STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676405	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forum Parkway Health & Rehabilitation	2112 Forum Parkway Bedford, TX 76021

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents received food that accommodate the allergies, intolerances, and preferences of 2 (Resident #1 and Resident #2) of 5 residents reviewed for food and nutrition services. 1. On 07/25/25 during dinner, the facility failed to accommodate the preference of Resident #1 when she was served a pork hotdog that caused her to become nauseous and vomit. 2. On 07/29/25 during lunch, the facility failed to accommodate the preference of Resident #2 when he was served beef tacos. The failure could affect residents who consumed food from the facility's kitchen by placing them at risk for allergic reactions, dissatisfaction, poor intake, weight loss, and decline in health. Findings include: Record review of Resident #1's face sheet, dated 07/29/25, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included Syncope and Collapse (loss of consciousness and posture), Type 2 Diabetes Mellitus (body does not produce enough insulin (help regulate blood sugar levels) leading to high blood sugar levels), Pure Hypercholesterolemia (high levels of bad cholesterol in blood), Dementia (loss of memory), Carpal Tunnel Syndrome (numbness and tingling in hand and arm), Metabolic Encephalopathy (brain dysfunction), Hypertension (force of blood pushing against artery walls consistently too high), Rheumatoid Arthritis (immune system attacking healthy tissues like joints causing pain), Muscle Weakness (reduced ability of muscles to give force), Lack of Coordination (muscles not moving smoothly), and Cognitive Communication Deficit (difficulty communicating). Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 0, which indicated severe cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 was dependent on staff for most ADLs, and required maximal assistance with eating. The MDS Assessment under Section K-Swallowing/Nutritional Status, reflected Resident #1 did not have a swallowing disorder. Further review of the section reflected Resident #1 was on a modified diet. Record review of Resident #1's care plan, dated 07/15/25, reflected no interventions for a special diet or preferences. Record review of Resident #1's dinner meal ticket, dated 07/25/25, reflected dietary restrictions, no pork, no beef/gravy in bowl. Resident #1's dinner meal ticket had grilled cheese sandwich, creamy coleslaw, French fries with one ketchup packet, chilled pears, shredded lettuce salad with dressing, milk, and tea. At the bottom of Resident #1's meal ticket was double meat, 2 side salads with no meat. Record review of Resident #1's consolidated physician order, dated 07/01-/25-07/31/2025, reflected the following: CCD (Consistent Carbohydrate) diet Regular texture regular consistency. Further review of this document reflected no documented allergies for pork or beef. Record Review of Resident #1's progress notes, dated 07/25/25 at 04:31 PM by RN F, reflected the following: Noted that patient vomited during rounds. Resident #1's family member stated Resident #1 was given pork for her meal, ate 1 to 2 bites. Vitals taken: T 97.4 ax. P 65 BP 142/63 O2 sat 97%. Zofran 4 mg given per standing order was notified. Record Review of Resident #1's progress notes, dated 07/26/25 at 04:29 PM by RN B, reflected the following: Patient noted alert with episodes of confusion. x 1 Persian assisted with Adls, transfer and mobility. Incontinent of bowel and bladder. Uses wheelchair for ambulation. No pork, no beef. Record Review of Resident #1's progress notes, dated 07/27/25 at 02:49 PM by RN B, reflected the following: AAO X2, Incontinent of bowel and bladder, x1 person assist with Adls, transfer and mobility. Resident #1's family members reported to writer @ 1:55 p.m. that she feels patient passed out. assessment done by writer, resident understood verbal commands, vitals BP 124/61, 97.2, 64, 16, 96%, bs 139. patient is stable at this time, no dizziness noted. Upon assessment, patient family member stated that Resident #1 is having pains in her head, and stomach. writer administer prn Tylenol and Zofran. No distress noted. Record Review of Resident #1's progress notes, dated 07/28/25 at 02:20 PM by RN A, reflected the following: Pt's family member placed Call light and when this nurse reached to the room to see the pt., the family member was C/O of the pt. is not eating and her BP also low. This nurse monitored BP and found 121/57 HR:55 and the c/o lower Diastolic pressure but this nurse educated well to the family member but still wanted to call EMS and the EMS came in and monitored V/S and was stable. As per family's request pt. was taken to the hospital. An interview on 07/29/25 at 07:26 AM was attempted with Resident #1's RP but there was no answer. The operator stated the mailbox of Resident #1's RP was full and could not accept messages at the time. A text message on 07/29/25 at 07:28 AM was sent to Resident #'1's RP with no response. In an interview on 07/29/25 at 08:28 AM, the Administrator stated he was not at the facility with the issue of Resident #1 eating a hotdog. He stated he was told by his