STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Ft. Worth	8001 Western Hills Blvd Fort Worth, TX 76108

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on interview and record review, the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status and/or a need to alter treatment significantly for 1 of 2 residents (Resident #2) reviewed for resident rights. The facility failed to notify Resident #2's representative and/or family, on [DATE], as appropriate of a significant change in Resident #2's mental status. This failure could prevent their representative's authority from being notified or exercised preventing them from receiving competent choices. Findings included: Record review of Resident #2's Face Sheet dated [DATE] revealed an [AGE] year-old female with an initial admittance date of [DATE]. Resident #2's primary diagnosis was dementia without psychotic disturbance (cognitive decline characteristic of the condition, but does not exhibit symptoms of psychosis, such as hallucinations or delusions) with secondary diagnoses in part of diabetes mellitus (a chronic metabolic disease characterized by high blood sugar levels), auditory hallucinations (hearing sounds or voices that are not present in the real world), cerebral infarction (stroke where blood flow to the brain is interrupted, leading to the death of brain cells), and schizoaffective disorder (a mental health disorder causing hallucinations, delusions, disorganized thinking and speech) having an onset date of [DATE]. Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating being cognitively intact. Record Review of Resident #2's Care Plan dated [DATE] revealed Resident #2 was care planned to use psychotropic medications on [DATE] for hallucinations and explosive disorders. Record review of Resident #2's Psychotropic Drug Regimen Review dated [DATE] revealed Prozac, Risperdal, and Trileptal were ordered on [DATE]. Record review of a Medical Power of Attorney/Living Will dated [DATE], revealed Family Member A had a medical power of attorney for Resident #2. (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: 455416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 8001 Western Hills Blvd Fort Worth, TX 76108	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:00 AM it was revealed Family Member A was Resident #2's Medical Power of Attorney. Family Member A stated she was never informed or consulted that Resident #2 had been diagnosed with any type of Schizophrenia and was not told she was put on the drug Risperidone. Family Member A said the last 1.5 years of Resident #2's life, dementia was so bad she could not turn off her phone nor be competent enough to sign for new drug treatments. Record review of Resident #2's Psychiatric Care Notes dated [DATE] indicated Resident #2 was assessed with having Bipolar Disorder. Record review of Resident #2's Psychiatric Care Notes dated [DATE] indicated Resident #2 was assessed with having Bipolar Disorder with episode manic severe with psychotic features. Record review of Resident #2's Psychiatric Care Notes dated [DATE] indicated Resident #2 was assessed with having Bipolar Disorder, Schizoaffective Disorder, and Dementia. [DATE] Psychiatric Care Notes failed to indicate the facility notified Resident #2's representative(s) and/or family when there was a significant change in the resident's physical, mental, or psychosocial status. Record review of Resident #2's Progress Notes in ,d+[DATE] failed to indicate Resident #2's representative(s) and/or family about the diagnosis of Schizoaffective Disorder. Record Review of Resident #2's Consent for Antipsychotic Medication Treatment HHS Form 3713 dated [DATE], revealed Resident #2 signed the form for the treatment of Schizoaffective Disorder, Auditory Hallucinations, and to take the drug Risperidone. The form failed to state notification to Resident #2's representative(s) and/or family of this change in the treatment or diagnosis of Resident #2 Record review of Resident #2's Progress Notes dated [DATE] indicated that Resident #2 had a Medical Power of Attorney and Living Will on file with the facility. Record review of Resident #2's Progress Notes dated [DATE] titled Care Conference failed to include notice to Family Member A or any POA for Resident #2 Record review of Resident #2's Doctor's Orders revealed Resident #2 was put on hospice care on [DATE]. Record review of Resident #2's Nursing Home and Swing Bed Tracking MDS dated [DATE] revealed Resident #2 died at the facility on [DATE]. In an interview with the DON on [DATE] at 6:40 PM, it was revealed that the DON expected the facility to notify a resident's representative or family whenever there was a change in a diagnoses or treatment. The DON stated she remembered Resident #2 had a lot of behavior problems. The DON stated the facility took over the current building in 2021 and it seemed at though the family of Resident #2 stopped signing forms for Resident #2 at that point in time. The DON stated the facility had the resident sign for consent for changes in diagnoses and treatment because she was her own responsible party. The DON said the potential harm that can come to a resident for not notifying her representatives or family could be the resident might decline where she may not be competent to sign for medications for herself. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Resident Rights Policy dated 2001 and revised in 2016 stated: Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect, misappropriation of property, and exploitation . f. communication with and access to people and services, both inside and outside the facility; g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States . k. appoint a legal representative of his or her choice, in accordance with state law .

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on interview and record review, the facility failed to have physician orders for the resident's immediate care at the time a resident was admitted for 1 of 1 (Resident #1) resident reviewed for physician orders. The facility failed to obtain physician orders for immediate care when Resident #1 admitted to the facility on [DATE] with a pressure wound to receive orders for treatment. This failure could place residents at risk for delayed treatment causing a decline in health by not receiving treatment until two weeks later. Findings included: Review of Resident #1's Face Sheet dated 02/05/25 reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses in part included hypertension (elevated blood pressure), neurogenic bladder (lack of bladder control due to brain, spinal cord, or never problem), quadriplegia (paralysis affecting all limbs and body from the neck down), diabetes (disease affecting the body's use of sugar), obesity (complex disease involving having too much body fat), and ulcer of the right buttocks, stage II (shallow, open wound that has broken through the top layer of skin and part of the layer below). Record review of Resident #1's Care Plan Report dated 1-29-2025 and revised on 2-17-2025 revealed actual impairment to skin integrity pressure injury to the sacrum r/t immobility, disease process. Record review of Resident #1's Hospital Records dated 1-29-2025 at 10:33 AM revealed an admitted [DATE] and a discharge date of [DATE]. The record indicated Resident #1 had a stage 2 pressure injury to his right buttock upon discharge. Record review of Resident #1's Nurse Note dated 1-29-2025 at 5:21 PM revealed a skin assessment was performed indicating bilateral buttocks redness observed. Record review of Resident #1's Nurse Notes dated from 1-29-2025 to 2-10-2025 failed to indicate the facility notified a physician about the pressure wound on Resident #1. Record review of Resident #1's Weekly Skin Observation Tool dated 2-7-2025 indicated Resident #1 had a pressure ulcer on his sacrum area. In an interview on 2-25-2025 at 3:50 PM, RN B (ADON) stated she conducted the Weekly Skin Observation Tool dated 2-7-2025 on Resident #1 but did not document that she contacted the doctor about seeing the wound on Resident #1's sacrum. RN B did not remember if she contacted a doctor about seeing the pressure wound. However, RN B was sure she told Physician A about Resident #1's pressure wound, when he came to the facility on [DATE]. RN B stated not notifying the doctor timely could allow the wound to get worse. RN B stated she did not see Resident #1's wound until 2-7-2025. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/28/25 at 2:26 PM, Physician A reported that Resident #1's wound prognosis had changed from when he assessed him on 02/10/25 (fair prognosis) to the 02/17/25 (poor prognosis). Physician A stated the first time he was aware of Resident #1's wounds were on 2-10-2025. Physician A stated a delay in treatment could be a contributing factor in the decline of health concerning Resident #1's pressure wounds. In an interview on 2-28-2025 at 6:40 PM it was disclosed that the DON expected the admitting nurse to call the doctor immediately when it was discovered that a new resident entered the facility with a wound to get orders from the doctor. The DON said it was the Admitting Nurse's responsibility to contact the doctor immediately. The DON stated the risk to the resident by not notifying the doctor of a wound in a timely manner was the wound could get worse. Record review of the facility's policy dated 2001 (Revised April 2018) and titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol reflected, The nursing team member and practitioner will assess and document and individual's significant risk factors for developing pressure ulcers; and shall describe and document/report the following .a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue . The policy also stated that, the team member and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions and the physician will order pertinent wound treatments.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48177

Based on observation, record review, and interviews, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 2 residents (Resident #1) reviewed for wound care services.

The facility failed to enter the wound care physician's orders given on 2-10-2025 until 2-13-2025, did not put the physician's orders that were given on 2-17-2025 until 2-20-2025, according to the TAR. Treatment for the wound did not start until the dates the orders entered, according to the TAR.

The facility failed to obtain orders for wound care when Resident #1 admitted to the facility on [DATE], from the hospital, with a stage II pressure injury to his buttocks. Wound care orders were not obtained until 2-10-2025 and not entered into the EHR System until 2-13-2025. Wound care orders were changed on 2-17-2025 and not entered into the EHR System until 2-20-2025. According to the TAR, treatment for Resident #1's wound did not start until the dates the orders were entered into the EHR System. Between 2-10-2025 and 2-17-2025, Resident #1's prognosis had changed from fair prognosis to poor prognosis. The wound was noted as a stage II pressure injury on 2-10-2025 and progressed to an unstageable pressure injury on 2-17-2025.

Findings included:

Review of Resident #1's Face Sheet dated 02/05/25 reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses in part included hypertension (elevated blood pressure), neurogenic bladder (lack of bladder control due to brain, spinal cord, or never problem), quadriplegia (paralysis affecting all limbs and body from the neck down), diabetes (disease affecting the body's use of sugar), obesity (complex disease involving having too much body fat), and ulcer of the right buttocks, stage II (shallow, open wound that has broken through the top layer of skin and part of the layer below).

Record review of Resident #1's Care Plan Report dated 1-29-2025 and revised on 2-17-2025 revealed actual impairment to skin integrity pressure injury to the sacrum r/t immobility, disease process upon admission.

Record review of Resident #1's Hospital Records dated 1-29-2025 at 10:33 AM revealed an admitted [DATE] and a discharge date of [DATE]. The record indicated Resident #1 had a stage 2 pressure injury to his right buttock upon discharge.

Record review of Resident #1's Nurse Note dated 1-29-2025 at 5:21 PM revealed a skin assessment was performed indicating bilateral buttocks redness observed upon admission into the facility.

Record review of Resident #1's Weekly Skin Observation Tool dated 2-7-2025 indicated Resident #1 had a pressure ulcer on his sacrum area.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In a review of Resident #1's wound care notes on 2-25-2025, dated 2/10/25, Physician A noted that Resident #1's coccyx wound was a Stage II wound with fair prognosis and that resident was receiving a dressing including calcium alginate. Review of Resident #'1s TAR reflected that the resident did not begin receiving this treatment until 2/13/25. In a review of Resident #1's wound care notes on 2-25-2025, dated 02/17/25, Physician A noted that Resident #1's coccyx wound had increased in size, was unstageable, and the wound dressing would now include applying a generous amount of honey to the calcium alginate. Physician A's prognosis was poor. Review of Resident #1s TAR reflected that the resident did not begin receiving this treatment until 2/21/25. In an interview on 2-25-2025 at 3:50 PM, RN B (ADON) stated she conducted the Weekly Skin Observation Tool dated 2-7-2025 on Resident #1. RN B said she noted seeing a pressure injury on Resident #1's sacrum but did not indicate what stage it was on the form. RN B said the facility had a standing order when a pressure wound is first observed, nurses can use a barrier cream on the wound area and did so on Resident #1. RN B stated however, the facility does not document using barrier cream. RN B stated the wound care doctor saw and assessed Resident #1's pressure injury on his sacrum on 2-10-2025. RN B said the facility's wound care nurse resigned, at the beginning of February, and the ADON's were making rounds with Physician A when he came to the facility. RN B said she believed Resident #1's pressure wound was worsening due to other disease processes, he was not able to move on his own, and did not like to be repositioned at times. RN B stated Resident #1 was receiving wound care treatment once a day. RN B stated the last time she saw Resident #1's pressure wound, to his sacrum, was on 2-10-2025 and it looked yellowish with redness. In an observation on 02/28/25 at 11:15 AM, RN B provided wound care treatment to Resident #1. She was noted using appropriate PPE, infection control practices, wound care techniques, and following physician orders. The coccyx wound based appeared moist, the wound crossed the gluteal cleft (both right and left buttocks) and was unstageable (the presence of eschar [a piece of dead tissue, usually appearing as a dry, crusty, and often dark-colored scab] was noted). The resident tolerated well. In an interview on 02/28/25 at 2:24 PM, RN B reported that she would put in PCC, the wound care orders when she was the one who did the rounds with Physician A. RN B reported that Physician A would tell her the changes he was making during the rounds, and then email the orders to her later the same day. RN B reported the nurse who attended the wound care rounds with Physician A, would then put the orders into PCC that day or the following morning if they had already left the facility for the day. RN B reported that when Physician A came to the facility on [DATE], the orders were not put in because she had been running late with everything and had left the facility without putting them in. RN B reported she had expected that the facility wound care nurse would enter them the next morning. However, RN B reported that the Wound Care Nurse had not put the orders into PCC on the next day, as she typically did, and quit working at the facility that day (02/11/25). RN B stated she put the wound care orders from 02/10/25 in the EHR on 02/12/25 when she realized they were not put in. RN B reported that on 02/17/25 she did wound care rounds with Physician A and received his orders on 02/18/25. RN B stated she should have placed these orders in the EHR on 02/18/25 and thought she did. RN B reported she was not sure why those orders were not placed in the EHR until 02/20/25. RN B reported that not having new wound care orders put in place could put the resident at risk for delayed wound healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/28/25 at 3:30 PM, the DON reported that she expected staff would enter and implement wound care orders when they were received by the physician, and that a delay could result in a delay in a wound healing. In an interview on 02/28/25 at 2:26 PM, Physician A reported that Resident #1's wound prognosis had changed from when he assessed him on 02/10/25 (fair prognosis) to the 02/17/25 (poor prognosis). Physician A reported that Resident #1's wound had changed from a Stage II to an unstageable wound during that time and that he considered an unstageable wound to be more severe than a wound that is a Stage II. Physician A reported that in the case of Resident #1, when he saw him on 02/17/25 the wound was unstageable due to eschar (a layer of dead, dried tissue that forms over a wound or burn) that limited assessment. Physician A stated this decline may have been related to the resident's size (obesity) and his near complete dependence in care. Physician A reported that when he made rounds with a nurse each week, he told them what he ordered, what he was changing, and later that day gave them written orders. Physician A stated his expectation was that the order would be entered into PCC right away so that any new wound care orders would begin the next day. Physician A reported he had no knowledge of any orders being entered days after he had written them. Physician A stated it was not ideal if it took several days for an order to be entered and implemented. Physician A reported that while he couldn't say for sure what caused Resident #1's wound deterioration, he stated this delay could be one of the contributing factors. In an interview on 2-28-2025 at 6:40 PM, the DON stated when a resident admitted into the facility with a wound, the process was the admitting nurse would do an assessment, fill out the assessment form in detail, notify the wound care nurse, DON, and the wound care doctor. After that, the facility would get an order from the doctor. The DON stated when the admitting nurse sees a wound on a new resident her expectation was for the doctor to be contacted immediately and get orders from the doctor. The DON said the admitting nurse was responsible to see that this happened. The DON stated her expectation was that nurses make notes and put in the Resident's Care Plan when they have wounds. Record review of the facility's policy dated 2001 (Revised April 2018) and titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol reflected, The nursing team member and practitioner will assess and document and individual's significant risk factors for developing pressure ulcers; and shall describe and document/report the following .a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue . The policy also stated that, the team member and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions and the physician will order pertinent wound treatments.