fracture of the distal radius (break in wrist bone) with mild apex volar angulation (small degree tilt or bending of fracture point). Surrounding soft tissue swelling. The carpal arcs are preserved (wrist bones were intact). Orders: Fracture non-mobile under fluoro (medical imaging technique), placed in volar (palm side of hand) resting splint, weight bearing status: NWB LUE, Ortho clinic 2 weeks, pain control per ER Record review of Resident #1's Nurses Note dated 02/03/25 by RN H revealed, Returned from the ER Hospital. Was sent there for left wrist fx. Returned with dx closed fx of distal end of left radius (broken bone at the wrist), unspecified fx morphology(shape/form) . A splint immobilizer was applied, wrapped with ace wrap. Plan is for surgical procedure - closed reduction (realign of fracture without surgery) for the wrist at surgical center. The center will call for further information. The [FM] aware. Assessed for pain continuing. Denied pain on arrival to reassess. Record review of Resident #1's Provider Investigation Report incident dated 02/08/25 at 2:30 pm, revealed the [FM] alleged that the nurse supervisor (Weekend Supervisor E) had hit Resident #1 in her mouth. There was a bruise on the right side of her chin and redness inside her mouth on the bottom gums. The resident denied any pain or discomfort. Treatment was provided and the resident was taken to the hospital. Statements, interviews, and resident safe surveys were completed and determined the facial bruising and swelling was from her fall 02/07/25. Findings: Unfounded. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Hospital Report dated 02/18/25 revealed, She admitted [DATE]: Review of systems: Jaw bruising and pain, Physical exam: Bruising on chin and swelling of left side of cheek, Bruising gums, patient has negative popsicle test (fractured jaw test). Assessment plan: Recurrent falls: 1:1 sitter in place, follow-up x-ray neck, head, perimandibular hematoma: supportive care and outpatient dental, Left distal radius fracture, osteoarthritis, vascular dementia, debility. Pertinent Items Requiring Follow-up Post-Discharge 1. Adjust psychiatric medications PRN, 2. Monitor thyroid function, 3. Follow up w/ hand clinic, 4. Follow up w/ dentist. Record review of the facility's Daily Staffing sheet dated 01/31/25 for the 10:00 pm - 6:00 am shift for five halls revealed, they had 1 RN, 2 LVN's, 0 MA and 5 CNA's total at the facility. (The census section was blank). Record review of the facility's Daily Staffing sheet dated 02/01/25 for the 10:00 pm - 6:00 am shift for five halls revealed, they had 1 RN, 2 LVN's, 0 MA and 5 CNA's total at the facility. (The census section was blank). Record review of the facility's Daily Staffing sheet dated 02/02/25 for the 6:00 am - 2:00 pm shift for five halls revealed, they had 1 RN, 4 LVN's, 3 MA and 4 CNA's. (The census section was blank) Record review of the facility's schedule sheet dated Friday 01/31/25 revealed CNA J was the only staff scheduled to work in the Memory care Unit Hall B during the 10:00 pm - 6:00 am shift. Record review of CNA J's Timesheet dated Friday 01/31/25 revealed she clocked in at 10:25 pm and clocked out at 5:52 am - 7.45 total hours. Record review of the facility's schedule sheet dated 01/31/25 revealed RN H was scheduled to work the A Hall from 10:00 pm - 6:00 am. Record review of the RN H's Timesheet dated 01/31/25 revealed RN H clocked in at 10:35 pm and clocked out at 7:29 am - 8.91 hours. Record review of the facility's schedule sheet dated Friday 01/31/25 on the 10:00 pm - 6:00 am shift, revealed LVN O was scheduled to work the E Hall (2nd floor). Record review of LVN O's Time sheet dated Friday 01/31/25 revealed she clocked in at 10:14 pm and clocked out at 6:25 am - 7.69 total hours. Record review of the schedule sheet dated 02/01/25 revealed CNA T was scheduled to work the B Hall Memory care from 2:00 pm - 10:00 pm. Record review of CNA T's Timesheet sheet dated 02/01/25 revealed she clocked in at 3:31 pm and clocked out at 10:08 pm - 6.61 hours. Record review of the facility's schedule sheet dated 02/01/25 revealed CNA J was scheduled to work the B Hall Memory Care unit from 10:00 pm - 6:00 am. Record review of CNA J's Timesheet dated 02/01/25 revealed she clocked in at 10:30 pm and clocked out at 6:11 am - 7.68 hours. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's schedule sheet dated Saturday 02/01/25 revealed CNA K was scheduled to work the A Hall from 2:00 pm - 10:00 pm and Hall B Memory care unit from 10:00 pm - 6:00 am. Record Review of CNA K's Timesheet dated 02/01/25 revealed she clocked in at 2:21 pm and clocked out at 6:36 am - 15.38 hours. Record review of the Facility's schedule sheet dated Saturday 02/01/25 revealed LVN N was scheduled to work the A Hall unit on the 10:00 pm - 6:00 am. Record review of the Facility's Timesheet sheet dated Saturday 02/01/25 for LVN N was requested but not provided by the facility. Record review of the facility's Schedule sheet dated Saturday 02/01/25 for the 10:00 pm - 6:00 am shift revealed, LVN O was schedule to work the D Hall (2nd floor). LVN O's Timesheet was requested for Saturday 02/01/25 but the DON gave the HHSC surveyor LVN's 01/31/25 timesheet. Record review of the facility's schedule sheet dated Saturday 02/01/24 revealed LVN A was scheduled to work 02/01/25 from 6:00 am to 2:00 pm. Record review of LVN A's Timesheet dated 02/01/25 revealed she clocked in at 6:17 am and clocked out at 2:08 pm, clocked in at 2:40 pm, clocked out 9:18 pm, clocked in at 9:50 pm and clocked out at 10:06 pm - 14.75 hours. Record review of the facility's schedule sheet dated Sunday 02/02/25 revealed LVN A was the only staff scheduled to work in the Memory care unit Hall B during the 6:00 am - 2:00 pm shift. Record review of LVN A's Timesheet revealed on Sunday 02/02/25 she clocked in at 6:20 am and clocked out at 10:09 pm - 23.81 total hours. Record review of the facility's schedule sheet dated Sunday 02/02/25 revealed MA P was scheduled to work A Hall from 6:00 am - 2:00 pm and 2:00 pm to 10:00 pm. Record review of MA P's Time sheet dated Sunday 02/02/25 revealed she clocked in at 9:33 am and clocked out at 12:27 pm for lunch and clocked back in at 1:02 pm and clocked out at 10:11 pm - 12.06 total hours. Interview and observation of Resident #1 on 02/13/25 at 7:10 pm at the hospital revealed, she had 1:1 monitoring (constant observation of the resident). A hospital sitter was in the room with her and she was watching TV and she had a beige bandage wrapped around her left wrist and forearm and cotton was underneath the bandage. She stated she had not fallen that she knew of and that her arm was broken because she was always picking up something too heavily. Her lower left chin and face was not swollen, discolored, or bruised. She stated she had no pain of her mouth or left wrist and said she could not remember where she lived prior to coming to this hospital. She stated she could not remember if anyone had been abusive to her and the people should know if they were abusive because she did not have time for that. She stated the IV port and hospital ID band on her right arm got on her nerves more so than the bandage around her left wrist. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Incident report dated 02/06/25 at 10:22 p.m., by LVN D revealed, Resident was seen walking slumped over when she tripped over her socks, this nurse and on shift CNA attempted to assist Resident to floor when she became combative and physically aggressive with staff, hitting herself in the mouth with her splinted left wrist. Resident was eased to the floor by staff and allowed to rest before being helped back to her feet and assisted to her room. Full head to toe assessment was completed resulting vital signs within normal limits, no apparent bruising, no s/s of respiratory distress. Resident had a complaint of pain in her lip where she hit her mouth with wrist. PRN pain medication administered, and pain has since subsided upon recheck. Resident seen lying in bed resting. Hydration and call light are within reach, bed is in lowest position possible. Care continues. Resident Description: She lost her footing because her socks were too slippery and did not need help getting up. Resident was eased to the floor by staff and allowed to rest before being helped back to her feet and assisted to her room. Full head to toe assessment was completed resulting vital signs within normal limits, no apparent bruising, no s/s of respiratory distress. Res had a complaint of pain in her lip where she hit her mouth with wrist. PRN pain medication administered, and pain has since subsided upon recheck. MD notified, DON/ADON notified. RP notified. Resident seen lying in bed resting. Hydration and call light are within reach, bed is in lowest position possible. Care continues. Resident taken to hospital: No. Injury location: face. Pain level 5 (moderate pain level), Alert, ambulatory with assistance. Mental status: Oriented to person, impulsiveness, lack of safety awareness, forgetful. Res the inside of her lip, Resident taken to rest room to rinse her mouth, given PRN pain med which was effective at recheck. Res resting in bed with eyes closed at this time. Confused, impaired memory, sundowning. Interview on 02/13/25 at 4:39 pm, CNA C stated Resident #1 was a new admit and walked without assistance and needed assistance to the toilet. She stated on Saturday 02/01/25 or Sunday 02/02/25, the dinner trays came out and as she helped Resident #1 lean up in her chair, she noticed her left wrist was swollen. She stated she told LVN B, and LVN B went to assess Resident #1 and later on she heard it was fractured and she was sent to the hospital. She stated she was not sure what happened to her wrist and the previous CNA (CNA I) said she did not know what happened or noticed any swelling or bruising of Resident #1's wrist. She stated LVN A said she did not know what happened to Resident #1's wrist either. She stated on Thursday 02/06/25 during the 2 pm - 10 pm shift, Resident #1 was walking down the hall, leaned backwards, and she and LVN D ran and guided Resident #1 down to the floor. She stated during that process Resident #1 got agitated and started swinging her arms and hit herself in her mouth with the soft cast. She stated Resident #1's mouth bled a little on the right side of her lip; it was a little swollen. She stated she did not hit her head on the wall or rail, and at that time, she had no bruising to her face. She stated she worked Saturday 02/08/25 and asked LVN A to help reposition Resident #1 but Resident #1 said she did not want to be bothered. She stated Resident #1 was sleeping sideways in the bed and she asked could she reposition her better in bed and Resident #1 said to leave her alone. She stated around 10:00 am, Weekend Supervisor E and LVN A went in Resident #1's room and she heard Resident #1 hit Weekend Supervisor E. She stated after the incident, she did not see any bruising on Resident #1's face all the way up to the end of her shift at 10:00 pm. She stated she had not seen anyone being abusive to Resident #1. She stated when she returned to work, she heard Resident #1 was taken to the hospital. She stated the facility had enough staff working in the dementia care unit Resident #1 was in. She stated their dementia care unit currently had 21 residents with one CNA and one LVN working per shift. She stated most of the residents walked without assistance. She stated Resident #1 was not good with expressing her needs. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/13/25 at 5:30 pm, LVN D stated Resident #1 admitted [DATE] and she discharged last weekend 02/08/25. She stated Resident #1 was ambulatory without assistance and used to work at a hospital because she always said she had to go to work. She stated Resident #1 had the typical dementia behavior and she was verbally and physically abusive to the staff. She stated Resident #1's mindset was that she was always at work and she required a lot of redirecting. She stated she heard Resident #1 went the hospital on 02/03/25 after her x-ray results showed she had a fractured wrist. She stated they were not sure how her wrist got fractured. She stated Resident #1 had a splint with an ace bandage around it to keep it in place. She stated Thursday 02/06/25, Resident #1 was walking around 10:00 pm or 11:00 pm down the hallway, by the dining room and she appeared to be unsteady. She stated she and CNA C tried to keep her from falling but Resident #1 said she did not want any help. She stated Resident #1 kept leaning backwards and they lowered Resident #1 to the floor and in the process Resident #1 hit the right side of her mouth with her soft cast. She stated Resident #1 never hit the floor, and she and CNA C turned Resident #1 around and eased her down to the floor. She stated she had one arm under Resident #1's arm and CNA C was on the other side under Resident #1's other arm. She stated she had minimum bleeding and her lip had a skin tear for which she gave her PRN Tylenol. She stated she called Resident #1's doctor and got a doctor's order for a skull series x-ray as a precaution. She stated she went to check on Resident #1 later and she was fine and with no bleeding or bruising. She stated she spoke to the FM about Resident #1 stumbling like she was about to fall and they tried to catch her before she fell. She stated on Friday 02/07/25, the x-ray tech came to do the x-rays but the FM told the x-ray tech to come back another time. She stated the last time she saw Resident #1 was Friday 02/07/25 around 10:30 pm and she was fine and had no signs or symptoms of distress, pain, or bleeding. She stated Resident #1 was her normal self, walking around with her juice saying she was getting her people together. She stated she informed the FM about seeing Resident #1 hit her mouth with her soft cast by mistake. She stated measures to prevent Resident #1 from falling was to continue with a lot of redirection and anticipating her needs. She stated after 5:00 pm, they did showers and got the residents ready for bed. She stated she reported Resident #1's fall on 02/07/25 to ADON F and added guided falls were considered falls that was why she did an incident report and contacted Resident #1's doctor, the FM, and the ADON. She stated she was not aware of Resident #1 having any other falls. Interview on 02/14/25 at 10:13 am, LVN B stated she worked Monday 02/03/25 and she sent Resident #1 to the hospital. She stated LVN A said they noticed Resident #1's arm was slightly swollen with no change in bone structure. She stated Resident #1 did not want her wrist touched and she explained to Resident #1 she needed to check to see how she was doing. She stated she kept Resident #1's wrist elevated with ice on it while she waited for the x-ray results. She stated Resident #1 had no signs of pain and slept most of the night. She stated Resident #1 got up once to use bathroom with the CNA's assistance while they were waiting for the x-ray results. She stated around 7:00 am, the doctor said to send Resident #1 to the ER, and she passed the information to the Administrator, DON, the FM, and the next nurse. She stated Resident #1's x-ray result showed she had an impacted wrist fracture and LVN A and no one else knew what caused her fractured wrist. She stated she informed the FM about the need to transfer her to the hospital and when she was being transferred, she had no bruises on her face or bleeding or swollen lip. She stated Resident #1 was laughing and said It sucks getting old when being transported to the hospital. She stated she contacted management for injuries of unknown origin because it was their protocol. She stated she notified the Administrator, DON, and ADON about Resident #1's x-ray results and the Administrator responded to call her (the FM). She stated she called and spoke to the Administrator about Resident #1's wrist fracture x-ray result. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/14/25 at 10:39 am, LVN A stated she worked double weekends. She stated Resident #1 admitted about three weeks ago, and she was very familiar with Resident #1. She stated Resident #1 normally walked but had an unsteady gait and they always made sure her bed was in the lowest position. She stated they also increased monitoring of Resident #1 and anticipated her needs and that she was A/O x1 (person). She stated Resident #1 was doing well walking without assist, but once or twice she was sent to the hospital (for the swollen wrist and bruised and swollen face). She stated she worked Saturday 02/01/25, and Resident #1 did not have any falls, unusual occurrences ,or wrist swelling, but she did have generalized and hip pain. She stated she called Resident #1's doctor and her Tylenol 300 mg was increased to 650 mg which was effective. She stated the FM said she did not want Resident #1 on narcotics and the hip pain was probably due to a fall she had at home. She stated she did not remember Resident #1 having a fall the weekend of Saturday 02/01/25 or Sunday 02/02/25. She stated on Sunday 02/02/25, Resident #1 was not a morning person and they would let her sleep in. She stated Resident #1 woke up around 9:00 am or 10:00 am on 02/02/25 and she had no swelling of her left wrist, but later that afternoon the FM visited and reported Resident #1's left wrist was swollen. She stated when she assessed Resident #1, she saw the swelling of her left wrist, but the FM said her left wrist was not swollen the previous day. She stated she took a picture of Resident #1's left wrist to show the DON and ADON F and to her doctor. She stated she asked Resident #1 to flex her arm, Resident #1 said it hurt, and her doctor ordered a STAT x-ray. She stated she was confused as to how Resident #1's left wrist got swollen even though Resident #1 said she fell a couple of days of ago. She stated the FM said Resident #1 could be saying she fell , but she could have fallen the night prior 02/01/25 or that day 02/02/25. She stated Resident #1 was fine on 02/02/25 and few hours later her left wrist was swollen then she did Resident #1's full body assessment. She stated Resident #1's left kneecap and left elbow had STs and Resident #1 said she fell but could not say how. She stated if she had a fall who could have helped her off the floor, because she did not have a lot of strength. She stated they could not say if Resident #1 was able to get up without assist after falling, and they did not know what caused Resident #1's swollen broken left wrist. She stated on 02/02/25, Resident #1's left wrist x-ray was done, and LVN B sent her to the hospital on 02/03/25. She stated when she returned to work Saturday 02/08/25, she noticed Resident #1 had a soft wrap bandage across Resident #1's left middle fingers up to her middle arm. On Saturday 02/08/25, Resident #1 was lying horizontally off the bed. She said she asked Weekend Supervisor E to help reposition the resident. She stated Resident #1 swung at and hit Weekend Supervisor E's head and they both stepped back and stopped trying to reposition Resident #1. She stated Resident #1 did not have any bruises or swelling to her face. She stated she called the FM about the incident regarding trying to turn her and noticed she was taking the cast wrapping around her arm apart. She stated the FM came to the facility around 1:00 pm and said, she was just frustrated and Resident #1 was sitting on the floor and calm in her room. She stated the FM said she would get Resident #1 off of the floor, cleaned up, and did not want the staff to assist her. She stated 30 to 45 minutes later, the FM asked her to go to Resident #1's room, said Resident #1's face and chin were swollen and Resident #1 was in pain. She stated that was when she noticed Resident #1 had slight swelling and a bruise on the right side of her chin. She stated Resident #1 was assessed and her vitals were checked. They were within normal limits, and she had no pain. She stated she was not sure but thought maybe the bruises were due to the fall she had 02/06/25. She stated she sent pictures of the bruise and video of the inside of her mouth to Resident #1's doctor, the ADON, and DON. She stated she received a doctor's order to send Resident #1 to the hospital, per the family's re [TRUNCATED]		