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	10/30/2025

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide and document sufficient preparation and orientation of resident to ensure safe and orderly transfer or discharge from the facility and ensure the orientation was provided in a form and manner that the resident could understand for one (Resident #1) of three residents reviewed for discharge.1. On 09/26/2025, the facility failed to ensure Resident #1's post-discharge destination and continued care provider could meet Resident #1's needs. Resident #1 required medication management and supervision with activities of daily livings, which the shelter did not provide. 2. On 09/26/2025 the facility failed to ensure Resident #1 was admitted to the shelter, as Resident #1 was left standing in line. On 10/03/2025 Resident #1 was found by a high school security guard approximately 14 miles away from the shelter where he had been dropped off to.This deficient practice could place residents at risks of accidents, and could result in serious harm, injury, impairment, and death.An Immediate Jeopardy was identified on 10/29/2025 at 2:26 p.m., while the IJ was removed on 10/30/2025 at 3:38 p.m., the facility remained out of compliance at a at a severity level of potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. Record Review of Resident #1's face sheet, dated 10/29/2025, revealed a [AGE] year-old man originally admitted on [DATE]. Resident #1 had diagnoses which included anoxic brain damage (brain does not receive enough oxygen), major depressive disorder serious mental health condition that significantly impacts a person's mood, thoughts, and behavior), anxiety disorder (excessive fear or anxiety), seizures (sudden, uncontrolled electrical discharges in the brain), lack of coordination, muscle weakness,, difficulty walking, sever protein-calorie malnutrition (does not consume enough protein and calories to meet their body's needs), chronic viral hepatitis C long-term infection of the liver caused by the hepatitis C virus), hyperlipidemia (high levels of lipids (fats) in the blood, including cholesterol and triglycerides), chronic pain syndrome, essential hypertension (high blood pressure without an identifiable underlying cause), and gastro-esophageal reflux disease without esophagitis (condition where stomach contents flow back into the esophagus (reflux) but do not cause inflammation or damage to the esophageal lining). Record review of Resident #1's discharge MDS assessment, dated 09/26/2025, revealed Resident #1 had a BIMS score of 7, which indicated severe impairment. Resident #1's functional abilities required supervision for all self-care needs. Record review of Resident #1's Care Plan, dated 06/19/2025, revealed Resident #1 had an ADL self-care performance deficit r/t impaired balance, required antidepressant medication for diagnosis of major depressive disorder, had potential for complications diagnosis of hypertension, was a risk for falls, had impaired cognitive function/dementia or impaired thought processes r/t anoxic brain injury, and was incontinent at times due to confusion, inability to communicate needs.Record review on 10/28/2025 of Resident #1's social services progress note revealed Resident #1 was discharged on 9/26/2025 to shelter. Record review on 10/28/2025 through 10/30/2025 of Resident #1's electronic health records from revealed no documentation of referral for alternate placement for Resident #1. Record review on 10/28/2025 through 10/30/2025 Resident #1's electronic health records revealed no documentation of verbal or written notice of intent to leave the facility. Record review on 10/28/2025 through 10/30/2025 Resident #1's electronic health records revealed no documentation that Resident #1 representative refused to pick Resident #1 up from the facility. [SP3] During an interview on 10/27/2025 at 3:28 p.m., the complainant revealed that she had received a call from Resident #1's family member who stated the nursing facility allegedly dropped Resident #1 off at a shelter (date unknown) and he was found at a school 14 miles away from the alleged shelter, by security. Resident #1 was currently at his family members home and will stay there until they find him placement.During an interview on 10/27/2025 at 3:33 p.m., Resident #1's assigned case manager revealed that she was assigned to Resident #1 case on 10/06/2025. She stated that Resident #1's family member was contacted by law enforcement on 10/03/2025 and stated that Resident #1 was located at or near a school. Resident #1's family went and picked him up on 10/03/2025. The case manager stated she had spoken with Resident #1's family and was told that Resident #1 was allegedly dropped off at a shelter (date unknown) and was found on 10/03/25 by law enforcement and someone Resident #1 was able to provide his brothers phone number, Resident #1 family was contacted, and the family member went to get Resident #1. The case manager stated that the family member had contacted Resident #1 and APS was involved also. She stated that APS had assisted with clinical records on 10/25/2025 after APS went to the nursing facility to sign the