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	01/13/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure medications were secured and inaccessible to unauthorized staff and residents for one medication cart on the second floor reviewed for medication storage.The facility failed to ensure the 2nd floor medication cart was locked when unattended. This failure could place residents at risk for drug diversion, drug overdose, and accidental administration of medications to the wrong residents. Findings included:During an observation and interview, on 01/13/2026 at 2:30 p.m., the second-floor nurse's station medication cart was unlocked. Observation of the unattended cart revealed the surveyor opened the top drawer and it contained biological and medications for residents. The MDS Coordinator walked up, said shit, closed the drawer, locked the cart, and walked behind the nurse's station. When asked who was responsible for the medication cart, LVN A denied the cart was observed unlocked. When informed the cart was observed unlocked and unattended and the MDS coordinator locked the cart, LVN A provided an interview. During an observation on 01/03/2026 at 2:29 p.m., revealed an in-house security camera located above the 2nd floor nurse's station and was reviewed at: 2:29:04 medication cart was observed unlocked and the top drawer was then opened by surveyor.2:29:07 MDS Coordinator approached, closed the drawer, and locked the cart. 2:29:13 MDS Coordinator walked behind the nurse's station.2:29:40 MDS Coordinator approached LVN A. 2:30:05 LVN A approached the medication cart, pushed on the lock, and stated it is locked.Durning an interview on 01/13/2026 at 2:35 p.m., LVN A revealed the risk of not locking the medication cart was a resident could open it. LVN A continued to deny the medication cart was observed unlocked. During an interview on 01/13/2026 at 3:10 p.m., the MDS Coordinator revealed she locked the medication cart because it was unlocked. She revealed the medication cart was unlocked, unattended, and able to be opened by someone other than the nurse responsible for the cart. She stated that a medication cart should be locked when the person responsible was not standing in front of the cart. She stated the risk could be a danger to residents and others and in no situation should a medication cart be left unlocked and unattended. During an interview on 01/13/2026 at 3:35 p.m., the Administrator revealed the expectation was medication carts were to be locked when not in use. The risk to the residents was they could get medications they were not supposed to have. During an interview on 01/13/2026 at 3:56 p.m., the DON revealed the mediation cart should never be unlocked without the nurse standing in front of it giving care to a resident. The expectation was as state regulation stated once you turn from the cart, it should be locked. The risk to the residents was the patient could access things [medications] in the cart. During a record review of policy titled Storage of Medications revision date 08-2020 revealed. Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. 2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications, mediation room, carts and (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication supplies are locked when they are not attended by persons with authorized access.