

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 06/13/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #67) of three residents reviewed for resident rights and dignity.</p> <p>Facility failed to ensure Resident #67 had a privacy cover for his indwelling catheter while he was in therapy room at 09:58 AM and while he sat by the entrance area into the facility at 3:00 PM on 06/12/24.</p> <p>This failure could place resident at risk for a loss of dignity, decreased self-worth, and decreased self-esteem.</p> <p>Finding included</p> <p>Review of Resident #67's face sheet, dated 06/13/24, reflected a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included paralysis that affects limbs and body from the neck down (Quadriplegia), a bedsore on scrum (pressure ulcer), uncontrolled blood sugars (diabetes mellitus), major depression, anxiety, post-traumatic stress, spinal cord disorder (cervical stenosis) and below the right knee amputee (Right BKA).</p> <p>Review of Resident #67's order summary, dated 06/13/24, reflected urinary catheter 16 FR, with 10 cc for pressure injury (aka pressure ulcer/bed sore). Monitor urinary output each shift. Start date 03/27/24.</p> <p>Review of Resident #67's quarterly MDS dated [DATE], reflected BIMS summary score of 15, indicating cognitively intact. Resident #67 could understand others and others could understand him.</p> <p>Review of Resident #67's care plan on 06/13/24 revealed Resident #67 had ADL's self-care performance deficit related to quadriplegia, cervical stenosis, and Right BKA. The goal was to anticipate and meet needs, dignity would be maintained, he would be kept clean, dry and odor free. Resident #67's interventions included: Ensure boot was applied to left foot as ordered, bathing/showering check nail length and trim on bath days as necessary, dressing- assist resident to choose simple comfortable clothing that enhanced resident's ability to dress himself. Initiated 7/12/23 with target date 5/21/24.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #67 on 06/12/24 at 09:58 AM, revealed Resident #67 in physical therapy room in his wheelchair, his catheter bag exposed without a privacy cover. Urine was clear yellow and 200-300 cc of urine could be seen walking by physical therapy room window. Resident #67 stated that he had not even noticed his catheter bag. He did not state how it made him feel. Resident #67 observed again at 3:00 pm and 3:15 pm seated in his wheelchair by the front entrance area watching TV . Catheter bag exposed without a privacy cover. Urine was half full in catheter bag. DON alerted by surveyor at 03:13 PM.</p> <p>In an interview with LVN D on 06/12/24 at 03:14 PM, she stated that she had Resident #67 assigned to her on her shift. She said that Resident #67 had a privacy cover earlier in her shift. LVN D did not state the risk to the resident for not having a privacy cover on his catheter bag with urine in it.</p> <p>In an interview with DON on 06/12/24 at 03:13PM, she stated, after looking at Resident #67's urine catheter bag, that the catheter bag should be covered with a dark privacy cover. She said the privacy cover promotes dignity and not having one risked dignity issues for Resident #67.</p> <p>In an interview with the ADM on 06/13/24 at 05:266 PM, she stated that she expected all nursing staff to promote privacy and dignity for all residents. She said that all catheter bags should have a privacy cover or in a dark privacy bag used in the facility. She said the risk to resident was their privacy and dignity.</p> <p>Record Review of the facility's policy titled Resident Rights, revision 12/2016, reflected, . To ensure that care and services provided by the facility promote and/or enhance privacy, dignity, and overall quality of life .A. dignified existence .H. To be supported by the facility in exercising his or her rights</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #1, #12, and #47) of nineteen residents reviewed for call lights.</p> <p>The facility failed to ensure Residents #1, #12, and #47 had cords attached to their call lights so that they could pull the call light switch to activate it when they needed assistance.</p> <p>This failure could place the residents at risk of falling, injury, and feelings of low self-worth due to not being able to call for help.</p> <p>Findings included:</p> <p>A Review of Resident #1's face sheet, dated 06/13/24, reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included syndrome of inappropriate antidiuretic hormone secretion a condition in which high levels of hormones cause the body to retain water, glaucoma in both eyes is an eye disease that causes vision loss, seizures, high blood pressure, cataract in both eyes and paranoid schizophrenia is a disease in which the mind does not agree with reality. Resident #1 was a full code, code status.</p> <p>Review of Resident #1 care plan on 06/12/24 reflected Resident #1 had communication impaired r/t dementia. The goal was for Resident #1 to make basic need known by signs and gestures. The intervention included to anticipate his needs and meet them and to ensure/provide a safe environment. Call light in reach. Resident #1 was also care planned for falls r/t walking and balance and poly medications. Goal was Resident #1 would be free of falls. Interventions were be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Care plan initiated 08/22/22, revision 01/29/24.</p> <p>B. Review of Resident #12's face sheet, dated 06/13/24, reflected a [AGE] year-old male that admitted to the facility on [DATE]. His diagnoses included cerebral infarction (stroke), muscle weakness, seizures (epilepsy), reflux, paranoid schizophrenia is a disease in which the mind does not agree with reality, high blood pressure (HTN) and heart disease without chest pain.</p> <p>Resident #12 had a code status of Full Code.</p> <p>Review of Resident #12 quarterly MDS dated [DATE], reflected a BIMS sore of three indicating severe cognitive impairment.</p> <p>Review of Resident #12 care plan on 06/12/24, reflected Resident #12 was a High risk for falls related to medications, high blood pressure, confusion, and Alzheimer. Goals included Resident #12 would be free from falls and he would be free of minor injury. The Intervention was Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Care plan initiated on 03/29/22, revision on 02/28/24 with a target date 03/09/24.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. Review of Resident #47's face sheet, dated 06/13/24, reflected a [AGE] year-old male that admitted to the facility on [DATE]. His diagnoses included dementia a condition of cognitive decline, high blood pressure, uncontrolled blood sugars (diabetes mellitus), eye problem due to diabetes, left arm fracture, and age related macular degenerative in both eye is an eye disease that causes vision loss in both eyes. Resident R47 was his own responsible party and had a code status of Full Code.</p> <p>Review of Resident #47 quarterly MDS dated [DATE], reflected a BIMS sore of three indicating severe cognitive impairment.</p> <p>Review of Resident #47 care plan on 06/12/24, reflected Resident #47 had ADL self-care performance deficit r/t weakness and impaired cognition. The goal was to maintain current level of function in through the review date. Interventions included encourage the resident to use bell to call for assistance. Care plan initiated 09/21/22 and target date 06/11/24. Resident #47 had fall care plan r/t impaired mobility and impaired cognition. Goal was not to sustain significant injury through the review date. Interventions were Be sure the resident's call light is within reach and encourage the resident to use it or assistance as needed. The resident needs prompt response to all requests for</p> <p>assistance. Resident #47 also care planned for musculoskeletal impaired r/t left shoulder fracture. The goal was to remain free of complications related to left shoulder fracture (blood clot, contracture, immobility). Interventions included Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Care plan initiated 09/21/22, revision 06/26/23, target date 06/11/24.</p> <p>Observation on 06/11/24 at 10:29 AM revealed Resident #1, #12 and #47's rooms had no call lights in the room. A brown switch box approximately five by three inches that looked like a light switch observed between bed A and bed B. The switch box was approximately five feet high from the floor. The call light switch box was placed in between bed A and bed B with an on and off button on it. There was no string attached to the switch call box to activate the call light.</p> <p>In an interview with CNA H on 06/11/24 at 10:37 AM, she demonstrated how the call lights were activated she pulling a yellow string made of yarn that was tied to a hook on the switch box to activate the call light she then reset the call light to turn it off. She stated that call light system worked and a light outside room would light up when activated. CNA H stated that most of the residents did not need the call light. She stated that most of the residents did things by themselves. She stated that they went to the bathroom by themselves and dressed themselves. CNA H did not state the risk to residents not having call lights in their rooms because she said they did not use it. She stated that she made rounds very frequently.</p> <p>In an interview with LVN G on 06/11/24 at 12:52 PM, he stated that call lights system had were reported to management and he was informed by the maintenance department that it was a hazard for the residents on the unit to have call lights cords because residents could tie it around themselves or chock on it on the call light cords. He stated that he believed a resident went around and removed the yellow strings attached to the call light switch boxes in the rooms. He said that he had not seen any residents use their call lights however he believed that any resident had a right to a call light. He stated the risk to the resident not having a call light was that in a moment of clarity a resident may use a call light to get help if needed.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with maintenance supervisor on 06/13/24 at 11:15 AM, he stated that he was aware of the missing strings from the call lights. He stated that the ADM had placed a work order on 06/11/24 and he completed it. He stated that some residents went around the unit and removed the yellow strings tied to the call light switch box. He said that the call system was old and had a switch to activate and not a normal pug in with a cord call light. He stated that he had never seen a resident on that unit use a call light. He stated that a string longer than twelve feet was a hazard, and he used the facility policy when he replaced the missing strings. He did not state the risk to the residents not having call lights. He stated, the gentlemen do not use the call lights.</p> <p>In an interview with ADM on 06/13/24 at 05:26 PM, she stated it was the responsibility of all staff to report to maintenance anything broken. She stated that the maintenance team was always in servicing staff on the electronic work order submission by using an external link on point care click a system used by all nursing staff. She stated that she expected to report anything broken. She stated the risk to the resident was not getting care when they needed it. She stated that residents may have periods of clarity and could operate the call light if they needed help. She also stated that it was part of regulation for residents to have call lights.</p> <p>Record review of facility QAPIP reflected . call light in reach of resident (check function) .bathroom call lights function .</p> <p>Record review of the facility's policy dated 12/2016, titled, Resident Rights, reflected, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. Respect and Dignity: . The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733</p> <p>Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by an interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 8 residents (Resident #13) reviewed for care plans.</p> <p>The facility failed to ensure Resident #13's care plan was revised to reflect the prescribed diet of regular texture, regular consistency, and double protein portions.</p> <p>These failures could place residents at risk of current needs not being met.</p> <p>The findings included:</p> <p>Review of Resident #13's Face Sheet, accessed on 6/12/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included Unspecified Dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), Parkinsonism, unspecified (term used to describe a collection of movement symptoms associated with several conditions-including Parkinson's disease which is a disorder of the central nervous system that affects movement), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), End Stage Renal Disease (terminal illness that occurs when the kidneys can no longer function properly and support the body's needs), Dependence on Renal Dialysis (complex and evolving process that involves the use of renal dialysis (renal replacement therapy) to sustain life when the kidneys are no longer able to function properly), Anxiety Disorder (mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and age-related Nuclear Cataract, Left eye (major cause of blindness that occurs when the proteins in the eye's lens break down and clump together, causing cloudy spots in the center of the lens).</p> <p>Review of Resident #13's Nutritional Risk Assessment, dated 2/26/24, indicated the RD recommended adding double protein portions with meals and nepro/novosource supplement once/day.</p> <p>Review of Resident #13's Nutritional Risk Assessment, dated 4/19/24, indicated the resident does not like puree/NTL diet .Recommend prostat supplement once/day to provide addition 100kcal , (kilocalorie)15g protein. Continue large protein portions at meals.</p> <p>Review of Resident #13's Nutritional Risk Assessment, dated 5/28/24, indicated the resident reported difficulty chewing but refused diet change, hated puree diet in the past. Dislikes tea, wants juice . Recommend Nepro/Novosource supplement BID (twice a day), double protein portions, and d/c [discontinue] prostat supplement. Recommend apple juice, lowest in K+.</p> <p>Review of Resident #13's Progress Notes, dated 4/25/24 at 11:55 AM, indicated care plan meeting today. Staff present were the LMSW, MDS, AD, ADON, and therapy. The resident was present for the meeting; his family was present via phone.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #13's MDS, dated [DATE], did not indicate a BIMS score.</p> <p>Review of Resident #13's MAR, accessed on 6/12/24, indicated he was on a Renal diet, regular texture, regular consistency, double protein portions.</p> <p>Review of Resident #13's Care Plan, initiated on 2/16/24, indicated he had a Nutritional Status problem. The care plan stated the resident had a potential for nutritional problems r/t dislikes of mechanically altered diet/fluids, risk for aspiration r/t non-compliance with diet d/t spouse/family bringing regular diet foods for consumption while at dialysis. The care plan indicated his diet was: Pureed, Renal, Nectar Thick Liquids. Related interventions, revised on 4/19/24, included explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Further interventions, initiated on 2/16/24, stated RD (Registered Dietitian) to evaluate and make diet change recommendations PRN.</p> <p>Observation on 6/12/24 8:10 AM revealed Resident #13 was sitting on the side of his bed in his room. Food tray was on his bedside table. Food on his plate consisted of scrambled eggs, bacon, and toast. CNA A entered the resident's room with coffee and assisted the resident with adding sugar and powdered creamer to his coffee and eating his food.</p> <p>During an interview on 6/13/24 at 10:45 AM with the RD , she stated she has been employed with the facility for one month. She stated she was not yet familiar with all the residents and was currently screening priority residents which will then be seen monthly. She stated any concerns or changes to residents' diets were typically discussed during monthly meetings. She stated Resident #13's current diet was Renal, regular texture, regular consistency, and double protein. She stated that when she ordered a change of diet for a resident, she would email the team (administrator, DON, ADON, dietary manager) to update them on the change. She stated if a diet order changed from a pureed to regular diet was not updated and followed, it would not affect the nutritional status but would affect the resident's preferences. She stated she did not update care plans; nurses update resident care plans.</p> <p>During an interview on 6/13/24 at 10:55 AM with the MDS nurse, she stated changes to care plans were the responsibility of herself and nursing. She stated she bases her changes to the care plan on the MDS or change of condition. MDS nurse stated changes to care plans were discussed in morning meetings after an order is given, or they wait on MDS. She stated Resident #13 was on a regular diet. She stated his care plan reflected a pureed diet with NTLs (National Dysphagia Diet Level 1). She stated if the resident was given a pureed diet, it would not affect the resident because nutritional value was the same. She stated if a care plan differed from actual orders, there would be conflicting information which could affect the residents' preferences and likes/dislikes. She stated that ultimately the resident would not be affected because the meal ticket was based on the orders and that is what is used to guide the food the resident was served. She stated anyone in nursing has the responsibility to change the care plan including the person who put the order in and nurses on the floor. She stated we care meetings were conducted weekly to discuss the residents' body systems (skin, weight, etc.) and any concerns. She stated IDT meetings were conducted quarterly to discuss the residents' plan of care, any concerns with the plan of care, and any concerns the resident may have. The MDS nurse stated she was updating the care plan during the interview to reflect orders for a regular consistency diet for Resident #13.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 1:19 PM with the DON, she stated care plans were changed and updated when an order was given. She stated if care plans were not updated immediately, they were updated quarterly during care plan meetings with the residents and their families. She stated anyone can update care plans when new orders were given. She stated Resident #13 was currently on a renal, regular consistency diet. She stated that he refused pureed food. She stated if the care plan was not updated from pureed to a regular diet, it would not harm the resident, but it would not reflect his preferences .</p> <p>During an interview on 6/13/24 at 5:26 PM with the Administrator, she stated care plans were updated when new orders were received. She stated nurses were responsible for updating care plans. She stated care plan meetings were conducted quarterly.</p> <p>Review of the Facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, revealed the policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It further revealed the policy interpretations and implementation with the following relevant information:</p> <ol style="list-style-type: none"> 1. The comprehensive, person-centered care plan: <ol style="list-style-type: none"> a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths; and e. Reflects currently recognized standards of practice for problem areas and conditions. 2. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 3. The interdisciplinary team reviews and updates the care plan: <ol style="list-style-type: none"> a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident had been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment. 		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733</p> <p>Based on interview and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 8 resident (Resident #13) reviewed for accidents.</p> <p>CNA A and CNA C failed to keep Resident #13 free from accidents and were seen on camera performing a transfer from wheelchair to bed without the use of a gait belt or mechanical lift. The transfer resulted in Resident #13 falling to the floor on 06/13/24.</p> <p>This failure could place residents at risk of injury, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Review of Resident #13's Face Sheet, accessed on 6/12/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included Unspecified Dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), Parkinsonism, unspecified (term used to describe a collection of movement symptoms associated with several conditions-including Parkinson's disease which is a disorder of the central nervous system that affects movement), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), ERS (terminal illness that occurs when the kidneys can no longer function properly and support the body's needs), Dependence on Renal Dialysis (complex and evolving process that involves the use of renal dialysis (renal replacement therapy) to sustain life when the kidneys are no longer able to function properly), Anxiety Disorder (mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), age-related Nuclear Cataract, Left eye (major cause of blindness that occurs when the proteins in the eye's lens break down and clump together, causing cloudy spots in the center of the lens), Malaise, presence of Cardiac Pacemaker (small, battery-powered device that prevents the heart from beating too slowly), and acute Osteomyelitis (inflammation of bone caused by infection).</p> <p>Review of Resident #13's MDS, dated [DATE], did not indicate a BIMS score. His MDS indicated the resident's functional abilities in chair/bed-to-chair transfer were Dependent (Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers was required for the resident to complete the activity). It further reflected toilet transfer was not attempted due to medical condition or safety concerns.</p> <p>Review of Resident #13's Care Plan, initiated on 2/16/24 and revised on 4/19/24, indicated he had an ADL self-care performance deficit r/t ESRD, Dementia, Parkinson's. Related interventions indicated:</p> <p>Transfers: Extensive to total x 1-2</p> <p>Wheelchair: Extensive x 1</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Toileting: Extensive to total x 2</p> <p>TRANSFER: The resident requires Mechanical Lift with 2 staff assistance for transfers on dialysis days or when he feels weak.</p> <p>Record review on 6/13/24 at 1:10 PM of Resident #13's camera recording, stamp dated 6/05/24 at 9:31 AM. The video revealed CNA A and CNA C were in the resident's room; the resident was in his wheelchair which was positioned parallel to his bed facing the HOB (head of bed). CNA A was positioned in front of the wheelchair and CNA C was behind and to the right of the wheelchair. At 9:32 AM, CNA A and CNA C assisted him to his feet without a gait belt or Hoyer lift. The resident appeared unsteady as he stood. As the resident rotated to sit on his bed, he fell on to his knees next to the bed. CNA C walked out of view as CNA A stood next to the resident. Resident #13 was seen on his knees, resting his upper body on the bed. The resident was not wearing underwear or an incontinence brief during this time. At 9:36 AM, the ADON came into view and was seen speaking with the resident and CNA A. CNA C was partially seen as she handed CNA A an incontinence brief which she then handed to the ADON. At 9:38 AM, the ADON was seen putting the brief on the resident as he remained on his knees on the floor. At 9:39 AM, the ADON and CNA A were seen assisting and lifting the resident onto the bed without a gait belt or Hoyer lift.</p> <p>During an interview on 6/11/24 at 10:22 AM with Resident #13, he stated he needed 2 people and a Hoyer lift to assist him with transfers. He stated the staff did not always use a lift and sometimes there was only 1 person to assist him. He stated staff only used the mechanical lift when the resident went to dialysis. He stated Resident #13 fell recently but did not sustain any injuries. He stated 2 aides were assisting him from his wheelchair to the bed and he could not hold his own weight. He stated his knees buckled and he fell on his knees onto the floor. Resident #13 became agitated and stated speak to my wife. She can tell you what happened.</p> <p>During an interview on 6/12/24 at 9:57 AM with Resident #13's family member, she stated she did not have any more information to add but she had a video from the camera in the resident's room that showed what happened that day. She requested a meeting away from the facility for later that day so the video could be reviewed.</p> <p>During an interview and meeting on 6/12/24 at 1:05 PM with Resident #13's representative, she stated she had video of the fall and shared the recording of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 10:36 AM with the ADON, she stated the aides were with Resident #13 and she was called in to assess Resident #13 who fell when being transferred from his wheelchair to his bed. She stated when she walked in, the resident was kneeling in front of the bed resting on the bed. She stated she raised his legs up onto the bed to transfer him safely onto the bed and assessed him for injuries and checked his vitals. She stated the resident had no complaint of pain r/t the fall. She stated if a resident fell, a nurse must be present to assess them, so aides were required to call a nurse. She stated the aides called for LVN D who was the charge nurse for the floor, but LVN D was in a meeting, so the ADON went to assess Resident #13. She stated a Hoyer lift was always used when Resident #13 went to dialysis. Otherwise, the resident assisted with transfers. She stated she had never used a gait belt for the resident. The ADON stated the resident has helped in the past and varies on the amount of assistance he needs for transfers. She stated she does not know what the resident's care plan says r/t transfers and assistance. She stated the MDS nurse conducted an in-service on transfers after the incident. She stated that transferring residents without a gait belt or Hoyer lift when it was required could cause the resident to fall.</p> <p>During an interview on 6/13/24 at 12:00 PM with CNA A, she stated Resident #13 went to the bathroom on the day of the fall. She stated that he pressed the call light for help to transfer from the toilet to his wheelchair. She stated she was in front of him, and CNA C was behind the wheelchair and he just let his weight go. She stated she asked him if he was hurt, and he denied pain. She stated he would not allow the staff to use the gait belt. She stated the staff usually use a gait belt or Hoyer lift to transfer him but sometimes he gets angry. She stated he required 1 or 2 people to transfer him. CNA A stated she told CNA C to get the nurse while she stayed with the resident until the nurse arrived. She stated if a resident falls, she would ensure their safety first. She stated she would never move them but call for the nurse to assess them. She stated they got in-serviced on transfers every 1-2 months. She stated if a resident needs assistance transferring and it was not done correctly, the resident could fall and get hurt. She stated she was taught not to move or assist the resident up if they fall because they can cause further injury.</p> <p>During an interview on 6/13/24 at 12:16 PM with CNA B, she stated if a resident fell, they were to ensure the resident were safe and would go find the nurse. She stated Resident #13 sometimes needed staff assistance with transfers but sometimes he needed a Hoyer lift. She stated staff would use a gait belt when he needs assistance. She stated he requires assistance of 1-2 people depending on how much he can help.</p> <p>During an interview on 6/13/24 at 12:19 PM with LVN E, he stated the staff had frequent in-services on transfers. He stated the last one was one week ago. He stated Resident #13 sometimes needed assistance but depends how the resident was feeling. He stated there were days that he required assistance and other days he was more independent. He stated if a resident falls, he would assess the resident, fill out an incident report, notify the DON, ADON, resident representative, and the doctor as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 12:32 PM with CNA C, she stated she attended an in-service for transfers when she was hired three months prior. She stated she did 2 person transfers for Resident #13 and used a gait belt and Hoyer lift. She stated that on the day of the fall, he went to the bathroom in his wheelchair and transferred himself to the toilet but needed help back onto his wheelchair. She stated he used the call light in the bathroom to call for assistance. She stated she and CNA A helped him transfer from the toilet to his wheelchair. They were also going to help him transfer from his wheelchair to his bed. She stated they positioned the wheelchair next to the bed. She stated she was behind the wheelchair. CNA C stated his knees gave out and fell to his knees. She stated the resident did not have a gait belt on. She stated that after he fell , she called for LVN D to assist and assess the resident, but she was unavailable. She stated the ADON assessed the resident and helped him off the floor. She stated if a resident falls, she would ensure their safety and call for help.</p> <p>During an interview on 6/13/24 at 1:19 PM with the DON, she stated she was informed of the fall involving Resident #13. She stated an in-service had been conducted after the incident to review the process of resident transfers .</p> <p>During an interview on 6/13/24 at 5:26 PM with the Administrator, she stated using a gait belt was necessary for dependent residents, but it was also their preference. She stated a care conference was conducted on 6/07/24 with the Ombudsman, Resident #13, and the resident's representative to discuss his concerns and a fall he had recently. She stated an in-service was conducted afterwards to educate the staff on the proper training of using a gait belt.</p> <p>Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, revealed the Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . It further revealed the policy interpretations and implementation with the following relevant information:</p> <ol style="list-style-type: none"> 1. Protect resident from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: .Facility staff 2. Develop and implement policies and protocols to prevent and identify: .Neglect of residents 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. <p>Review of the facility's Safe Lifting and Movement of Residents policy, revised July 2017, revealed the Policy Statement: In order to protect the safety and well-being of staff and resident, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. It further revealed the policy interpretations and implementation with the following relevant information:</p> <ol style="list-style-type: none"> 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Manual lifting of resident shall be eliminated when feasible.</p> <p>3. Staff responsible for direct resident care will be trained in the uses of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.</p> <p>4. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48520</p> <p>Based on observation, interview, and record review, the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one (South Suites Medication Cart) of 5 Medication Carts reviewed for security.</p> <p>LVN D failed to ensure Medication Cart was locked when unattended in South Suites hallway on 06/12/24 at 7:55 AM.</p> <p>This failure could cause accidental ingestion of medication by a resident not prescribed the medication and could cause access, loss, and diversion of medications.</p> <p>Finding included:</p> <p>Observation and interview with LVN D on 06/12/24 at 07:55 AM, revealed LVN D on Suites South of the hallway. The hallway started from room seventeen to room thirty. Nurse Medication Cart was against the wall by room twenty-five facing the hallway. The Medication Cart's lock was open and in the unlocked position. The hallway was busy with staff passing breakfast trays. LVN D observed walking away from her Medication Cart unlocked and unattended to room nineteen. LVN D then walked back to the Med Cart after five minutes and resumed working. LVN D said that she forgot to lock the Medication Cart before walking away. She stated leaving a Medication Cart unlocked could allow medication to go missing and cause harm to the residents.</p> <p>In an interview with DON on 06/12/24 at 03:13PM, She stated she expected that medications to be locked in the medication carts and the carts be always locked when not in use. She said residents could get into medications left unsecured. She said they could have an adverse reaction to unprescribed medication.</p> <p>In an interview on ADM on 06/13/24 at 05:26 PM, she stated she expected staff to follow the facility's medication security policy. ADM stated that it was good nursing practice that nurses lock the medication cart when not in use. She said leaving medications unsecured placed residents at risk of harm because they could consume medications not prescribed to them and have an adverse reaction.</p> <p>Record review of facility policy titled Medication Labeling and Storage revised in February 2016, reflected . compartment (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843</p> <p>Based on observations, interviews and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen.</p> <p>The facility failed on [DATE] to ensure items found in the walk-in refrigerator, were labeled with the use by date.</p> <p>These failures could place resident at risk for food-borne illness and food contamination.</p> <p>Findings included:</p> <p>Observation on [DATE] at 9:11 am revealed in the facilities only walk-in refrigerator the following items not labeled or dated:</p> <ul style="list-style-type: none"> - Large Ziplock bag containing cheese. - Large Ziplock back containing a sandwich, chips, packaged crackers, personal packet of mayonnaise. - Large Ziplock bag containing cooked bacon. <p>Observation on [DATE] at 9:11 am revealed in the facilities only walk-in refrigerator the following items in open packaging:</p> <ul style="list-style-type: none"> - Box of lunch meat on the shelf uncovered. - Box of 24 count eggs with 18 eggs remaining in the open box. <p>Interview on [DATE] at 2:20 PM with Admission Director; revealed he has been helping in the kitchen during preparation time because the dietary manager quit about three weeks ago. He stated he assist with ordering food and food preparation. He has a position within the facility that limited his time in the kitchen. He stated that he did remind dietary staff to maintain safe store practices.</p> <p>Interview on [DATE] at 3:06 PM with DON; she stated that food should be closed and sealed. The risk to the residents was cross contamination.</p> <p>Interview on [DATE] at 05:22 PM with Administrator; she stated food should be labeled for us to know that the food was not expired and safe for human consumption.</p> <p>Review of the policy titled Food Storage, dated 2018 reflected; d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview and record review, the facility failed to ensure storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for one (Suites Medication Room) of two medication rooms reviewed for storage and biologicals.</p> <p>The facility failed to store food brought in by family or visitors with labels of resident's names, expiration date, and stored in a way that was separated and distinguishable from residents, facilities, and staff's foods in the Suites Medication Room refrigerator on [DATE].</p> <p>This failure could affect residents by placing them at risk for food-borne illness.</p> <p>Finding included:</p> <p>Observation and interview with ADON on [DATE] at 03:06 PM, revealed Suites Medication Room had a tall white refrigerator with 3 shelves. Temperature reading 40 degrees Fahrenheit. No medications in the refrigerator. On the top shelf- were a box of thickened water, a 2-liter coke bottle in a shopping bag, a brown box opened at top, a gallon pitcher with red drink undated with a loose fitted plastic wrap, half a sandwich undated in an open sandwich bag, an ensure bottle and unidentified yellow/orange container open to one side in the back of refrigerator. On the second shelf- were a white empty grocery bag, a half bag of mixed shredded cheese, a Mrs. Freshley's honey bun (name of product) that was undated and a box of cinnamon Chex. On the last shelf- was an open twenty can Coca-Cola box with resident name on it, a large pizza box and 2 smaller pizza boxes stacked together from pizza [NAME] dated [DATE]. A grey bag tied at top of unknown contents with no date or name. On the very bottom of refrigerator was a slightly open drawer, yellow and brown sticky substance on bottom of refrigerator and inside door shelves. ADON said that she was unsure of the food in the refrigerator belonged to the staff or residents. She said the pizzas and the 2-liter drink belonged to a resident that liked to order uber eats (an outside food delivery service). She said the nursing staff were responsible for cleaning out the refrigerator and making sure food was up to date and labelled with resident's name as applicable. She said only nursing staff had access to medication rooms refrigerators. She said the risk to the residents was eating something that could make them sick because it had expired.</p> <p>In an interview with DON on [DATE] at 03:13PM, she stated that she was unaware of the status of the refrigerator in Suites Medication Room. She said that she would get it cleaned and start an in service with the nursing staff about labeling and dating the items in the fridge. She said the risk to the residents was eating something contaminated that could make them ill.</p> <p>In an interview with the ADM on [DATE] at 05:266 PM, she stated that she expected all nursing staff to follow facility policy and make sure that all foods labelled with resident's name and dated. She said she expected all staff to monitor that the food was safe for human consumption. She said the risk to resident was not knowing if food was safe to eat.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy titled Food safety for Residents revised ,d+[DATE] reflected . 2. Cover, label with name, date stored and the date it must be used or discard. We recommend a use by date of 3 days after the food was prepared or purchased .plastic containers with tight fitting lids are recommended .</p> <p>Review of facility policy titled Cleaning & Sanitation of Refrigerators & Freezers on Units revised ,d+[DATE] reflected . Only residents' food will be stored in the pantry refrigerators. All food will be labeled, dated, and covered. Refrigerators</p> <p>Will be checked each day for any food or supplement over 72 hours old and any outdated food will be discarded .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843</p> <p>49733</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 5 staff members (CNA A and RN F) reviewed for infection control.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that the designated handwashing sink located in the facility kitchen had a functional soap dispenser. Dietary Aide A used the hand soap from a bag of soap located in the sink to wash her hands instead of using the soap dispenser. 2. While assisting Resident #13 with his breakfast, CNA A failed to wash her hands before assisting him with eating. CNA picked up 2 strips of bacon with her bare hands and handed them to the resident. 3. While serving meals in the dining room, RN F failed to perform hand hygiene in between direct contact with 13 residents. <p>These deficient practices have the potential to affect all residents in the facility by placing them at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>Observation on 06/11/2024 at 9:10 am revealed designated kitchen hand washing sink had a full bag of antibacterial hand soap laying in the sink with a steel scrub pad sitting on top of it. In the bottom of the sink was food residue. Located on the ledge of the sink was a 7.5 FL OZ (ounces) empty bottle of hand soap with the top off. The wall soap dispenser did not produce soap when operated.</p> <p>Interview with Dietary Aide A on 06/11/2024 at 9:10 am revealed the kitchen hand washing sink was the hand washing sink that staff used to wash their hands.</p> <p>Observation on 06/12/2024 at 11:02 am revealed designated kitchen hand washing sink had a bag of antibacterial hand soap laying in the sink. Wall hand soap dispenser was open with no hand soap installed. During meal prep Dietary Aide A was observed going to the hand washing sink, picking up the soap in the disposable bag, squeezing the bag to dispense soap into their hands, placing the soap bag back into the sink, and finally washing their hands with soap and water.</p> <p>Interview with Admissions Director on 6/12/2024 at 11:02 am revealed the bag of soap located in the sink was the soap used by staff to wash their hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Admissions Director on 06/12/2024 at 2:20 pm revealed the soap dispenser on the wall above the hand washing sink was functional and stated the reason the bag of soap was not in the dispenser was because when staff change out the bags, they throw away the spout. He stated that he did not think that squeezing the hand soap out of the bag was an infection control issue if staff did not touch the bag after they washed their hands.</p> <p>Interview with DON on 06/13/2024 at 3:16 pm revealed the expectation was that the soap be placed and the soap dispenser and the sink clean of all debris. The risk to the residents was cross-contamination.</p> <p>Review of the Policy titled Handwashing/Hand Hygiene reflected 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.</p> <p>2. Review of Resident #13's Face Sheet, accessed on 6/12/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included Unspecified Dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), Parkinsonism, unspecified (term used to describe a collection of movement symptoms associated with several conditions-including Parkinson's disease which is a disorder of the central nervous system that affects movement), Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), End Stage Renal Disease (terminal illness that occurs when the kidneys can no longer function properly and support the body's needs), Dependence on Renal Dialysis (complex and evolving process that involves the use of renal dialysis (renal replacement therapy) to sustain life when the kidneys are no longer able to function properly), Anxiety Disorder (mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), age-related Nuclear Cataract, Left eye (major cause of blindness that occurs when the proteins in the eye's lens break down and clump together, causing cloudy spots in the center of the lens), and acute Osteomyelitis (inflammation of bone caused by infection).</p> <p>Review of Resident #13's MDS, dated [DATE], did not indicate a BIMS score. His MDS indicated the resident's functional ability in eating required substantial/maximal assistance. It further indicated the resident had an unhealed stage 4 pressure ulcer present upon admission/entry or reentry.</p> <p>Review of Resident #13's Care Plan, initiated on 2/16/24 and revised on 4/19/24, indicated he had an ADL self-care performance deficit r/t ESRD, Dementia, Parkinson's. Related interventions indicated the resident required extensive x 1 assistance with eating.</p> <p>During an observation on 6/12/24 at 8:10 AM, Resident #13 was observed sitting on the side of his bed in his room. Food tray was on his bedside table. Food on his plate consisted of scrambled eggs, bacon, and toast. CNA A entered the resident's room with coffee and assisted the resident with adding sugar and powdered creamer to his coffee and assisted him with eating. CNA A failed to sanitize her hands upon entering the room or before assisting the resident. While assisting him with eating, CNA A picked up 2 strips of bacon with her bare hands and handed them to the resident.</p> <p>3. During an observation on 6/12/24 at 12:17 PM, RN F was observed passing lunch trays in the main dining room. She was observed handling resident wheelchairs and other items in the dining room and did not wash or sanitize her hands between residents when serving meal trays.</p> <p>(continued on next page)</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/24 at 12:00 PM with CNA A, she stated she always washed her hands prior to assisting residents with their food. She stated she would never pick up a resident's food with her bare hands. She stated she would use utensils or put gloves on. She stated that failure to sanitize hands when assisting residents or touching their food with bare hands could spread germs and could potentially cause the residents to become ill. She stated it was policy to perform hand hygiene before and after resident interactions. She stated the facility provided in-service about once a month on infection control.</p> <p>During an interview on 6/13/24 at 12:16 PM with CNA B, she stated she has been employed with the facility since December 2023. She stated she washes her hands before assisting residents with eating. She stated hand hygiene was important when assisting them to eat to help prevent the spread of germs. She stated that failure to wash hands could cause a resident to become sick. She stated she never touches a resident's food with her bare hands because the food can get contaminated with germs. She stated the facility provided in-service on infection control recently but could not remember when she last attended.</p> <p>During an interview on 6/13/24 at 12:27 PM with CNA C, she stated it was policy for staff to wash their hands before, after, and in-between resident care. She stated she helped residents with eating and always washed her hands before and after. She stated if she had to pick up a resident's food, she would put on gloves. CNA C stated sanitizing hands when caring and assisting residents was important because it stopped the spread of germs that could cause infection. She stated the staff regularly attend in-service on infection control.</p> <p>During an interview on 6/13/24 at 12:44 PM with the corporate nurse, she stated hand sanitizing was applicable when actually coming in contact with residents or their food. She stated hands should also be sanitized in between every few residents to prevent the spread of germs to the residents.</p> <p>During an interview on 6/13/24 at 1:13 PM with the RD, she stated she has been employed with the facility for one month. She stated hand hygiene was to be conducted anytime there was interaction between 2 residents to prevent the spread of germs. She stated staff should not be touching the residents' food with their bare hands for safety of the residents.</p> <p>During an interview on 6/13/24 at 1:19 with the DON, she stated the staff were to sanitize their hands in between residents and before assisting residents with eating. She stated staff should never touch the residents' food with their bare hands. She stated staff can have contamination on their hands and spread germs causing harm to the residents. She stated the facility had an infection control in-service on 5/31/24.</p> <p>During an interview on 6/13/24 at 4:13 PM with the Infection Preventionist, she stated aides were required to conduct hand hygiene prior to feeding or assisting the residents with their food. She stated aides should not use their bare hands to feed the residents. She stated they were to use utensils so there would not be contamination of the food. She stated that failure to do so could cause germs to be passed to residents and could potentially cause them harm. She stated she recently conducted an in-service on infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/24 at 5:26 PM with the Administrator, she stated her expectation was for staff to use hand sanitizer to clean hands prior to feeding residents and never touch the residents' food with their bare hands. She stated their hands could have germs and the residents could get ill. She stated the staff were regularly in-serviced on infection control.</p> <p>Review of the facility's policy on Handwashing/ Hand Hygiene, revised August 2019, identified the policy statement as This facility considers hand hygiene the primary means to prevent the spread of infections. Policy interpretation and implementation included:</p> <ol style="list-style-type: none"> 1. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, resident, and visitors. 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: <ol style="list-style-type: none"> .o. Before and after assisting a resident with meals. <p>Review of the facility's policy on Infection Control, revised October 2018, identified the policy statement as This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy interpretation and implementation included:</p> <ol style="list-style-type: none"> 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer worker, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source. 2. The objectives of our infection control policies and practices are to: <ol style="list-style-type: none"> a. Prevent, detect, investigate, and control infections in the facility; b. Maintain safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; 		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>43843</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to maintain and effective pest control program to ensure the facility was free of pests for kitchen area.</p> <p>The facility failed to ensure an effective pest control program was implemented to prevent the presence of gnats and flies in the kitchen area.</p> <p>This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life.</p> <p>Findings included:</p> <p>Observation on 06/11/2024 at 9:10 am revealed 4-5 gnats fly from the trash can located next to the handwashing sink in the kitchen area. Observation of 4-5 flies around the stove, three compartment sink and juice dispenser. Observation of the kitchen backdoor used for taking out the trash and receiving delivers was partially open.</p> <p>Observation on 06/12/2024 11:27 am revealed 4-5 flies around the steam table. Staff members were observed waving their arms at flies to prevent them from landing on food. Fly was observed landing on meal tray.</p> <p>Interview with Dietary Aide on 06/12/2024 at 1:15 pm revealed there were several flies because during delivery the backdoor was left opened and this allows the flies to come into the building. He stated that pest control will come and treat the kitchen area when there were a lot of flies and gnats. He stated that the gnats were usually around the dish machines and drains. The risk to the residents was they can lay eggs that become maggots and the residents can get sick.</p> <p>Interview with the Admissions Director on 06/12/2024 at 2:20 pm revealed there is an issue with flies in the kitchen area. He stated that the flies enter the building when food is delivered through the backdoor because it is held open during the delivery. He stated that it was not sanitary to have flies around food when it was being prepared or served.</p> <p>Interview with Maintenance director on 06/13/2024 at 4:23 PM revealed he stated that he was not aware of the flies and gnats until 06/13/2024. He stated that when he was told of the issue, he would contact pest control and they would come out and treat the affected areas. He stated the flies were coming in through the backdoor and the gnats were coming through the drains because staff was not mopping the floors.</p> <p>Record review of pest control services dated 06/12/2024 at 5:00 pm reflected facility requested additional pest service. Pest control on site for emergency service regarding flies. Upon arrival administrator requested full facility fly wipe down to treat for flies. Few flies were observed in hallways (2-3), then made it to the kitchen where the highest concentrations of flies and some gnats. Once all food items were put away and aerosol fly bait was applied to strategic corners of the kitchen to reduce fly and gnat's pressure.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Pest Control policy reflected a request for facility policy was not received prior to exit</p>		