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	04/16/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of 3 residents, reviewed for medications. The facility failed to ensure Resident #1's order for Wellbutrin 300 mg was not duplicated on the MAR.The facility failed to ensure the staff signed off on the MAR correctly. Staff signed off that they administered 600 mg when they only administered 300 mg. This failure placed residents at risk for medication related errors and medication overdose.Findings included: Review of Resident #1's Quarterly MDS Assessment, dated 02/12/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 15, indicating her cognitive skills were intact. Her diagnoses included heart failure and end-stage kidney disease. There were no diagnoses for anxiety disorder or depression listed. Review of Resident #1's Face Sheet, dated 04/16/26, reflected her diagnoses included blindness, generalized anxiety disorder, and major depressive disorder. Review of Resident #1's Comprehensive Care Plans, dated 02/19/26, reflected Resident #1 was non-compliant with medication administration and facility interventions included talk to the resident to determine reasons for refusal of care.Review of Resident #1's Medication Administration Record for March 2026 reflected two separate orders for Wellbutrin 300 mg daily was administered 03/01/26 - 03/23/26. Review of Resident #1's Psychiatric Subsequent Assessment, dated 03/09/26, reflected the NP had documented the resident was receiving Wellbutrin 600 mg daily. Review of Resident #1's Psychiatric Subsequent Assessment, dated 03/23/26, reflected the NP had documented the resident was receiving Wellbutrin 600 mg daily and changed the dose to 450 mg daily. An interview on 04/16/26 at 11:42 AM with Resident #1 revealed she was not receiving her medications correctly. She said the facility was overdosing her by giving her 600 mg of Wellbutrin instead of 300 mg daily. She said she would tell the nurse who said they had already spoken to the doctor about the dose. Resident #1 said she would refuse the dose when they tried to give her 600 mg instead of 300 mg. In an interview on 04/16/26 at 1:40 PM, LVN A revealed she would administer medications to Resident #1 if the medication aide called in. LVN A said Resident #1 would refuse medication including Wellbutrin. LVN A said she did not know why the resident would refuse Wellbutrin. In an interview on 04/16/26 at 1:55 PM, the DON revealed she did not know if Resident #1 received Wellbutrin 600 mg daily from 03/01/26-03/23/26 as ordered. In an interview on 04/16/26 at 3:30 PM, the ADON revealed Resident #1 had an order for Wellbutrin 600 mg daily in March 2026 but did not receive 600 mg. She said it was a duplicate order listed on the Medication Administration Record. The ADON said the NP found the error. The ADON said she spoke with staff who said they only administered 300 mg, not 600 mg. In an interview on 04/16/26 at 3:50 PM, the NP said she identified Resident #1 had an order for Wellbutrin 600 mg daily on 03/23/26. The NP said she lowered the dose to 450 mg daily. The NP said Resident #1 never asked her for a dose reduction of the medication. The NP said Resident #1 would see an outside NP and maybe they ordered the additional order for Wellbutrin 300 mg daily to total 600 mg. The NP said if a resident received 600 mg of (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wellbutrin, they could experience stomach upset, diarrhea, stomach pain, insomnia, and increased anxiety. The NP said Resident #1 never reported those symptoms to her. In an interview on 04/16/26 at 4:00 PM, the Physician said he oversaw the care provided by the NP. He said he did not know why Resident #1 had an extra order for Wellbutrin 300 mg daily to total 600 mg. Interviews on 04/16/26 from 4:10 PM to 4:55 PM with MA B, MA C, MA D, MA E, and LVN F revealed they administered Wellbutrin 300 mg daily instead of Wellbutrin 600 mg as ordered on the Medication Record for 03/01/26 - 03/23/26. They said they signed they gave 600 mg in error. They said they had been trained to sign only the medications they administered. In an interview on 04/16/26 at 5:15 PM, the DON revealed the facility had a QAPI meeting to put a system in place to ensure the Medication Administration Record was correct. The DON said she was made aware of the issue on 04/16/26 when it was brought to her attention by the Surveyor. She said the ADON was responsible for checking Medication Administration Records occasionally. The DON said Resident #1 would have been at risk for side effects including seizures and agitation if she received 600 mg of Wellbutrin daily. The DON said the resident did not report those side effects. The DON said she did not know why Resident #1 refused Wellbutrin. Record review of the facility policy, Medication Administration, not dated, reflected: .Nursing staff will keep in mind the [seven] rights of medication when administering medication:A. The right medicationB. The right dose.