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	11/14/2025

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 0755 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administer of all drugs and biologicals to meet the needs of 1 (Resident#1) out of 3 residents reviewed. The facility failed to ensure Resident#1 medication were administered all drugs and biological via G-Tube administration and/or orally. This failure could place residents at risk of not receiving medications as prescribed. Findings include: Record review of Resident#1 face sheet reflected, she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident#1 was diagnosed with but not limited to, Type 1 diabetes mellitus with ketoacidosis with coma (body lacks significant insulin), altered mental status, urinary tract infection, site not specified and cognitive communication deficit. Resident#1 MDS dated [DATE] reflected, Resident #1 had a BIMS of 03 which indicated severed impaired cognition. Record review of Resident#1 October TAR and MAR reflected: *Phenytoin oral suspension 125mg/ml Give 5ml via G-Tube three times a day related to unspecified convulsions, started 09/25/25 and DC 10/07/25. *Polyethylene Glycol powder Give 17mg via G-Tube two times a day for constipation, started 09/25/25 and DC 10/07/25. *Peg 3350 17gm/scoop powder-Give 17 gram via G-Tube every 24 hours as needed for constipation, started 09/25/25 and DC 10/07/25. Record review of Resident#1 November TAR and MAR reflected: *Phenytoin oral suspension 125mg/ml/ml Give 5ml via G-Tube three times a day related to unspecified convulsions, started 10/09/25 and DC 11/07/25. *Resident#1 was hospitalized [DATE] and 10/07/25. *Resident#1 refused phenytoin oral suspension 125mg/ml on 10/19/25 at 1:00 pm. *Peg 3350 17gm/scoop powder-Give 17 gram via G-Tube every 24 hours as needed for constipation. started 10/09/25 and DC 11/07/25. *Phenytoin Oral Suspension 125 MG/5ML- Give 5 ml by mouth three times a dayrelated to unspecified convulsion, started 11/07/25 and DC 11/13/25. *Lactulose Oral Solution 10 GM/15ML -Give 30 ml by mouth every 12 hours asneeded for Constipation, started 11.07.25 and DC 11.13.25 *PEG 3350 17 GM/scoop Powder - Give 17 gram by mouth every 24 hoursas needed for Constipation, started 11/07/25 and DC 11/13/25 Record review of Resident#1 hospital records dated 11/12/25 reflected: Resident#1 was admitted to the hospital on [DATE] at 12:53 pm. Resident #1 chief complaint was vomiting. Resident#1 visit diagnosis was Diabetic ketoacidosis without coma associated with type 1 diabetes mellitus (Without enough insulin, the body begins to break down fat as fuel. This causes a buildup of acids in the blood (primary). Note dated 11/10/25. *Brief neurology notes [Resident#1] with seizure disorder on Phenytoin 125mg TID previously but level < 1.8 as she has not been receiving it at the facility [Resident#1] has been given unknown time.[Resident#1] would re-start as below: Start 100mg TID for 5 days, then check through level subtherapeutic (being a dose that is below what is used for treating disease), then increase to the 125 TID as [Resident#1] was on previously. *Internal medicine and psychiatry notes reflected, stool ball seen on image, large BM in the am after Bisacodyl suppository.CTAP showing distended rectum due to stool burden with stercoral colitis (inflammation of the colon due to fecal impaction,) *Hospital laboratory results dated [DATE] reflected Phenytoin value level of < 1. 8 and a reference range of 10.0-20.0., flagged for low level. During an interview and observation on 11/12/25 at 4:50 pm revealed Resident#1 did not recall why she was in the hospital. Resident#1 stated she received her insulin shots at the facility, and she took her medications. Surveyor observed HPCT feeding Resident#1 through G-tube. Surveyor observed HN take Resident#1 BS and Resident#1 BS was 170. During an interview on 11/12/25 at 5:15pm the Hospital physician stated Resident#1 Phenytoin levels were extremely low and showed that she was not getting the medication. The Hospital physician stated Resident#1 had pending lab results for infection and she would provide that information. During an interview on 11/13/25 at 9:58 am CNA C stated Resident#1 BMs were documented on the POC daily and every shift. CNA A stated Resident#1 was in and out the hospital and did not recall the last time she had a BM. CNA C stated if a resident did not have a BM the information would be shared with the ADON. During an interview on 11/13/25 at 10:10 am LVN D stated Resident#1 medication was given through the G-Tube. LVN D stated Resident#1 did not like the G-Tube and would sometimes refuse medication. During an interview over the phone on 11/13/25 at 10:24 am LVN E stated he gave Resident#1 all her medications through the G-Tube. During an interview over the phone on 11/13/25 at 12:40 pm Resident#1's PCP stated Resident#1 would refuse medications and this was a continuous struggle with Resident#1. The PCP stated Resident#1 Phenytoin levels were low and he was trying to see why they were low. The PCP stated if the Resident were not getting