

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 05/08/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Ft. Worth		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177</p> <p>Based on interview, and record review, the facility failed to ensure residents were free from abuse for one of five residents (Resident #2) reviewed for abuse, neglect, and exploitation.</p> <p>The facility failed to ensure Resident #2 was free from staff to resident abuse when CMA A slapped a glass of water out of Resident #2's hand on 4-23-2025, causing her to cry experiencing psychosocial harm.</p> <p>This noncompliance was identified as a PNC. The noncompliance began on 4-23-2024 and ended on 4-30-2025.</p> <p>This failure could place residents at risk for decreased quality of life, decreased self-esteem, and mental anguish.</p> <p>Findings Included:</p> <p>Record review of Resident #2's Face Sheet dated 5-8-2025 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Dementia with other behavioral disturbance (a decline in mental ability severe enough to interfere with daily life) and secondary diagnoses of Parkinsonism (a broad term encompassing various conditions that share similar movement symptoms with Parkinson's disease, such as slowness, stiffness, and tremors), Epilepsy without Epilepticus (a neurological disorder characterized by recurrent, unprovoked seizures), and Bipolar Disorder (a mental health condition characterized by extreme mood swings, including periods of intense elation or irritability (mania or hypomania) and periods of deep sadness or hopelessness).</p> <p>Record review of Resident #2's Comprehensive MDS assessment dated [DATE], indicated Resident #2 had a BIMS Score of 13 which indicated she was cognitively intact. Behavioral Symptoms reflected: Physical and Verbal behavioral symptoms directed toward others 0 meaning behavior not exhibited.</p> <p>Record review of Resident #2's Care Plan dated 2-10-2025 revealed Resident #2 was identified as PASRR (Preadmission screening and resident review) positive for having an intellectual disability and epilepsy and was care planned for using anti-anxiety medications.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review on 5-8-2025 at 10:00 AM, of the facility's Provider Investigation Report (PIR) #1005912 dated 4-30-2025, revealed CMA A was witnessed slapping a glass of water out of Resident #2's hand on 4-23-2025. The facility's self-report failed to name a time of the incident. The PIR stated FNP G sent an email of the incident to the Administrator on 4-23-2025 at 6:06 PM. The email stated FNP G was sitting across from the DON's Office, in a conference room, on 4-23-2025 at approximately 5:00 PM, when she heard Resident #2 speaking with CMA A. FNP G stated in the email the conversation between Resident #2 and CNA A started to get louder when FNP G heard Resident #2 call CMA A a bitch. CMA A responded to Resident #2 saying who are you speaking to. Resident #2 responded back to CMA A I'm speaking to myself. CMA A then responded back to Resident #2 saying You better be glad you are talking to yourself, or I will pour the cold water you are holding, on your head. FNP G stated right after that statement she heard a slapping sound and Resident #2 started crying. FNP G went to see what occurred and CMA A was picking the water cup up off the floor. CMA A then proceeded to get in Resident #2's face telling her to apologize. Resident #2 continued to cry and ask for staff to call the cops. Resident #2 then said she would throw herself on the floor. FNP G then stated staff then escorted Resident #2 to her room away from the situation. FNP G stated she asked RN E, who witnessed the incident, what occurred, and RN E said CMA A slapped the water out of Resident #2's hand. The facility's PIR stated the Administrator interviewed CMA A on 4-23-2025 at 5:30 PM and revealed CMA A said that Resident #2 had called her a bitch. CMA A then said she told Resident #2 you better not be talking to me and apologize. CMA A then said Resident #2 did not apologize to her, so I slapped the glass of water on her. She shouldn't have called me a bitch. The PIR further indicated the Administrator interviewed Resident #2 and asked Resident #2 what happened today with CMA A. Resident #2 stated I called her a bitch, and she poured the glass of water on me. It went on my shirt and on my face. I told her I was sorry. The PIR indicated the allegation of CMA A abusing Resident #2 was confirmed and CMA A was terminated. The PIR revealed abuse and neglect in-services were completed for staff on 4-30-2025 and safe surveys were completed with cognitive residents showing no additional findings of abuse.</p> <p>On 5-8-2025 at 10:45 AM, record review of CMA A's background check was performed on CMA A showing a clear status.</p> <p>On 5-11-2025 at 10:19 PM, an email was sent to FNP G asking FNP G to call me to speak with me about the event on 4-23-2025 between CNA A and Resident #2. No email or phone called was received from FNP G.</p> <p>In an interview with CMA B on 5-8-2025 at 11:55 AM, it was conveyed that CMA B trained CMA A to be a medication aide. CMA B stated CMA A never exhibited aggressive behavior toward residents when she was training her but was a good aide. CMA B said she was told what CMA A did when she came back from vacation. CMA B said the facility did in-services on abuse and neglect covering different types of abuse (physical, verbal, punching, and mental) and neglect. Staff are supposed to redirect residents who are cussing, calling people names, or getting agitated.</p> <p>In an interview and observation on 5-8-2025 at 12:00 PM, revealed Resident #2 was sitting in a wheelchair holding a cup and drinking its contents. Resident #2 was not able to recall the event with CMA A that occurred on 4-23-2025 except she said CMA A called her a bitch. Resident #2 got confused when asked further questions about the event with CMA A.</p> <p>On 4-23-2025 at 3:45 PM, a phone call was made to CMA A and a voice message was left asking CMA A to return the call. A return call was never received.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with RN E on 5-8-2025 at 4:45 PM, revealed RN E witnessed the incident between Resident #2 and CMA A on 4-23-2025. RN E said Resident #2 was trying to use the land line phone at the nurse's station located in the Suites section of the facility when Resident #2 called CMA A a bitch. RN E said Resident #2 was holding a glass of water in her hand at the time when CMA A slapped the glass of water out of Resident #2's hand causing the water to go all over Resident #2 and on the floor. RN E said Resident #2 began to cry after CMA A slapped the glass of water out of her hand. RN E said she then told CMA A to leave the area and CMA A did. RN E then said Resident #2 was assessed showing no physical injuries but was emotionally upset. RN E said the facility in-serviced staff on abuse and neglect on 4-23-2025 after this incident occurred. RN E said staff are never to use physical aggression and retaliate against residents because of what they say or do.</p> <p>In an interview with the DON on 5-8-2025 at 7:41 PM, it was conveyed that she expects facility staff to redirect residents when they are calling them names and not to react physically by slapping items out of resident's hands. The DON said the nurses are responsible to monitor the behaviors of the CNA/CMAs. The DON stated the risk to a resident, who got a glass of water slapped out of their hand, was that it could have caused emotional trauma, and they could have gotten physically hurt.</p> <p>In an interview with the Administrator on 5-8-2025 at 7:55 PM, it was revealed she was in the building when the incident occurred between Resident #2 and CMA A. The Administrator said she interviewed CMA A immediately after the incident occurred. The Administrator said CMA A admitted to slapping the glass of water out of Resident #2's hand, and then she suspended and escorted CMA A off the facility property right after the interview. The Administrator said the nurses on duty are responsible for monitoring the behavior and interactions of the CNAs/CMAs on duty. The Administrator said the nursing staff ultimately answers to the DON. The Administrator said the potential risk to residents who get treated the way CMA A treated Resident #2 on 4-23-2025 was that it could depress residents and they could be scared. The Administrator's expectation was for staff to remain professional and not slap water out of a resident's hand when they are called names.</p> <p>Record review of the facility's abuse policy titled Identifying Types of Abuse dated 2001 revised on September 2022 stated:</p> <p>As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents .</p> <ol style="list-style-type: none"> 1. Abuse of any kind against residents is strictly prohibited . 4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. <ol style="list-style-type: none"> a. Abuse includes .mental, and psychosocial well-being . b. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish . c. Abuse includes verbal abuse .and mental abuse . <p>Mental and Verbal Abuse</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1. Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation .		

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<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from Misappropriation of Resident Property for 1 of 5 residents (Resident #1), reviewed for drug diversion.</p> <p>The facility failed to prevent the misappropriation of over 150 tablets of Norco (hydrocodone and acetaminophen an opioid which is a Schedule II controlled Substance), and 1 bottle of morphine (30 mL), by allowing the ADON (AP) to remove the medication from the nurses' cart, without authorization, for personal gain and never recovering the medication. Resident #1 experienced pain for two-three days at a level of 7-8, after his toe amputation, when his pain would have been relieved with Norco.</p> <p>This noncompliance was identified as a PNC. The noncompliance began on 4-14-2024 and ended on 4-28-2025.</p> <p>This failure could place residents at risk of misappropriation if medication resulting in unrelieved pain and substandard quality of life.</p> <p>Findings Included:</p> <p>Record review of Resident #1's Face Sheet dated 5-8-2024 revealed a 63-yr-old male who admitted to the facility on [DATE] with a primary diagnosis of Unspecified Dementia without behavioral disturbance (when someone experiences memory loss, thinking difficulties, and changes in social abilities that significantly impact their daily life, but the specific cause of the dementia is not determined), and secondary diagnoses of Type 2 Diabetes Mellitus (a chronic metabolic disorder characterized by elevated blood glucose levels due to the body's inability to effectively use insulin, or insulin resistance, and insufficient insulin production by the pancreas), End Stage Renal Disease (a severe condition where the kidneys have lost the ability to filter waste and excess fluid from the blood), Pain in Unspecified Joint (pain experienced in a joint, without a specific joint being identified), and Acquired Absence of Right Leg Below Knee (loss of the right leg distal to the knee joint, typically due to surgical amputation or a similar medical intervention).</p> <p>Record review of Resident # 1's Quarterly MDS assessment dated [DATE], revealed a BIMS Score of 15 indicating Resident #1 was cognitively intact. The Pain Assessment Section of the MDS conveyed Resident #1 experienced pain at a level 5 occasionally.</p> <p>Record review of Resident #1's Care Plan dated 1-9-2024 indicated Resident #1 had chronic pain related to Neuropathy (damage or dysfunction of the peripheral nervous system) of his below the knee amputation. Resident #1's Care Plan stated anticipate the resident's need for pain relief and respond immediately to any complaint of pain and evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.</p> <p>Record review of Resident #1's electronic physician orders with a start date of 7-4-2024 and no end date, revealed an active order for Norco 10-325 MG to give 1 tablet by mouth every 6 hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Physician Orders dated 5-8-2025 revealed Tylenol with Codeine #3 30-300 MG and Acetaminophen 325 MG 2 tablets was ordered with a start date of 4-24-2025 at 6:30 AM.</p> <p>Record review of Resident #1's MAR dated 5-8-2025 indicated Resident #1 was routinely given Tylenol with Codeine #3 30-300 MG and Acetaminophen 325 MG 2 tablets totaling 650 MG, when he returned from the hospital, from 4-18-2025 until 4-28-2025. The MAR indicated the Norco Drug was restored on 4-28-2025. Resident #1's MAR indicated his pain levels were at a zero for 4-19-2025 & 4-20-2025, a 7 on 4-21-2025, no entry for 4-22-2025, 5 on 4-23-2025, a 5 on 4-24-2025, a 8 on 4-25-2025, a 5 on 4-26-2025, a 0 on 4-27-2025, and a level 7 on 4-28-2025 when Norco was restored.</p> <p>Record review of the facility's PIR (Provider Investigation Report) dated 4-29-2025 revealed it was discovered Resident #1 was missing 4 cards of Norco medication and another resident (not named) was missing 2 cards of Norco on 4-22-2025. LVN H said on 4-10-2025 ADON (AP) came to the Nursing cart and told her she was doing a Narcotics audit and was pulling out any Narcotics that were 90 days, not being used, or that were discontinued. LVN H said the ADON (AP) took some Narcotic cards but was not sure of everything she took. LVN H said she did not think anything wrong at the time because the ADON (AP) was part of the management team. On 4-18-2025, a Friday night, when Resident #1 came back from the hospital, after having a toe amputated, LVN H noticed Resident #1 did not have any Norco medication on the nurses' cart. LVN H then texted the DON to ask what the procedure was for pulling Narcotic cards from the nurse cart. The DON was busy at an event that night, so LVN H said she would talk with her about the procedure on Monday 4-21-2025. On Monday 4-21-2025 LVN H followed up with the DON. The DON explained to LVN H the procedure for pulling Narcotics off the nurses' cart was for the medication to be discontinued or not used for 90 days. On Tuesday morning 4-22-2025, LVN H asked the ADON (AP) about Resident #1's Norco cards and the ADON (AP) said the Norco cards for Resident #1 were destroyed because she was told Resident #1 was not coming back to the facility. LVN H then went to the DON on 4-22-2025 and asked if Resident #1's Norco Medication had been discontinued. The DON said no it had not been discontinued. LVN H then told the DON the ADON (AP) had pulled Resident #1's Norco cards and he does not have any left. The DON told LVN H no drugs had been destroyed for the facility this month. It was determined that the ADON (AP) mishandled or misplaced over 4 Norco Medication Cards that were never recovered and the ADON (AP) was terminated. The PIR indicated that on 4-24-2025 at 8:02 AM a drug test was performed on ADON (AP) showing negative results.</p> <p>The PIR indicated on 4-22-2025 the facility conducted in-services with all nursing staff concerning Narcotics. The facility changed its policy to reflect that moving forward only the DON may remove Narcotic cards whether empty or full. Under no circumstances will anyone, other than the DON, be allowed to remove any Narcotic medications from any cart.</p> <p>The PIR also indicated, in a voluntary statement dated 4-22-2025, by the Administrator given to the [Local Police Department], that one bottle of morphine (30 mL) for Resident #1 was missing.</p> <p>On 5-8-2025 at 10:45 AM a record review of ADON (AP)'s background check was performed with negative results.</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Actual harm Residents Affected - Some	<p>In an interview on 5-8-2025 at 11:15 AM, Resident #1 said he returned from the hospital in mid-April because he had his big toe amputated and needed pain medication. Resident #1 said he had a prescription for Norco, on file with the facility, before he went into the hospital. Resident #1 said he returned from the hospital, in about 10 days, and asked a nurse for his pain medication and the nurse told him he did not have any left because the ADON (AP) pulled them off the medication cart. Resident #1 stated he was provided Tylenol #3 with codeine, but they did not relieve his pain like the Norco. Resident #1 said his pain level was at a 7 or 8 for about 2-3 days then it subsided. Resident #1 said it was about a week until he started receiving Norco again.</p> <p>In an interview with CMA B on 5-8-2025 at 11:55 AM, it was learned that she was told that the ADON (AP) had illegally taken Norco pills from the medication cart and was fired. CMA B said she was in-serviced on abuse, neglect, and misappropriation to include resident Narcotics. CMA B said the new policy stated that only the DON will remove any narcotics from the med carts even if the cards are empty. CMA B said the Narcotics are kept double locked inside the medication carts.</p> <p>On 5-8-2025 at 2:45 PM, an attempted interview was made with the ADON (AP); however, the phone immediately went to a recording stating the phone cannot receive messages.</p> <p>In an interview with RN E on 5-8-2025 at 4:45 PM, it was revealed that RN E worked the 2:00 PM-10PM shift. RN E said on 4-14-2025 ADON (AP) approached her, while she was working the medication cart, and told her Resident #1 was hospitalized more than 72 hours and staff are not supposed to keep Norco medication on the Med Cart when this occurs. RN E said she did not question if this was correct as ADON (AP) was part of the management team. RN E said she found out later it was not the protocol, of the facility, to not keep Norco in the medication cart if a resident was hospitalized over 72 hours. RN E said on 4-14-2025 ADON (AP) took 4 Norco cards over 100 pills from the nurse's cart that evening. RN E said she was in-serviced later, after the facility determined that Norco was missing, that the facility implemented a new policy that only the DON can remove any narcotic cards from the medication carts. RN E said the Narcotics will stay double locked in the medication carts unless the DON removes them.</p> <p>In an interview with RN F on 5-8-2025 at 6:42 PM, it was stated the ADON (AP) came to her one evening, in the month of April 2025, and told her she cannot keep Norco over 3 months in the nurse's cart. RN F said the ADON (AP) told her it was a new policy of the facility to remove the Norco. RN F said the ADON (AP) took cards of Norco from the nurse cart she was using but she did not know how many cards of Norco she took. RN F said she was in-serviced a few weeks ago regarding removing Narcotics from the carts. The facility now has a new policy when a Narcotic medication card is empty, they contact the DON and the DON will sign for it along with another nurse. RN F said only the DON can take the Narcotics from the carts.</p> <p>In an interview with CMA C on 5-8-2025 at 7:23 PM, it was revealed that she was in-serviced on narcotic medications a few weeks ago. CMA C said now only the DON can discard empty Narcotic cards. CMA C said only the DON can sign for full narcotic cards so only one person is responsible for disseminating and destroying them. CMA C said the Narcotics are kept in a lockbox within the medication carts. CMA C said this new policy keeps better control of these substances, so they don't come up missing. CMA C said the risk to residents not having their Norco was it could allow their pain levels to not be controlled.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the DON on 5-8-2025 at 7:41 PM, it was revealed that before Norco medication became missing last month, when the narcotic cards were empty, the nurses would discard the cards themselves. If there were still pills left in the cards, for discarded Narcotics, they would bring the leftover pills to her, count the pills with her, and put them in a locked box attached to the wall in her office. The DON said now the policy for removing narcotic cards was only the DON can remove the cards. If there are any medications left in the cards, the policy was still to have 2 people verify it but only the DON removes them. The DON said she is responsible for the safe keeping and monitoring of Narcotics at the facility. The DON said her expectations were for all nurses and CMAs to follow the new procedures. The DON said the risk to the residents having medications missing was that they may not get the medication they need, be in pain, and could have withdrawal side effects.</p> <p>In an interview with the Administrator on 5-8-2025 at 7:55 PM it was conveyed, that prior to the Norco missing at the facility, the DON was responsible for monitoring the disposal and the security of Narcotics at the facility. The Administrator said now the DON is the only one who can remove the Narcotics from the medication carts for disposal. The Administrator believed this would prevent Narcotics from missing at the facility. The Administrator said the risk to residents by having narcotic medication missing was there would be delayed pain treatment.</p> <p>Record review of the facility's Proper Storage of Controlled Medications dated 4-25-2025 stated:</p> <p>The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) .</p> <p>The charge nurse on duty maintains the keys to controlled substance containers. The [DON] maintains a set of back-up keys for all medication storage areas .</p> <p>The Director of Nursing (DON) identifies staff members who are authorized to handle controlled substances .</p> <p>Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed .The director of nursing services maintains and disseminates to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers.</p>		