

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 43791</p> <p>Based on observation, interview, and record reviews, the facility failed to review and revise care plans for 2 (Residents #1 and #2) of 5 residents reviewed for care plan revision.</p> <p>The facility failed to revise Resident #1 and #2's care plans to reflect their need for direct supervision while smoking.</p> <p>This failure could place the residents at risk of harm to themselves or other residents</p> <p>Findings included:</p> <p>Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included paralysis, seizures, stroke affecting left side, and cardiac pacemaker.</p> <p>Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating she was cognitively intact. Her Functional Status indicated she required a wheelchair for mobility, and limited assistance with her ADLs.</p> <p>Review of Resident #1's care plan revealed she did not have a focus area on smoking and/or smoking with supervision.</p> <p>Review of Resident #1's monthly Safe Smoking Assessment, dated 04/20/24, reflected: This resident requires direct supervision while smoking .All smoking materials will be kept at the nurses station.</p> <p>Observation and interview on 04/20/24 at 3:20 PM revealed Resident #1 was in the smoking area with a lit cigarette and smoking with no staff present to monitor. Resident #1 extinguished the cigarette when the DON and the surveyor approached her. Resident #1 denied smoking. Ash from a cigarette was observed on her pants leg, and a suspected cigarette burn hole in her pants was near the same spot. The DON brushed away the ash and asked Resident #1 when the burn in her pants had occurred. Resident #1 stated it had happened about a month ago.</p> <p>Review of Resident #2's undated Admission Record revealed the resident was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included diabetes, history of falls, heart failure, and amputation of the left leg above the knee.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating she was cognitively intact. Her Functional Status indicated she required minimal assistance for her ADLs.</p> <p>Review of Resident #2's care plan, dated 03/19/24, revealed she did not have a focus area on smoking with supervision.</p> <p>Review of Resident #2's Safe Smoking Assessment, dated 04/20/24 reflected This resident requires direct supervision while smoking All smoking materials will be kept at the nurses station.</p> <p>Observation and interview on 04/20/24 at 3:20 PM revealed Resident #2 was in the smoking area with a lit cigarette and no staff supervision. Resident #2 continued to smoke when the DON and the surveyor approached her. The DON advised the resident that it was not a designated smoke time and asked who had lit her cigarette. Resident #2 refused to answer the DON. Resident #2 had no obvious burns to her hands or her clothing.</p> <p>Interview on 04/20/24 at 3:30 PM the DON stated residents were only allowed to smoke at designated times when staff were present to monitor them. Resident smoke times began at 7:30 AM and were every other hour throughout the day. The DON stated CNAs rotate the monitoring of smoke times throughout the day. The DON stated it was hard to keep the residents from smoking on the off times because they sneak cigarettes from outside the facility, and smoke any time t hey wanted to. The DON stated the risk of residents smoking unsupervised were they could harm themselves or another resident with a lit cigarette.</p> <p>Review of the facility's undated policy Comprehensive Care Planning, reflected:</p> <p>The resident's care plan will be reviewed after each Admission, Quarterly, Annually and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 43791</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident receives adequate supervision and assistance devices to prevent accidents for 5 (Residents #1, #2, #3, #4, and #5) of 5 residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure Residents #1, #2, #3, #4, and #5 were supervised while smoking</p> <p>This failure could place the residents at risk of injuring themselves or harming another resident.</p> <p>Findings included:</p> <p>Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included paralysis, seizures, stroke affecting left side, and cardiac pacemaker.</p> <p>Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating she was cognitively intact. Her Functional Status indicated she required a wheelchair for mobility, and limited assistance with her ADLs.</p> <p>Review of Resident #1's care plan revealed she did not have a focus area on smoking and/or smoking with supervision.</p> <p>Review of Resident #1's monthly Safe Smoking Assessment, dated 04/20/24, reflected This resident requires direct supervision while smoking All smoking materials will be kept at the nurses station.</p> <p>Observation and interview on 04/20/24 at 3:20 PM revealed Resident #1 was in the smoking area with a lit cigarette and smoking with no staff present to monitor. Resident #1 extinguished the cigarette when the DON and the state surveyor approached her. Resident #1 denied smoking. Ash from a cigarette was observed on her pants leg, and a suspected cigarette burn hole in her pants near the same spot. The DON brushed away the ash and asked Resident #1 when the burn in her pants had occurred. Resident #1 stated it had happened about a month ago, and she did not report it to staff.</p> <p>Review of Resident #2's undated Admission Record revealed the resident was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included diabetes, history of falls, heart failure, and amputation of the left leg above the knee.</p> <p>Review of Resident #2' quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating she was cognitively intact. Her Functional Status indicted she required minimal assistance for her ADLs.</p> <p>Review of Resident #2's care plan, dated 03/19/24, revealed she did not have a focus on smoking with supervision.</p> <p>Review of Resident #2's Safe Smoking Assessment, dated 04/20/24, reflected This resident requires direct supervision while smoking All smoking materials will be kept at the nurses station.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 04/20/24 at 3:20 PM revealed Resident #2 was in the smoking area with a lit cigarette and no staff supervision. Resident #2 continued to smoke when the DON and the state surveyor approached her. The DON advised the resident that it was not a designated smoke time and asked who had lit her cigarette, Resident #2 refused to answer the DON. Resident #2 had no obvious burns to her hands or her clothing.</p> <p>Review of Resident #3's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included surgical amputation of left leg below the knee, diabetes, alcohol abuse, and depression.</p> <p>Review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 15, indicating he was cognitively intact. His Functional Status indicated he was mostly independent in his ADLs.</p> <p>Review of Resident #3's care plan, dated 03/07/24, revealed he did not have a focus area for smoking with supervision.</p> <p>Review of Resident #3's monthly Safe Smoking Assessment, dated 01/18/24, This resident requires direct supervision while smoking. No monthly smoking assessments were completed for February, March or April of 2024.</p> <p>Observation on 04/20/24 at 10:25 AM revealed Resident #3 was in the smoking area smoking a cigarette without staff supervision.</p> <p>Interview on 04/20/24 at 10:30 AM with Resident #3 revealed he had his own smoking materials in his room because he liked to smoke when he wanted to and, and he did not want to hassle with the staff. He stated he was safe to smoke without any supervision, and he had not burned himself.</p> <p>Review of Resident #4's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included heart failure, diabetes, kidney disease, and amputation of left toes.</p> <p>Review of Resident #4's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating she was cognitively intact. Her Functional Status indicted she was mostly independent in her ADLs.</p> <p>Review of Resident #4's care plan, dated 03/16/24, revealed she did not have a focus for smoking with supervisio but did have a focus for her being non-compliant with the smoking policy with an intervention to have supervision while smoking.</p> <p>Review of Resident #4's monthly Safe Smoking Assessment, dated 03/21/24, reflected: This resident requires direct supervision while smoking All smoking materials will be kept at the nurses station.</p> <p>Observation on 04/20/24 at 10:30 AM of Resident #4 was in the smoking area smoking with no staff supervision.</p> <p>Review of Resident #5's undated Admission Record revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included emphysema, diabetes, high blood pressure, and bipolar disorder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #5's quarterly MDS, dated [DATE], revealed she had a BIMS score of 13 indicating she was cognitively intact. Her Functional Status indicted she required minimal assistance with her ADLs.</p> <p>Review of Resident #5's care plan, dated 02/18/24, revealed she had a focus area for smoking but no focus area for smoking with supervision.</p> <p>Review of Resident #5's monthly Safe Smoking assessment dated [DATE] reflected This resident requires direct supervision while smoking .All smoking materials will be kept at the nurses station. There were no monthly assessments since October 2023.</p> <p>Observation on 04/20/24 at 10:30 AM revealed Resident #5 was in the smoking area smoking a cigarette with no staff supervision.</p> <p>Interview on 04/20/24 at 3:30 PM the DON revealed the residents were not permitted to smoke except at designated smoke times and only when there were staff present. The smoking materials were kept in a locked box at the 200 Halls nurse station. The DON stated the risk of residents smoking without supervision were harming themselves or another resident with a lit cigarette.</p> <p>Interview on 04/20/24 at 3:40 PM with the Administrator revealed staff periodically conducted sweeps in resident rooms looking for things like dishes, utensils, and extra linen. Residents were asked for permission to look in their personal areas, and residents, who were not compliant with the smoking rules, would always deny the request. The Administrator stated she knew residents kept their own smoking materials, and they did what they could to confiscate them when they saw them.</p> <p>Review of the facility's policy Smoking Policy, dated 11/01/17, reflected:</p> <p>The facility is responsible for enforcement of smoking policies .</p> <ol style="list-style-type: none"> 1. Matches, lighters, or other ignition sources for smoking are not permitted to be kept or stored in a resident's room. 2. A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel 3. If the facility identifies that the resident needs assistance/supervision and/or additional protective devices for smoking, the facility includes this information in the resident's care plan, and reviews and revises the plan periodically as needed. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	
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 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791</p> <p>Based on observation, interview, and record review, the facility failed to assure full visual privacy for 2 (Residents #6 and #7) of 5 residents reviewed for privacy.</p> <p>The facility failed to provide privacy curtains for Residents #6 and #7 while their curtains were being laundered.</p> <p>This failure could place the residents at risk of decreased feelings of self -worth.</p> <p>Findings included:</p> <p>Review of Resident #6's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included bone infection, diabetes, amputation of right leg below the knee, and Opioid abuse.</p> <p>Review of Resident #6's admission MDS, dated [DATE], revealed a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicted he was mostly independent in his ADLs.</p> <p>Review of Resident #6's care plan, dated 04/20/24, revealed he had a focus area for a surgical incision to his right toes and left leg requiring wound care and a focus area for the resident's self-care deficit.</p> <p>Review of Resident #7's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included diabetes, legal blindness, amputation of both feet, and high blood pressure.</p> <p>Review of Resident #7's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicted he required extensive assistance with his ADLs.</p> <p>Review of Resident #7's care plan, dated 03/30/24, revealed he had cognitively impairment related to stroke, and he had an ADL self-care deficit.</p> <p>Observation on 04/20/24 at 9:20 AM revealed there were no privacy curtains in Resident #6 and #7's room.</p> <p>Interview on 04/20/24 at 9:20 AM with Resident #6 revealed the privacy curtains had been removed on 04/13/24 because Resident #7 was reported to possibly have bed bugs. All linens and the curtains were taken to be laundered. Resident #6 stated he and Resident #7 were moved to another room while their room was treated. They were moved back into their room on 04/17/24, but their personal property was not moved back in and no new curtains were hung. Resident #6 stated Resident #7 required wound care, and sometimes incontinence care, and there was no privacy for him.</p> <p>Interview on 04/20/24 at 9:24 AM with Resident #7 revealed he did not like the idea that he could be seen by anyone when he was exposed. He stated since he was blind, he depended on staff to provide privacy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2024
NAME OF PROVIDER OR SUPPLIER Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 424 S Adams St Fort Worth, TX 76104	

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 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/20/24 at 4:00 PM with the Administrator revealed the privacy curtains for Resident #6 and #7 were in the process of being re-hung. She stated the curtains should have been replaced by maintenance as soon as the treatment for bed bugs had been completed, before the residents were moved back in. She did not know why that did not happen. The Administrator stated there was not a policy for privacy curtains.</p>