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	02/04/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for one (Hall C Nurse Cart) of five medication carts reviewed. LVN A failed to ensure that Hall C nurse cart was not left unlocked and unattended with the keys still in the lock mechanism in between rooms [ROOM NUMBERS]. This failure placed residents at risk of having access to medications not ordered for them or more than recommended doses.Observation and interview on 02/03/26 at 3:48 PM, revealed a medication cart on C hall was left unlocked and unattended with the keys still in the lock mechanism in the middle of C hall between rooms [ROOM NUMBERS]. The MDS nurse walked toward the cart while surveyor was standing by the unlocked and unattended medication cart, and she pushed the lock mechanism in (indicating locking position) and she pulled the keys out of the lock mechanism. She stated, this cart should be locked. She said the nurse should not have left the cart unlocked when unattended. The Surveyor asked the MDS nurse who the unlocked medication cart belonged to, and she stated the medication cart belonged to LVN A. In an interview with LVN A on 02/03/26 at 4:11 PM, revealed the unattended and unlocked medication cart on C Hall belonged to her and it was a nurse cart. She said she had just finished cleaning the medication cart and she dashed into the med room to get some blood sugar strips. She said she forgot to lock the cart, and she forgot to take the keys with her. She stated it was important to keep the med cart locked, and keys safely removed and within nurse's position. She stated the risk was medication safety of the residents' obtaining narcotics medications because keys were left in the cart and to prevent them or anyone from getting into the cart. In an interview with the DON on 02/04/26 at 11:19 AM, revealed she expected her staff to lock their medication carts and take the keys with them. She said that she had already started an Inservice, and the nurse (LVN A) was suspended for the incident. She said all nurses were responsible for securing their medication carts. She said she was responsible for monitoring that staff were following medication safety. She said the risk was that anyone could access get into the medication cart. Review of facility policy titled Medication Storage, revised 01/2026, reflected: Medication carts must be locked and always secured unless under direct and continuous supervision of authorized personnel during medication administration. These standards are required to ensure resident safety and regulatory compliance. 2. Key Security: keys must always remain on the authorized staff member person. Keys must not be left in the cart locked, placed on cart, left on surfaces, given to unlicensed personnel or left unattended.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1 (Resident #1) of 7 residents reviewed for infection control. 1.LVN B and CNA C failed to wear PPE gown during incontinence care for Resident #1 who was on Enhanced Barrier Precautions for G-tube and Wounds. 2. LVN B failed to change her gloves and failed to perform hand hygiene when she did not remove her dirty gloves after finishing incontinence care for Resident #1 before connecting her feeding tube back to the feeding. These failures could place residents at risk of infectious disease. Resident #1 Record review of Resident #1's admission record dated 02/03/26 revealed a [AGE] year-old female with an initial admission to the on 12/11/23 and readmitted to the facility on [DATE]. Her diagnoses included senile degeneration of Brain (this is a brain condition that progressively destroys memory and other important mental functions and causes state of confusion and forgetfulness), gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing) and non-pressure chronic ulcers to both ankles. Record review of Resident #1's quarterly MDS dated [DATE] indicated Resident #1 had severe cognitive impairment. The MDS indicated she had a feeding tube and received 51 percent or more of her total calories through tube feeding. MDS also indicated she was always incontinent with bowels and bladder and dependent on toileting, showers, and transfers. MDS did not indicate any wounds or pressure sore Record review of Resident #1's care plan initiated 07/18/24 revealed Resident #1 was on enhanced barrier precautions related to wounds and device care. The goal was to follow enhanced barrier precautions. Interventions included staff wearing clean gowns and gloves while performing high contact care. Observation on 02/03/26 at 3:05 PM, revealed Resident #1 had a sign outside the resident's door which indicated the resident was on EBP. LVN B and CNA C did not wear gowns while providing incontinent care to Resident #1. Continuous observation of Resident #1's incontinent care also revealed that LVN B did not change her dirty gloves or wash her hands after wiping Resident #1's bottom before reconnecting Resident #1 back to her feeding via g-tube. Interview with LVN B on 02/03/26 at 3:27 PM, she said she had already washed her hands before starting care. She said she was not aware that a g-tube was considered an indwelling medical device which would require EBP. She said unless a resident had secretions that were bloody, she did not need to wear a gown. She said she had not been trained on EBP in a while and was thinking that EBP was only for wounds and foley catheter. She stated now she understood anyone with a g-tube or anything invasive would require PPE. She stated the risk was contamination. She said that she should have changed her gloves before connecting back the feeding as that was infection control and contamination. Interview with CNA C on 02/03/26 at 3:37 PM, she stated if a resident was on any type of isolation, and she did not understand the precautions then she would ask the nurse. She said that she did not wear a gown because the nurse (LVN B) was not wearing a gown and was in the room with her, so she did not think it was required to wear a gown. She said she was not sure what the risk was. In an interview with the DON on 02/04/26 at 11:19 AM, revealed if a resident was on EBP isolation it meant staff were to wear gloves and gowns while providing care. She stated all staff were expected to wear PPE to prevent the spread of infection. She said that the nurse should have changed her gloves and completed hand hygiene before moving on to connect the G-tube. She said the risk was contamination and spread of infection Interview with the administrator on 02/04/26 at 11:20 AM, he said he expected staff to follow the policy and procedures that were in place. He said all staff were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to prevent spreading of infection. Record review of facility in-service titled Enhanced Barrier Precautions dated 02/03/26 led by DON revealed one on one completion for LVN B and CNA C. Review of the facility policy titled Standard and Enhanced Precautions revised 10/24/22 revealed.D. Gownsi. A gown is worn to protect skin and prevent soiling of clothing during proceduresand resident care activities that are likely to generate splashes or sprays of blood,body fluids, secretions, or excretions or cause soiling of clothing G. Lineni. Transport and processing of used linen soiled with blood, body fluids, secretions,and excretions is handled in a manner that prevents skin and mucous membraneexposures, contamination of clothing, and avoids transfer of microorganisms toother residents and environments. Review of policy Implementation of Standard and Transmission-Based Precautions dated 03/24, revealed, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO .post signage .high-contact resident care activities requiring gown and glove use .