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	03/19/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 5 residents (Resident #73) reviewed for nutritional status. The facility failed to recognize, evaluate, and address timely interventions for Resident #73 when the Dietitian made the recommendation for it on 01/02/26. Resident #73 experienced weight loss of 7.07% (7.4 pounds) from 12/24/25 to 03/01/26. This failure could place residents at risk for improper care, weight loss, malnutrition, and overall health decline. Findings included: Review of Resident #73's admission MDS Assessment, dated 12/29/25, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. She had a BIMS score of 03 indicating she had severe cognitive impairment. Her active diagnoses included non-alzheimer's disease (a disease that causes memory impairment, difficulties in planning and organization, and challenges in performing daily activities), malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), and depression (feelings of severe despondency and dejection). Her MDS did not indicate she had any weight loss and her admitting weight was 105 pounds. Review of Resident #73's Order Summary Report, dated 03/19/26 reflected she had an order for a regular diet and snacks at bedtime. There were no orders for protein shakes or nutritional supplements. Review of Resident #73's Care Plan, revised 01/08/26, reflected the following: Focus: [Resident #73] has potential nutritional problem r/t protein-calorie malnutrition due to Cognition [sic] deficient, Diet restrictions, Loss of appetite.Interventions: Observe/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Review of Resident #73's undated Weight Summary List, reflected the following weights:12/24/25 104.6 lbs01/06/26 103.2 lbs02/05/26 98.4 lbs03/01/26 97.2 lbs Review of Resident #73's Nutritional Assessment, dated 01/02/26, reflected her current weight was 105 pounds, her usual body weight was 105 pounds and her DBW was 115 pounds (+/- 10%). Notes: .Poor po intake since admit reported. Suggest starting nutritional supplement BID to increase calorie and protein intake.Reported UBW of 105-110# [sic] . Observation and interview on 03/17/26 at 10:46 AM of Resident #73 revealed she was lying in bed and had loose skin. Resident #73 said the food was not good so she did not eat a lot of it. Resident #73 said she recently had lost quite a bit of weight but she was not sure how much. Interview on 03/18/26 at 10:03 AM with CNA B revealed Resident #73 usually ate about 70% of her meals for breakfast and lunch. CNA B said if Resident #73 ate less than 50% of her meal he would let the nurse know and offer a supplement shake. CNA B said he was not aware of Resident #73 losing any weight. Interview on 03/18/26 at 11:40 AM with LVN A revealed Resident #73 liked to eat in her room. LVN A said most of the time, she ate 50% of her meal but if she ate less than that a supplement shake would be offered to her. LVN A said he was not aware of Resident #73 losing any weight. Interview on 03/19/26 at 9:49 AM with ADON C revealed Resident #73 was normally very thin but saw she had lost weight based on her monthly weights and that warranted her to email the Dietitian recently, but she was not sure when (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was. ADON C said the Dietitian was new back in January when Resident #73's nutritional assessment was completed and the facility did not have a process set up at the time for to communicate between the facility and the Dietitian for any recommendations made. ADON C said now the Dietitian will email the recommendations directly to her and then she fills out a form and provides it to the doctor to sign off on. ADON C said Resident #73 sometimes ate well and sometimes did not as far as she knew. ADON C said if the staff notice a resident had weight loss they reach out to the Dietitian to see what recommendations need to be made. ADON C said based on the January Nutritional Assessment, the Dietitian recommendations were not entered in as an intervention for Resident #73. Phone interview on 03/19/26 at 10:08 AM with the Dietitian revealed when Resident #73 first admitted she was not eating as much as she should have. The Dietitian said she made the recommendation for the nutritional supplement to be added for her twice daily back in January 2026. The Dietitian said the nutritional supplements would have added about 500 calories per day for her if she had received them. The Dietitian said she was new to the facility back in January and there was not an established communication method between her and the facility regarding her recommendations at that time. The Dietitian said she assumed the facility staff would be reviewing her assessments and seeing the recommendations that way but she found out later on they preferred she email them to the ADON instead. The Dietitian said if Resident #73 would have received the recommended nutritional supplements twice daily and was eating well she would have had more weight stability or would not have lost as much weight as she had. The Dietitian said Resident #73 would have had a more gradual weight loss rather than a 7% weight loss over the last few months. The Dietitian said since she was emailing her recommendations to the ADON she expected them to communicate those with the doctor for approval. Phone interview on 03/19/26 at 10:36 AM with Resident #73's RP revealed she was contacted by the facility recently about Resident #73's weight loss. Resident #73's RP said she came every day to the facility to check on Resident #73 and was told by the resident that the food did not taste good and so she did not eat a lot of her meal. Phone interview on 03/19/26 at 11:26 AM with Physician D revealed Resident #73 had recently lost weight after being admitted back in December 2025. Physician D said normally she was provided a form when she was at the facility that included the dietitian's recommendations, and she would review them and approve them then. Physician D said Resident #73's weight loss was a concern and needed to be looked into but could not specify anything else. Interview on 03/19/26 at 3:24 PM with the DON revealed the Dietitian wrote recommendations and then those were given to the ADON who then gave it to the doctor to review and approve. The DON said the facility wanted to ensure residents had optimum weight and if dietitian recommendations were not followed a resident could lose weight. The DON said normally a resident's weight was monitored by the MDS Nurse, ADON, and Dietitian. The DON said he was ultimately responsible for ensuring Dietitian recommendations were followed up on. The DON said he expected the Dietitian recommendations be reported to the doctor. Review of the facility's policy, revised September 2008), and titled Weight Assessment and Intervention did not address following dietitian recommendations.

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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 observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 residents (Residents #2 and #31) reviewed for pharmacy services.1. LVN J failed to administer a Potassium Chloride Extended-Release tablet in the proper form, when she crushed the tablet, before administering it to Resident #2 through the resident's enteral feeding tube. 2. RN H failed to ensure Resident #31 received his morning dose of sodium chloride 1 gram when RN H prepared the medication and left it on the 100-hall medication cart. RN H did not return to administer the medication to Resident #31 when he came back to the room.These failures could place residents at risk for ineffective drug therapy and medication error.Findings included:1. Record review of Resident #2's admission MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included gastronomy status (presence of an artificial opening into the stomach), and cognitive communication deficit. The MDS further reflected the resident required a feeding tube for nutrition. Resident #2's cognition was intact with a BIMS score of 15. Record review of Resident #2's care plan dated 02/20/26 reflected the resident required tube feeding to rule out dysphagia (difficulty swallowing). The plan reflected: Goal - Insertion site will be free of sign and symptoms of infection through the review date. Interventions- Administer tube feeding and water flushes as ordered. See MD orders for current feeding orders.Record review of Resident #2's order dated 03/16/ 2026 reflected the following: Potassium Chloride ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride) Give 1 tablet via G Tube every 6 hours for Hypokalemia. Please dissolve in 8oz of water, allow 2 min to totally dissolve and pour into G-tube . Observation on 03/18/26 at 3:00 PM revealed LVN J administering the following medication to Resident#2 through the resident's gastronomy tube:- Acetazolamide 250 mg (used to treat glaucoma, altitude sickness, edema (fluid retention, and certain types of seizures);- Oxycodone 2.5 mg (used for managing moderate-to-severe pain); and- Potassium 20 MEQ (used to treat or prevent low potassium levels).LVN J performed hand hygiene and put on the appropriate PPE (gloves and gown). She then crushed all the medication putting them in different cups. She crushed Potassium instead of dissolving in 8 oz of water for two minutes as per the directions on the physician orders. She elevated the resident's head, checked for gastronomy placement. She then flushed the resident's gastronomy tube with 30 ml of water before administering the medication and with 10-15 ml of water between the medications and 30 ml of water after administering all medications. Interview on 03/18/26 at 3:10 PM with LVN J revealed she was supposed to dissolve the potassium in 8 oz of water. She stated she checked the physician orders that stated dissolve potassium in water for 2 minutes, but she did not know she was not supposed to crush potassium. LVN J stated the risk of crushing and not dissolving could alter chemical balance and medication absorption. Interview on 03/19/2026 at 1:09 PM with the DON revealed his expectation was for LVN J to read the orders and understand the medication administration. He stated LVN J was not supposed to crush potassium the instructions were to dissolve in water. The DON further stated the risk was Resident #2 gastronomy tube being clogged and potential for malabsorption. The DON stated he had done gastronomy feeding teaching with staff and discussed during the onboarding process, and he expected LVN J to do the right thing. Record review of the facility's training record on Enteral Tube Medication Administration, dated 12/22/25, reflected: always follow special instruction. The training record reflected that LVN J was not in attendance.Review of the facility's Administering Medications through an Enteral Tube policy, revised March 2015, reflected the following: .4. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved Do Not Crush Medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	List.a. Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing. b. Do not crush enteric coated, sustained release, buccal, sub-lingual, or enzyme-specific medications.c. Do not crush the contents of an opened capsule.Record review retrieved at https://www.drugs.com/potassium_chloride.html reflected the following: Potassium Chloride.Warnings.Do not crush, chew, break, or suck on an extended-release tablet or capsule.Breaking or crushing the pill may cause too much of the drug to be released at one time.2. Record review of Resident #31's admission MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included heart failure, unspecified. The MDS further reflected the resident required a feeding tube for nutrition. Resident #2's cognition was intact with a BIM score of 15. Record review of Resident 31's care plan dated 03/13/26 reflected resident has Heart Failure. The Goal - Will be free of peripheral edema through the review date. Interventions- Give cardiac medications as ordered. Monitor Lab work; K+, NA, BUN, Creatinine as ordered.Record review of Resident #2's physician's order dated 03/16/ 2026 reflected the following: Sodium Chloride Oral Tablet (Sodium Chloride) Give 1 gram by mouth three times a day for Hyponatremia . Observation on 03/18/26 at 2:06 PM with RN H of the 100 hall cart revealed there was a white pill in a cup. The cup was not labeled, and RN H stated the pill was sodium chloride for Resident #31.Record review of Resident #31's March 2026 MAR on 03/18/26 reflected the following: Sodium Chloride Oral Tablet (Sodium Chloride). Give 1 gram by mouth three times a day for Hyponatremia (Low sodium in the body) at 6:00 AM,14:00 [2:00 PM] and 20:00 [8:00 PM] It was last administered on 03/18/26 6:00 AM.Physcian order was addressed above.Interview on 03/18/26 at 2:11 PM with RN H revealed the medication in the cup was for Resident #31. She stated she had popped the medication, and she went to give it to the resident, but he was not in the room. She stated the resident had gone to therapy. She stated she forgot to administer the medication when Resident #31 returned from therapy. She stated she was supposed to discard the medication or go to therapy area and administer the medication to Resident #31. She stated she was not supposed to keep the medication in the cart and document it as having been administered. She stated she was supposed to put the name of the resident on the cup or the name of the medications. She stated she had signed the MAR before she administered the medication, and she knew she was not supposed to sign the MAR before the resident got the medications. She stated failure to administer medication could lead to residents not getting the right therapy, and she stated signing the MAR and not administering the medication could lead to a medication error.Interview on 03/19/26 at 1:06 PM with the DON revealed his expectation was for nurses to administer medication once popped and not put in the cart. He stated he talked to the nurse, and she stated she forgot to administer the medication. The DON stated RN H had no reason as to why she signed off on the MAR before administering the medication. He stated failure to administer and documenting that a medication was given would lead to medication errors. Review of facility policy Administering Medications policy, revised December 2012, reflected the following: 17. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the individual administering the medication will return to the missed resident to attempt to administer the medication within the allowed medication administration time limit.Record review of the facility's training record on Medication Administration, dated 10/09/25, reflected: do not store loose or opened medications on cart. The training record reflected that RN H was in attendance.