STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676293	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing & Rehabilitation	6825 Harry Hines Blvd Dallas, TX 75235

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for supervision. The facility failed to provide adequate supervision for Resident #1 during a routine incontinent change which involved CNA A and CNA B which led to Resident #1 hitting their head on the bedside table. This failure could place residents at risk of injury. Findings include: Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's Care Plan dated 6/19/2025 reflected Resident #1 had diagnoses which included Dementia (Decline in cognitive abilities such as memory, thinking, problem solving, judgment), Hypertension (High blood pressure), Chronic Kidney Disease (Kidneys lose the ability to filter waste), Osteo Arthritis (Joint disease that causes pain in the joints), Neuropathy (Damaged nerves), Constipation (Difficulty passing stool), Depression (Mental health disorder that significantly impacts mood, thought, behavior), Anxiety Disorder (Mental health disorder of excessive worry, fear, or nervousness), Alzheimer's (Neurodegenerative disorder that affects memory, thinking, behavior), Hyperparathyroidism (Parathyroid gland produce too much hormone), Muscle Weakness (Decrease in muscle strength and function), Cognitive Communication Deficit (Difficulty communicating because of memory, attention, function) and Tinea Unguium (Fungal infection of the nails). Resident #1 required 2 person assist. Resident #1 had Activities of Daily Living self care performance deficit related to Alzheimer's, confusion, and dementia. Interventions were listed as bed mobility, roll left to right-partial/moderate assist, sit to [NAME]-substantial/maximum assist, [NAME] to sit-substantial/maximum assist, Sit to stand-substantial/maximum assist. Personal Hygiene was documented as substantial/maximum assist. Bowel and bladder incontinent related to Alzheimer's and Dementia. 10/17/2025 documented Resident #1 had Right eyebrow laceration. 10/17/2025 documented to maintain proper alignment while turning and repositioning. Record review of CNA B's, undated, employee witness statement, reflected she was performing care on Resident #1 with CNA A. Resident #1 hit her head on the bedside table as she was being turned over. Record review of Resident #1's MDS record dated 10/4/2025 revealed Resident #1 had a bims of 00 (severe cognitive impairment). Resident #1 had a score of 01 (Dependent) for Toileting Hygiene and Roll left and right. Record review of CNA A's employee witness statement, dated 10/14/2025, reflected she was performing perineal care (cleaning or washing of the genitals) on Resident #1 with CNA B. Resident #1 began to fall out of the bed while they were in the middle of turning her over. They were able to prevent the fall by keeping her in a secure position on the bed but were unable to prevent her from hitting her head on the bedside table. The injury caused bleeding. Record review of Resident #1's weekly skin check, dated 10/14/2025, reflected Resident #1 had injuries to the following: Bruise to the right eye, and Laceration to the right eyebrow. Record review of the incident report, completed on 10/14/2025, by LVN C, reflected Resident #1 was being assisted by CNA A and CNA B when the accident occurred. During her assessment she observed a straight line injury on top of the right eyebrow and a swollen black eye. She cleansed with normal saline, pat dry and applied dressing. She administered pain medication, Tylenol 325 mg 2 tablets. Vitals were taken with normal ranges. Blood Pressure 120/80, Temperature 97.3, Pulse 80, Oxygen 97% on room air. She repositioned Resident #1. Notifications were made to the responsible party, Medical Director, and Director of Nursing. She documented Resident #1 as being alert and oriented. Record review of Resident #1's X-Ray results, dated 10/15/2025, reflected Resident #1 had an X-Ray to the facial bones which showed no serious injury. The reason the X-Ray was performed was because of localized swelling, mass, and lump. The radiology results reflected Resident #1 did not have fracture. The osseous structure was intact. The sinus appeared clear. Soft tissues appeared unremarkable. Record review of Neuro Evaluation Check, completed on 10/15/2025, reflected Resident #1 had normal vitals and was alert and oriented. Record review of Resident #1's weekly skin check, dated 10/16/2025, reflected Resident #1 had injuries to the following: Right eye discoloration from the incident on 10/14/2025, Right eyebrow laceration from the incident on 10/14/2025. Observation of Resident #1 on 10/23/2025 at 11:00 AM revealed Resident #1's had a large discolored yellow bruise about 3 inches by 4 inches on the upper right side of her face. Interview was attempted but unsuccessful due to Resident #1's cognitive function. Interview on 10/23/2025 at 10:10 AM with Director of Nursing E, revealed Resident #1 received a black eye as result of her injury on 10/14/2025. She stated Resident #1 was assessed by both a skin assessment and a neuro assessment. She stated an