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	06/25/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for one (Residents #1) of 5 residents reviewed for resident rights. The facility failed to ensure CNA A did not leave her computer tablet unattended on a bedside table that was located on the 200 hall. It was unlocked and displayed Resident #1 was incontinent for bowel movements. This failure could place residents at risk of having their medical information disclosed by residents and visitors which could cause embarrassment, frustration, and feelings of decreased privacy, resulting in a decline in their health and psycho-social well-being. The findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] and signed by the DON revealed, a [AGE] year-old male who admitted [DATE]. He had a BIMS score of 10 (moderately impaired cognition), walked without assistance and needed supervisory with touch assist for all ADLs. He was always continent of bowel and bladder and had active diagnoses of stroke and diagnoses of hypertension (high blood pressure), heart failure (heart muscle too weak to pump blood), renal failure (kidney lose ability to filter waste and excess fluid), hyperlipidemia (high levels of fat lipids), CVA, non-Alzheimer's dementia (cognitive loss), hemiplegia (one sided paralysis), anxiety (persistent worrying causing stress) depression (serious mood disorder). He had shortness of breath and at risk of developing pressure sores but had no skin issues. Record review of Resident #1's Care Plan dated 03/18/24 revealed, [Resident #1] had functional bowel and bladder incontinence related to activity tolerance, impaired mobility, physical limitations. Goal: Will remain free from skin breakdown due to incontinence and brief use through review dateObservation on 06/25/26 at approximately 11:52 am revealed Resident #2 pressed his call light. CNA A entered his room to assist Resident #2 with looking for his wallet that was eventually found. Observation on 06/25/26 at 11:54 am revealed, on the hall, there was a computer tablet on a bedside table by room [ROOM NUMBER]. This computer tablet displayed Resident #1's plan of care showing he was incontinent of his bowel. (No one was observed around this computer tablet. Observation and interview on 06/25/26 at 11:55 am, CNA A walked out of Resident #2's room and quickly grabbed the computer tablet and started walking away very fast. She was stopped and agreed to have an interview. CNA A said she went to answer a resident's call light. She stated the call light was on and she went to answer it and she should not have left the tablet open because it was a HIPAA violation. She stated the tablet disclosed resident information. She stated she was in Resident #2's room for about two to three minutes to help Resident #2 find his wallet. She stated she was in his room a little longer than she thought she would be. She stated she had just finished charting on a resident and was about to start charting Resident #1's ADLs. She stated she was moving too fast, and she was trying to answer the call light, but she knew she was not supposed to leave the resident info displayed on the computer tablet. She stated other people could use the resident's medical information for their own benefit or a family or resident could have taken pictures and read the resident's information. She stated for future reference she would slow down and lock the screen before she walked away from it. Interview on 06/25/26 at 6:06 pm, the DON stated they were good with the confidentiality of the resident's records. She stated she was not aware CNA A left the computer tablet unlocked and showing Resident's #1's ADL records for anyone (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to see. She stated if CNA A's computer was up, then yes, that was a problem. She stated incontinent care status was private information especially if the residents were incontinent. She stated the DON and Administrator were responsible for ensuring the facility was HIPAA complaint. She stated they needed to make sure computer screens were locked and they were not available for anyone to see Resident Information. Interview on 06/25/26 at 6:48 pm, the Administrator stated HIPAA compliance was expected to keep personal healthcare information protected at all times. He stated he was not aware CNA A left the computer tablet open on the hallway with a resident's information disclosed. He stated they were absolutely going to do a 1:1 training session with her about HIPAA compliance that day. He stated, ultimately, he was responsible for ensuring the facility had no HIPAA compliance issues. Record review of the facility's Resident Rights policy dated August 2020 revealed, Purpose: To promote and protect the rights of all residents at the facility. Procedure: I. Stated and federal laws guarantee certain basic rights to all residents of the facility. These rights include, but are not limited to, a resident's right to: E. Privacy and confidentiality including the right to privacy in his/her specific oral, written, and electronic communications. Record review of the facility's Medical Records policy dated June 2020 revealed, Purpose: To ensure the accurate documentation and maintenance of medical records by the facility. Policy: Clinical records, paper or electronic, will be kept for each resident admitted for care. Content will be in compliance with licensing and certifying governmental agency requirements and professional standards. Procedures: V. Protected health information contained in the record is confidential and will only be released in accordance with the Facility's HIPAA policies. VII. Unlawful or unauthorized access to, use or disclosure of protected health information will be reported in accordance with the Facility's HIPAA polices.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure within 14 days after the facility determined, or should have determined, that there had been a significant change assessment completed for the resident's mental condition for 1 (Resident #2) of 5 residents reviewed for resident assessments. The facility failed to ensure a comprehensive MDS significant change assessment was completed for Resident #2, after he made suicidal ideation statements on 05/07/26, 05/18/26 and 05/25/26, 06/03/26 and 06/22/26. This failure could place residents at risk of not getting all of their medical needs met, which could cause residents to harm themselves resulting in decreased health and psycho-social well-being. The findings included:Record review of Resident #2's admission MDS assessment dated [DATE] and signed by the DON on 05/18/26 revealed, a [AGE] year-old male who admitted [DATE], his BIMS score was 14 (cognition intact). For section D. Resident mood interview (Say to resident: Over the last 2 weeks, have you been bothered by any of the following problems?) was coded 0 for not having any interest or pleasure in doing things and feeling down, depressed, or hopeless. He used a wheelchair and had upper and lower extremity impairments and needed Partial/moderate assistance and substantial/maximal assistance for most ADLs. His primary active diagnosis were stroke, and his other diagnoses[SH4.1] were hypertension (high blood pressure), benign prostatic hyperplasia (non-cancerous enlarged gland), diabetes mellitus (high blood sugar level), hyperlipidemia (high levels of fat lipids), thyroid disorder (abnormal hormone gland), and aphasia (neurological language disorder). Record review of Resident #2's Quarterly MDS assessment dated [DATE] and signed by the DON 06/02/26 revealed, a [AGE] year-old male who admitted [DATE], he had a BIMS score of 12 (moderately impaired cognition). For section D. Resident mood interview (Say to resident: Over the last 2 weeks, have you been bothered by any of the following problems?) . it was coded 0 for not having any interest or pleasure in doing things and feeling down, depressed, or hopeless. He used a wheelchair and walker and had upper extremity impairment and no lower extremity impairment and needed supervisory or touch assistance and Partial/moderate assistance for most ADLs. His primary active diagnoses were stroke, and his other diagnoses were hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperlipidemia, thyroid disorder, and aphasia. Record review of Resident #2's Care Plans revealed Resident #2 had a behavioral problem related to ongoing suicidal ideations, date initiated 06/23/26 and revised 06/25/26 Resident #2 has a behavior problem related to suicidal thoughts. Date initiated and revised 06/05/26 The resident needs in room socialization and sensory stimulation. Date initiated and revised 05/06/26 the resident has had an actual fall related to poor balance. Record review of Resident #2's Hospital Discharge summary dated [DATE] revealed, resident was assessed and cleared of suicidal ideation and Melatonin was ordered to promote sleep. Record review of Resident #2's Psychiatric Subsequent Assessment by Psychiatric NP C dated 06/08/26 revealed, reason for referral: Depression, worrying, irritability, delusions, suicidal/homicidal, resident was sent out for suicidal ideation with a plan. Physical examination: speech slow, soft, sad, flat affect, no plan for suicidal ideation, no risk of aggression, moderate depression. No medication changes and assessment plan: Primary insomnia and unspecified mood disorder. Revisit in 2 weeks. Record review of Resident #2's June 2026 MAR revealed, 88 mcg Levothyroxine sodium 1 tablet for morning, 3 mg. Melatonin 2 tablet at bedtime, 40 mg Pantoprazole 1 tablet 1 x D, 0.4 mg Tamsulosin 1 capsule at bedtime, 400 mg Magnesium Oxide 2 tablets 2 x D, 500 mg Metformin 2 tablets 2 x D, 40 mg Propranolol 1 tablet 2 x D, 1 gm Sucralfate 1 tablet 4 x D, 50 mg Armodafinil 1 tablet 1 x D, 2 mg Imodium A-D, 4% Lidocaine to lower back topically for morning, 4 mg Ondansetron 1 tablet every 6 hours, as needed, Resident exhibits depressive target behavior (each shift chart the number of episodes the targeted behavior occurred, intervention used and the outcome of the intervention), 325 mg Acetaminophen 1 tablet every 6 hours, as needed. Record review of Resident #2's Nurse Progress notes dated 05/07/26 at 11:34 am, by ADON D (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, Change in condition reported on this change in condition were behavioral symptoms.Nursing evaluations, evaluation and recommendations are: Resident reported to IDT team that he was planning suicide by jumping out the window and/or wrapping cords around his neck and rolling out of bed. MD notified. Transfer to emergency room for suicidal ideation. Record review of Resident #2's Social Worker note by SW B dated 05/18/26 at 1:07 pm, Late Entry: SW sent psychiatric referral due to resident's suicidal ideations. Resident will be evaluated today. Record review of Resident #2's Social services note by SW B dated 05/25/26 at 9:55 am revealed, PHQ-2 to 9: Little interest or pleasure in doing things - symptom presence: no. little interest or pleasure in doing things - symptom frequency: never or 1 day, feeling down, depressed, or hopeless - symptoms presence: No. feeling down, depressed, or hopeless - symptom frequency - never or 1 day. Score: 0.0. Record review of Resident #2's Nurse Progress note dated 05/25/26 at 11:24 am, change in condition: Behavioral status evaluation: Danger to self and others suicide potential.primary provider feedback, recommendations: sent to emergency room and new testing orders. Record review of Resident #2's Nurse progress note dated 05/25/25 at 1:50 pm by ADON D revealed, Psychiatrist came to visit resident, and he told her he want [sic] to kill himself, the doctor advised the ADON of the situation, so this nurse called 911 and went to sit with patient until EMT arrived. Patient told EMT that he planned to kill himself on a certain day, but he will not tell them the date because they would try to stop him, patient said that he would jump out the window so he could die. Patient sent to psychiatric hospital. Record review of Resident #2's Nurse Progress notes dated 06/03/26 at 12:13 pm by LVN E revealed, This nurse call 911 because patient was saying he wanted to kill himself. Psychiatric (through 911) came out to evaluate and said that they would not take him because he can't walk and they just came and got him and returned back to the facility after a couple of days. Record review of Resident #2's Nurse Progress notes dated 06/22/26 at 1:44 pm by LVN E revealed, Patient called 911 and told them he was planning to kill himself at 6 pm today, this nurse was at the dining room when patient called 911. Patient placed on continuous observation and safety precautions initiated per facility protocol. Potential hazards removed from patient's environment Provider notified of assessment findings and recommendation for emergent psychiatric evaluation. Interview and observation on 06/25/26 at 11:28 am, Resident #2 was lying in bed and appeared calm and not in any distress. His wheelchair was next to his bed. He stated he did not feel sad or depressed, and had no plan on jumping out of the window, but a couple of days ago, he felt that way. He stated he took medications for depression that worked he believed because right now he did not want to kill himself. He stated he would love to get shaved by the staff before he left this facility. He stated he saw the psychologist at this facility, and had been sent to the hospital's psychiatric ward several times because of not wanting to live anymore. He stated he was currently getting ready to go to a rehabilitation hospital for therapy. Interview on 06/25/26 at 12:47 pm, the DON stated Resident #2 had been suicidal since becoming a resident at the facility last month. She stated the nurses called Resident #2's doctor when he had suicidal thoughts, and was transferred to the hospital for psychiatric services. She stated once he was cleared for safety, he was sent back to this facility. She stated Resident #2 received psychiatric services from their provider and SW B talked to him a lot, when he had a bad day. She stated the Hospital had a team that also came out to evaluate him with two LE and a psychiatric nurse for his crisis moments. She stated the hospital team gave Resident #2 tacos and assessed and cleared him. She stated the nurse's communication for each shift and staff training was done to ensure Resident #2 was safe. She stated the staff made sure he had plastic ware, encouraged him to come out of his room and 1:1 when he had a bad day. She stated they also care planned this and added Resident #2 was scheduled to go to a rehabilitation hospital today. She stated the plan was for him to return to this facility since he could not return home. She stated Resident #2 was his own RP and she had not spoken to his family about his suicidal thoughts, but was sure SW B had spoken to them about it. She stated she would have to go through his notes to see if he had any plan to kill himself or just made the statements of wanting to die. She stated she did not know how often Resident #2 made suicidal (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statements off the top of her head and would follow-up with HHS after reviewing his records. She stated Resident #2 did not want to be in any nursing home at all and said she would ensure SW B to talk to him about his options to return here or go to another facility. Interview on 06/25/26 at 2:20 pm, the DON stated after she reviewed Resident #2's records, she said on 05/07/26 he made a suicidal statement, and he was sent to the hospital for evaluation and he returned after clearance. Interview on 06/25/26 at 3:13 pm, the DON stated Resident #2 also made suicidal statements on 05/18/26 and 05/25/26 and was sent to the hospital both times and he was cleared and returned. And on 06/03/26 he made suicidal statements and the hospital psychiatric team came to evaluate and cleared him at this facility. Then on 06/23/26 he made suicidal statements and was sent to the hospital and was cleared. She stated his 06/24/26 hospital discharge planning paperwork, said he wanted to go somewhere else and so he was sent to the rehabilitation hospital today (06/25/26). Interview on 06/25/26 at 4:36 pm, SW B stated Resident #2's first suicidal statements started on 05/07/26 during their IDT meeting and shortly after they put procedures in place to keep him safe. They put him on 1:1 monitoring then he was sent to the hospital for a psychiatric evaluation. She stated he was also seen by this facility's psychiatrist and counselor, and they checked on him often to make sure he was not feeling suicidal anymore. She stated that week, Resident #2 made a suicidal statement 06/22/26 and he was sent to the hospital and he just returned yesterday 06/23/26. She stated Resident #2 said he wanted to go back to the rehabilitation hospital, so he went back there today. She stated he was pretty good with talking to her when she went to check on him daily, when she worked. She stated when MDS assessments were not accurate the residents may not get full access to their rights. She stated for suicidal statements, it could affect the resident (she did not go into detail after re-questioning) and said she was not aware that the MDS was linked to the care plans. She stated the MDS assessments had what the resident's care needs were. She stated she knew how to do the MDS assessments, and no one had told her they were wrong. Interview on 06/25/26 at 5:19 pm, MDS F stated she was on vacation and was not aware Resident #2 made suicidal statements in May 2026. She stated Resident #2 was identified by the IDT as being suicidal on 06/02/26, and they discussed the plan to address it. She stated she was responsible for having accurate MDS assessments. She stated the MDS assessments were important because they were a reflection of the care provided to the residents. She stated if the MDS assessments were not accurate, the staff may not provide all the care for the residents. She stated for MDS Assessment they were supposed to interview the residents and review their medical records for the MDS sections to complete. Interview on 06/25/26 at 6:48 pm, the Administrator stated he was informed about Resident #2's first suicidal ideation on 05/07/26 and he was sent to the hospital. He stated Resident #2 had been sent to the hospital for making suicidal statement since then. He stated Resident #2 was alert and oriented X 3, and he did not want to be at this facility. He stated there was nowhere to put suicidal ideation on the MDS assessment, section D. for Mood and would have to talk more to the nursing department. He stated there were no problems with Resident #2's MDS assessments, and the care plans were based on what the MDS data was. He stated CMS just recently changed and now the MDSs were based on what the care plan data was. He stated they had a QAPI meeting in April 2026, about the MDS software issue with their signature sheets not transmitted properly and not with what was coded for the residents. He stated the MDS Coordinator was responsible for accurate MDS assessments.Record review of SW B's Inservice Training Report dated 06/25/26 revealed, Subject: MDS Accuracy - Check and review RAI manual for additional guidance. The instructor was MDS C and summary of the meeting: Review MDS sections - verbalize understanding and accuracy. And signed by SW B. Record review of the facility's Minimum Data Set policy version 1.17 undated revealed, Purpose: To utilize the most current version of the RAI manual to guide all IDT members on the proper procedure for coding items on MDS assessments, completing of Care Area Assessments (CAAs), and other instructions relating to MDS procedures. Policy: The facility will follow RAI guidelines for all areas related to MDS processes. Procedure: 1. IDT to utilize RAI for all processes pertaining to MDS. 2. MDS (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse or IDT member to produce section of RAI referenced to support coding or other MDS processes as indicated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's assessments accurately reflected their statuses for 1 (Resident #2) of 5 residents reviewed for resident assessments. 1) The facility failed to ensure SW B correctly completed Resident #2's 05/07/26 MDS assessment. SW B did not review and capture his suicidal ideations in the prior 14 days. SW B failed to ask this resident if in the past 14 days did, he have suicidal ideations; subsequently Resident #2 made suicidal statements which were within 14 days of this assessment and not included in Section D.0500 (i).2) The facility failed to ensure SW B correctly completed Resident #2's 06/02/26 Quarterly MDS assessment. SW B did not review and capture his suicidal ideations. SW B failed to ask this resident if in the last 14 days did, he have suicidal ideations; subsequently Resident #2 made suicidal statements which were within 14 days of this assessment and not included in Section D.0500 (i).These failures could place residents with mood disorders at risk of not getting all of their medical needs met for mental health issues, which could cause residents to harm themselves resulting in decreased health and psycho-social well-being. The findings included:Record review of Resident #2's admission MDS assessment dated [DATE] and signed by the DON on 05/18/26 revealed, a [AGE] year-old male who admitted [DATE], his BIMS score was 14 (cognition intact). For section D. Resident mood interview (Say to resident: Over the last 2 weeks, have you been bothered by any of the following problems?) was coded 0 for not having any interest or pleasure in doing things and feeling down, depressed, or hopeless. He used a wheelchair and had upper and lower extremity impairments and needed Partial/moderate assistance and substantial/maximal assistance for most ADLs. His primary active diagnosis were stroke, and his other diagnoses were hypertension (high blood pressure), benign prostatic hyperplasia (non-cancerous enlarged gland), diabetes mellitus (high blood sugar level), hyperlipidemia (high levels of fat lipids), thyroid disorder (abnormal hormone gland), and aphasia (neurological language disorder). Record review of Resident #2's 05/07/26 MDS - Version 3.0 Resident assessment and care screening nursing home comprehensive item set revealed, Section D 0150.i. thoughts that you would be better off dead, or hurting yourself in some way. Record review of Resident #2's Quarterly MDS assessment dated [DATE] and signed by the DON 06/02/26 revealed, a [AGE] year-old male who admitted [DATE], he had a BIMS score of 12 (moderately impaired cognition). For section D. Resident mood interview (Say to resident: Over the last 2 weeks, have you been bothered by any of the following problems?) . it was coded 0 for not having any interest or pleasure in doing things and feeling down, depressed, or hopeless. He used a wheelchair and walker and had upper extremity impairment and no lower extremity impairment and needed supervisory or touch assistance and Partial/moderate assistance for most ADLs. His primary active diagnoses were stroke, and his other diagnoses were hypertension, benign prostatic hyperplasia, diabetes mellitus, hyperlipidemia, thyroid disorder, and aphasia. Record review of Resident #2's 06/02/26 MDS - Version 3.0 Resident assessment and care screening nursing home comprehensive item set revealed, Section D 0150.i. thoughts that you would be better off dead, or hurting yourself in some way.Record review of Resident #2's Care Plans revealed, Resident #2 had a behavioral problem related to ongoing suicidal ideations, date initiated 06/23/26 and revised 06/25/26 Resident #2 has a behavior problem related to suicidal thoughts. Date initiated and revised 06/05/26 The resident needs in room socialization and sensory stimulation. Date initiated and revised 05/06/26 the resident has had an actual fall related to poor balance. Record review of Resident #2's Hospital Discharge summary dated [DATE] revealed, resident was assessed and cleared of suicidal ideation and Melatonin was ordered to promote sleep. Record review of Resident #2's Psychiatric Subsequent Assessment by Psychiatric NP C dated 06/08/26 revealed, reason for referral: Depression, worrying, irritability, delusions, suicidal/homicidal, resident was sent out for suicidal ideation with a plan. Physical examination: speech slow, soft, sad, flat affect, no plan for suicidal ideation, no risk of aggression, moderate (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression. No medication changes and assessment plan: Primary insomnia and unspecified mood disorder. Revisit in 2 weeks. Record review of Resident #2's June 2026 MAR revealed, 88 mcg Levothyroxine sodium 1 tablet for morning, 3 mg. Melatonin 2 tablet at bedtime, 40 mg Pantoprazole 1 tablet 1 x D, 0.4 mg Tamsulosin 1 capsule at bedtime, 400 mg Magnesium Oxide 2 tablets 2 x D, 500 mg Metformin 2 tablets 2 x D, 40 mg Propranolol 1 tablet 2 x D, 1 gm Sucralfate 1 tablet 4 x D, 50 mg Armodafinil 1 tablet 1 x D, 2 mg Imodium A-D, 4% Lidocaine to lower back topically for morning, 4 mg Ondansetron 1 tablet every 6 hours, as needed, Resident exhibits depressive target behavior (each shift chart the number of episodes the targeted behavior occurred, intervention used and the outcome of the intervention), 325 mg Acetaminophen 1 tablet every 6 hours, as needed. Record review of Resident #2's Nurse Progress notes dated 05/07/26 at 11:34 am, by ADON D revealed, Change in condition reported on this change in condition were behavioral symptoms.Nursing evaluations, evaluation and recommendations are: Resident reported to IDT team that he was planning suicide by jumping out the window and/or wrapping cords around his neck and rolling out of bed. MD notified. Transfer to emergency room for suicidal ideation. Record review of Resident #2's Social Worker note by SW B dated 05/18/26 at 1:07 pm, Late Entry: SW sent psychiatric referral due to resident's suicidal ideations. Resident will be evaluated today. Record review of Resident #2's Social services note by SW B dated 05/25/26 at 9:55 am revealed, PHQ-2 to 9: Little interest or pleasure in doing things - symptom presence: no. little interest or pleasure in doing things - symptom frequency: never or 1 day, feeling down, depressed, or hopeless - symptoms presence: No. feeling down, depressed, or hopeless - symptom frequency - never or 1 day. Score: 0.0. Record review of Resident #2's Nurse Progress note dated 05/25/26 at 11:24 am, change in condition: Behavioral status evaluation: Danger to self and others suicide potential.primary provider feedback, recommendations: sent to emergency room and new testing orders. Record review of Resident #2's Nurse progress note dated 05/25/25 at 1:50 pm by ADON D revealed, Psychiatrist came to visit resident, and he told her he want [sic] to kill himself, the doctor advised the ADON of the situation, so this nurse called 911 and went to sit with patient until EMT arrived. Patient told EMT that he planned to kill himself on a certain day, but he will not tell them the date because they would try to stop him, patient said that he would jump out the window so he could die. Patient sent to psychiatric hospital. Record review of Resident #2's Nurse Progress notes dated 06/03/26 at 12:13 pm by LVN E revealed, This nurse call 911 because patient was saying he wanted to kill himself. Psychiatric (through 911) came out to evaluate and said that they would not take him because he can't walk and they just came and got him and returned back to the facility after a couple of days. Interview and observation on 06/25/26 at 11:28 am, Resident #2 was lying in bed and appeared calm and not in any distress, his wheelchair was next to his bed. He stated he did not feel sad or depressed and had no plan on jumping out of the window, but a couple of days he felt that way. He stated he took medications for depression that worked he believed because right now he did not want to kill himself. He stated he would love to get shaved before he left this facility. He stated he saw the psychologist at this facility and had been sent to the hospital psychiatric ward several times because of not wanting to live anymore. He stated he was currently getting ready to go to a rehabilitation hospital for therapy. Interview on 06/24/26 at 12:10 pm, LVN E stated Resident #2 has made statements of self-harm a month ago. She stated each time he had suicidal ideation his Doctor and 911 was called and he was taken to the hospital for evaluation and cleared for safety and returned back to this facility. She stated when he returned back to this facility they tried to get him up to go to activities and explained to him how important it was to do activities. He was taking psychotropic medication, but he refused to take them or go to activities. She stated Resident #'2 Doctor told the staff to continue to monitor him for signs of suicidal ideation. She stated the Psychiatric NP C who visited him regularly, to ensure he was safe. She stated two weeks ago she spoke to the DON about Resident #2 made suicidal ideation statements almost every other day that ?He doesn't want to live and wants to kill himself and the DON said they were working on a care plan for him. She stated she had not seen Resident #2 trying to hurt himself, but she and the other staff (continued on next page)

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	676293	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing & Rehabilitation	6825 Harry Hines Blvd Dallas, TX 75235

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still kept an eye on him. Interview on 06/25/26 at 12:23 pm, ADON D stated Resident #2 had been suicidal three or four times since being admitted to this facility. She stated in the past he was going to kill himself but did not reveal the date or time for anyone to stop him. She stated Resident #2 said on occasion he was going to jump out of the window for the past month. She stated the LA and Hospital psychiatric services came out at times and he was also transferred to the hospital a few times in the past 30 to 45 days. She stated Resident #2 was cleared for safety after his evaluations, but they were still monitoring him closely. She stated the last time he went to the hospital was 06/22/26 for suicidal thoughts and said they were trying to encourage him to get up for activities to get him out more and sometimes he would get up and sometimes not. She stated the staff continued to check Resident #2 more often and documented in his MAR his mood. She stated he had no Suicidal thoughts today (06/25/26) but yesterday (06/24/26) he did. She stated she went and talked to him, and he was up this morning and was doing fine today (06/25/26). She stated today he planned to go to a rehabilitation hospital for more therapy. She stated Resident #2 had a care plan for suicidal thoughts and he received counseling from their psychiatric provider. She stated Resident #2 took propanol for psychiatric and Depakote for his psychiatric issue and was getting psychology and psychiatric services. She stated they have had IDT meetings on a regular basis and Resident #2 was discussed for his suicidal thoughts. She stated their IDT meetings included the DON, both ADON's, Administrator, MDS and SW. Interview on 06/25/26 at 12:47 pm, the DON stated Resident #2 had been suicidal since being a resident at this facility, last month. She stated the nurses called Resident #2's Doctor when he had suicidal thought and was transferred to the hospital for psychiatric services. She stated once he was cleared for safety he was sent back to this facility. She stated Resident #2 received psychiatric services from their provider and their SW B talked to him a lot, when he had a bad day. She stated the Hospital had a team that also came out to evaluate him with two LE and a psychiatric nurse for his crisis moments. She stated this hospital team gave Resident #2 tacos and assessed and cleared him. She stated the nurse's communication for each shift and staff training was done to ensure Resident #2 was safe. She stated the staff made sure he had plastic ware, encouraged him to come out of his room and 1:1 when he had a bad day. She stated they also care planned this and added Resident #2 was scheduled to go to a rehabilitation hospital today. She stated the plan was for him to return to this facility since he could not return home. She stated Resident #2 was his own RP and she had not spoken to his family about his suicidal thoughts, but was sure SW B had spoken to them about it. She stated she would have to go through his notes to see if he had any plan to kill himself or just made the statements of wanting to die. She stated she did not know how often Resident #2 made suicidal statements off the top of her head and would follow-up with HHS after reviewing his records. She stated Resident #2 did not want to be in any nursing home at all and said she would ensure SW B to talk to him about his options to return here or go to another facility. Observation on 06/25/25 at 1:20 pm, Resident #2's was not in the room and his belongings were gone. (ADON D stated he had just left the facility to go to the rehabilitation hospital). Interview on 06/25/26 at 1:24 pm, the Administrator stated Resident #1 admitted last month and he had no suicidal statements prior to his admission [DATE] but would review his notes to be sure. He stated Resident #2 was his own RP and was cognitively intact. He stated Resident #2 made suicidal statements for which they were sending him to the hospital for and was seen by their psychiatric provider. He stated he knew Resident #2 had been sent out several times for suicidal thoughts and went to the hospital and they cleared him saying he was safe and was no longer a harm to himself. He stated Resident #2 said he did not want to be in a nursing home, but he could not return home with his family. He stated Resident #2 made a statement to put him out on the street, and he told him No they could not do that. He stated Resident #2 was transferred to a rehabilitation hospital for therapy today (06/25/26). He stated he was taken there to increase his functional ability. He stated if he returned to this facility, they would have to have a care plan meeting with Resident #2 and his family to see if there was anything else that could be done to help Resident #2. He stated he spoke to Resident #2 with AD E (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and SW B, and they asked what could be done to make it better for him, because he stayed in his room most of the time. He stated Resident #2 said he liked coffee, so they made sure he received his coffee every morning. Interview on 06/25/26 at 2:20 pm, the DON stated after she reviewed Resident #2's records, she said on 05/07/26 he made a suicidal statement, and he was sent to the hospital for evaluation and he returned after clearance. Interview on 06/25/26 at 3:13 pm, the DON stated Resident #2 also made suicidal statements on 05/18/26 and 05/25/26 and was sent to the hospital both times and he was cleared and returned. And on 06/03/26 he made suicidal statements and the hospital psychiatric team came to evaluate and cleared him at this facility. Then on 06/23/26 he made suicidal statements and was sent to the hospital and was cleared. She stated his 06/24/26 hospital discharge planning paperwork, said he wanted to go somewhere else and so he was sent to the rehabilitation hospital today (06/25/26). Interview on 06/25/26 at 4:36 pm, SW B stated Resident #2's first suicidal statements started on 05/07/26 during their IDT meeting and shortly after they put procedures in place to keep him safe. They put him on 1:1 monitoring then he was sent to the hospital for a psychiatric evaluation. She stated he was also seen by this facility's psychiatrist and counselor, and they checked on him often to make sure he was not feeling suicidal anymore. She stated this week Resident #2 made a suicidal statement 06/22/26 and he was sent to the hospital and he just returned yesterday 06/23/26. She stated Resident #2 said he wanted to go back to the rehabilitation hospital, so he went back there today. She stated he was pretty good with talking to her when she went to check on him daily, when she worked. She stated she planned to work with the rehabilitation hospital on his discharge plans before his therapy was completed. She stated she coded Resident #2's 06/02/26 MDS assessment for not being depressed and not having little interest in doing things because he said he felt fine that day for the 05/07/26 MDS assessment and 06/02/26 MDS assessment. She stated when she interviewed him, he was not suicidal. She stated she did not talk to the nursing staff or reviewed his progress notes to see that on 05/25/26 he made suicidal statements and was sent to the hospital. She stated she did not know she was supposed to ask him about his mood for the past 14 days of the MDS Assessment Section D. Mood. She stated when MDS assessments were not accurate the residents may not get full access to their rights. She stated for suicidal statements, it could affect the resident (she did not go into detail after re-questioning) and said she was not aware that the MDS was linked to the care plans. She stated the MDS assessments had what the resident's care needs were. She stated she knew how to do the MDS assessments, and no one had told her they were wrong. Interview on 06/25/26 at 5:19 pm, MDS F stated she was on vacation and was not aware Resident #2 made suicidal statements in May 2026. She stated Resident #2 was identified by the IDT as being suicidal on 06/02/26 and they discussed the plan to address it. She stated she completed the Mood section of Resident #2's admission MDS 05/18/26 and she coded that he had no mental health issues when she interviewed him, he said he was not suicidal at that time. She stated she reviewed his nurse's notes, then said she did not remember on the top of her head if she reviewed them. She stated she needed to see if he had any suicidal ideation in May 2026 by looking at his records. She stated she was not aware Resident #2 wanted to kill himself on 05/07/25 and was not sure if the IDT discussed it in the meeting. She stated sometimes she was busy with assessments or other tasks and could not remember if she was in any May 2026 IDT meetings. She stated she remembered on 06/02/26 they had an IDT meeting about his suicidal statements, then said she did not remember when she found out he was suicidal. She stated she would have to get her computer to review his records. She stated after review, she read that Resident #2 made suicidal statements on 05/07/26 and went to the hospital, but was not aware of it until today (06/25/26). She stated she was aware of his 06/02/26 suicidal statement and he had a psychiatric evaluation and was cleared. She stated there was not a place on the MDS for her to have coded his suicidal statements for the 05/18/26 MDS Assessment. And after it was pointed out where, by the HHS investigator, she stated it was greyed out because Resident #2 said he had no mood issues at that time. She stated she was responsible for having accurate MDS assessments. She (continued on next page)

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