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	08/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident received adequate supervision to provide an environment that was free of accident hazards for one (Resident #1) of five residents reviewed for accidents. -The facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents when Resident #1 cut his wrist with a sharp object, had to be hospitalized with a 4cm laceration to his wrist and was admitted for a psychiatric evaluation. Resident #1 had diagnoses of mental illness and IDD, a history of having razors in his possession, and a history of aggressive behaviors. The non-compliance was identified as past non-compliance (PNC). The Immediate Jeopardy began on 8/12/25 and ended on 8/14/25. The facility had corrected the non-compliance before the state's investigation began. This failure could place residents at risk for accidents that could lead to serious injury, harm, or death. Findings included: Record review of Resident #1's face sheet, dated 8/15/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 8/12/25. Resident #1 had diagnoses that included: vascular dementia (brain disorder that affects thinking, memory, and behavior caused by a stroke), type 2 diabetes (body's inability to control blood sugar), schizophrenia (mental disorder that affects thinking, mood, and behavior), and moderate IDD (significant limitations in intellectual and adaptive behaviors). Record review of Resident 1's quarterly MDS assessment, dated 6/18/25, reflected the resident's BIMS score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section D-Mood, reflected Resident #1 had not shown any mood problems within the last two weeks and rarely isolated. The MDS Assessment under Section E-Behavior, reflected Resident #1 had not exhibited any behaviors. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 required supervision with all ADL's. Record review of Resident #1's care plan, revised 8/12/25, reflected the resident had a potential for mood problem r/t dx of schizophrenia with interventions that included: administering medications as ordered, providing a program of activities, behavioral health consult as needed, monitoring and recording change in mood or possession of weapons and reporting to MD as needed. Further review of the document reflected Resident #1 had a behavior problem AEB physical aggression with interventions that included: anticipating the resident's needs, providing positive interaction and attention, administering medication as ordered, assessing contributing sensory deficits, providing physical and verbal cues to alleviate anxiety, intervening as necessary to protect the rights and safety of others and self, modifying environment, and monitoring, documenting and reporting PRN any s/sx of resident posing danger to self and others. Record review of Resident #1's psychiatric progress note, dated 7/28/25, reflected in part the following: Reason for Referral:[Resident #1] was referred to [Behavioral Health Provider] due to: vascular dementia, schizophrenia, agitation, aggressive behavior. Chief Complaint/HPI:[Resident #1] is being seen today for the management of psychotropic medications and side effects, and to monitor the effect of medication and for dosage adjustment. [Resident #1's] psychotropic medication is beneficial in this case to control their psychiatric symptoms and to manage the [Resident #1's] condition and to prevent relapse or hospitalization. [Resident #1] reports to I'm okay. Staff report [Resident #1's] behavior has improved.[Resident #1] is seen in the secure memory care unit. [Resident #1] does not appear to be feeling sad, nervous, angry, or elated today. [Resident #1] presents no delusions and does not appear to be responding to internal stimuli. [Resident #1] has been sleeping well, with adequate daytime energy. [Resident #1] has a good appetite. [Resident #1] participates in some of the available activities. Current Medication:Other MD:1 Benztropine Mes 0.5 Mg Tab SIG: Take 1 twice daily (used to treat Parkinson's Disease)2 Melatonin 3 Mg Odt SIG: 1 po q 24h (a natural hormone that regulates sleep)3 Oxcarbazepine 150 Mg Tablet SIG: Take 1 twice daily (used to treat seizure and mood disorder)4 Risperdal 1 Mg Tablet SIG: 1 at night (anti-psychotic medication)5 Sertraline Hcl 100 Mg Tablet SIG: 2 po qd (used to treat mood disorder)6 Trazodone 50 Mg Tablet SIG: 1 po qhs (used to regulate sleep and stabilize mood) Assessment/Plan:Schizophrenia: Sertraline, RisperidoneSleep: Trazodone, MelatoninSz and mood stabilization: Oxcarbazepine. Record review of Resident #1's progress notes, dated 7/1/25 at 7:08 AM by LVN Q, reflected the following: CNA removed razors from [Resident #1's] room and [Resident #1] became upset, knocking carts over in hallway and attempting to grab and hit CNA. CNA went into nursing station and [Resident #1] sttempted [sic] to reach over door to hit and grab CNA. [Resident #1] made threats that he was going to come after CNA and 'get him.' [LVN Q] explained that razors are not allowed to be left in the room