STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455651	A. Building B. Wing	04/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downtown Health and Rehabilitation Center	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect for one (Resident #1) of one incident reviewed for reporting according to facility policy. CNA A failed to follow the facility's policy to report allegations of abuse when allegedly she observed CNA B hold Resident #1 down in a choke hold on 04/24/24. This failure could place the residents in the facility at risk of abuse and lack of timely reporting of incidents. Findings included: Review of the facility's policy titled Abuse/Neglect, revised 03/29/18, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. .3 Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's face sheet revealed the resident was [AGE] year old male, admitted on [DATE], with diagnosis of Alzheimer's disease (brain disorder that causes memory loss), muscle weakness, difficulty in walking, abnormalities of gait and mobility, abnormal posture (involuntary position of the body), and delusional disorders (one or more persistent beliefs that are not based on reality). Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 00, indicating Resident #1 was not able to complete. Resident #1 required substantial/maximum assistance with toileting. The resident's active diagnoses included non-traumatic brain dysfunction (an acquired brain injury caused by internal factors, such as lack of oxygen). Review of Resident #1's care plan reviewed on 04/27/24 reflected the resident had cognitive function/impaired thought processes. The care plan nterventions included asking yes/no question to determine resident needs. Identify yourself with each interaction, face Resident #1 when speaking, provide necessary cues-stop and return if agitated. Resident #1 resides in the Secure Care Unit. Intervention included to allow resident to perform activities of daily living activities, notify physician of any changes. Resident #1 had Activity of Daily Living deficit. Interventions included toileting, personal hygiene, dressing required extensive assist by one person, Review of Resident #1's last assessment in his clinical record dated 04/23/24 at 1:47 PM written by Nurse C indicated he was always incontinent of bowel and bladder. The assessment revealed Resident #1 did not indicate any pain. Review of the facility's Incident and Accident reports with a date range of 02/25/24-04/25/24 revealed no incidents or accident involving Resident #1. Observation of the Administrator's office door on 04/27/24 at 7:00 AM revealed a posting reflecting she was the facility's designated Abuse Coordinator, and it detailed her name and contact information. Her office was located near the front entrance. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/24 at 5:21 PM with CNA A revealed she recently started at the facility working in the Memory Care Unit. According to CNA A, she completed training with CNA B. She stated during her training she heard CNA B being verbally aggressive with residents while she provided them with care. CNA A stated when CNA B would say something or give directions to the residents, the residents would jump or act scared when she would tell them to do something. CNA A stated Resident #1 seemed uncomfortable being around CNA B. CNA A stated when Resident #1 refused to be changed on 04/24/24 between 8:00 PM-9:00 PM, CNA B grabbed the resident by the back of his neck and held him down in a choke hold saying out loud, You better get in there, now! According to CNA A, she did not intervene, and she did not say anything to CNA B about being verbally or physically abusive. CNA A stated she did not report what she had witnessed to RN G or the Abuse Coordinator. CNA A stated she did not intervene because she was scared of CNA B stating she was a big girl and could beat me up. CNA A stated, I seen her speak loudly, aggressively and get up into staff face, and they have not done anything to her. They let her work here. CNA A stated from the time she started a week ago, she had observed CNA B's behavior and saw that this abuse had been going on before she arrived. CNA A stated by the way CNA B was speaking to residents she thought to herself this behavior had been going on for a long time, and figured no one is doing anything about it. CNA A stated RN G had heard her speaking rudely to residents but did nothing to protect the residents. CNA A stated CNA B had friends and family that worked in the facility, so she did not know who she could trust in the facility. CNA A stated she felt if she reported the abuse to administrative staff, the facility would retaliate against her, and she would be terminated. CNA A stated she did discuss the allegation with CNA E and Hospitality Aide F; however, it was not clear what day she talked to them. CNA A stated she was aware abuse should be reported to the Abuse Coordinator; however, she feared retaliation. CNA A stated she recently had an inservice covering abuse and neglect and was aware to report it. CNA A stated not reporting abuse placed residents at risk of harm and endangerment. Observation and interview on 04/27/24 at 7:45 AM of Resident #1 revealed he was sitting at the dining room table watching television. Resident #1 was observed to be clean, dressed, and wearing no skid socks. He stated he was waiting on breakfast. Resident #1 did not display any signs of fear or distress. He also did not have any obvious physical signs of abuse. Observation of the resident's neck did not reveal any physical injuries such as indentions, hand prints, scratches, or bruises. Interview on 04/27/24 at 9:45 AM with Resident #1's Family Member revealed she did come to the facility to visit with Resident #1. The Family Member stated the facility had contacted her in the past with any concerns about his care, medication change, and any incidents. The Family Member stated she had not been contacted recently about anything recently. Interview on 04/27/24 at 10:05 AM with the ADON revealed she had not been notified of any abuse against Resident #1. The ADON stated skin assessments were completed weekly, and nurses would be able to document and report any changes. The ADON stated Resident #1 walked around and mostly stayed to himself. The ADON stated while she was not the nurse over the Memory Care Unit, she did recently have eyes on him during an assessment and did not notice any bruising or signs of abuse. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/24 at 10:24 AM with CNA C revealed she had not seen any bruising or signs of abuse with Resident #1. CNA C revealed there was a recent behavior change with Resident #1. CNA C stated she noticed Resident #1 had become aggressive when she attempted to provide him with incontinence care. CNA C stated she noticed that he would ball up his fist. When she asked him what was wrong, he responded nothing. CNA C stated this behavior was not normal for him as they had a good relationship. CNA C stated she did not report to anyone that Resident #1 was having a behavioral change because she was able to talk him through it and he allowed her to provdie him with incontinence care. CNA C stated she had worked with CNA B in the past. She stated she had never seen CNA B or anyone become physically aggressive towards residents on the Memory Care Unit. She stated, I guess the way her voice is. I would say it is forceful, not sweet. According to CNA C, the facility protocol was to report any change in residents and refusals to the nurse, and to report any signs of abuse to the Abuse Coordinator, which was the Administrator. CNA C stated she had access to the Administrator's phone number to report abuse. CNA C stated she was responsible to report any changes in residents, not doing so placed them at risk of abuse or being injured, hurt or in distress. Interview on 04/27/24 at 10:48 AM with CNA B revealed she worked on the Memory Care Unit. CNA B stated she noticed Resident #1's mood had changed. She stated the resident had started eating foreign objects, and she reported this to nursing staff. According to CNA B, she had to stop him from eating foreign objects. She denied being aggressive or physical when interacting with Resident #1. When asked about Resident #1's incontinence care, CNA B stated she had never had any issues with providing care for him. When asked if she had ever held Resident #1 down in a choke hold, she responded no. According to CNA B, she did not speak aggressively to residents in the facility. When asked if she had worked with other staff while working on the Memory Care Unit, she revealed new staff were working on the unit and she assisted with training. CNA B stated she did not observe new staff that she was training to be verbally or physically aggressive with residents and never did anything that would look like abuse to residents. According to CNA B, not reporting abuse would place residents at risk of harm. CNA B stated she last in-serviced on abuse and neglect during the previous week. CNA B revealed she would be able to identify signs and symptoms of abuse and neglect and would report abuse to the Abuse Coordinator. Interview on 04/27/24 at 6:10 PM with RN G revealed she worked the 2:00 PM-10:00 PM shift and stated CNA A was a recently hired to work in the Memory Care Unit. RN G stated there was recently an in-service on abuse and neglect. She stated she was aware of the signs and symptoms of abuse, and she knew to report to the Abuse Coordinator immediately. RN G stated she had worked with both CNA A and CNA B and not observed them with any abusive behavior while working with residents. According to RN G, she had not seen any change in Resident #1 or been notified of any changes in his behavior. RN G stated residents receive weekly skin assessments, and she had noticed any signs and symptoms of abuse, she had not witnessed any bruising around his neck. RN G stated she had observed CNA B to talk loud, but I don't think she is being aggressive in her tone. According to RN G, residents responded to CNA B the same as they would to her. According to RN G, it was never reported that CNA B grabbed Resident #1 by the back of his neck and held him down in a choke hold. RN G stated not reporting abuse placed residents at risk of being abused over and over by the same person and causing harm to them. RN G stated all staff were required to report allegations, changes and signs and symptoms of abuse to the Administrator. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/24 at 6:27 PM with CNA E revealed she recently completed an in-service on abuse and neglect. CNA E stated she had not been told about any allegations of abuse, and she denied that CNA A had told her about any allegations of abuse regarding Resident #1 and CNA B. CNA E stated she was aware of signs and symptoms of abuse and to report to the nurse or unit manager. Interview on 04/27/24 at 6:52 PM with Hospitality Aide F revealed he recently completed an in-service on abuse and neglect. Hospitality Aide F reported CNA A did not report alleged abuse by CNA B towards Resident #1. Hospitality Aide F stated while working in the Memory Care Unit he observed CNA B as having her own way of communicating. He stated he had never seen her be abusive towards residents. Hospitality Aide F stated he was aware of the signs and symptoms of abuse and to report to the Director of Nursing and up the chain to the Abuse Coordinator which was the Administrator. Interview on 04/27/24 at 7:05 PM with the Administrator revealed she had not had any allegations of abuse reported to her. The Administrator was not aware of the alleged incident involving Resident #1 and CNA B until surveyor inquiry on this date. The Administrator stated she recently completed an in-service over abuse and neglect. The Administrator stated both CNA A and CNA B had worked in the Memory Care Unit. She stated CNA A was a new hire, who started last week. The Administrator stated RN G was the charge nurse on the 2:00 PM-10:00 PM shift and had been a previous DON and worked as a nurse for several years and would not allow any abuse. The Administrator stated she recently spoken with CNA A to see how things were going in the facility and open the floor to report anything good or bad she had noticed in the facility. She explained this was part of their new hire process to follow-up with new hires, and CNA A did not report anything to her when she spoke with her. The Administrator stated it was her expectation for all staff to report observations of abuse immediately. The Administrator stated her phone number was posted outside her door, and if staff could not reach her in a timely manner, the expectation was to contact the Director of Nursing or on the weekend they were to contact the manager on duty. The Administrator stated the on-call phone was also available for reporting. The Administrator stated not reporting abuse placed residents at risk of weight loss, isolation, along with other negative effects. The Administrator stated upon hire it was revealed CNA A worked for their company in a sister-facility and was terminated due to CNA A making false accusations simliar to the ones she was now making. Record review of CNA E and Hospitality Aide F's time sheets revealed neither employee was scheduled to work at the time of the alleged incident. CNA E's shift ended at 2:30 PM on 04/24/24, and Hospitality Aide F was not scheduled to work on 04/24/24. Record review of an in-service record titled Abuse/Neglect dated 04/25/24 revealed the Administrator trained CNA A, CNA B, CNA E, Hospitality Aide F. They signed off as having received this in-service training.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the Administrator of the facility for 1 (Resident #1) of 5 residents reviewed for reporting abuse and neglect. CNA A failed to immediately report to the Administrator an allegation of abuse involving CNA B and Resident #1 that allegedly occured on 04/24/24. The failure placed residents at risk of not having abuse allegations reported. Findings included: Review of Resident #1's face sheet revealed the resident was [AGE] year-old male, admitted on [DATE], with diagnosis of Alzheimer's disease (brain disorder that causes memory loss), muscle weakness, difficulty in walking, abnormalities of gait and mobility, abnormal posture (involuntary position of the body), delusional disorders (one or more persistent beliefs that are not based on reality). Review of Resident #1's MDS dated [DATE] revealed the Resident #1 had a BIMS score of 00, indicating Resident #1 was not able to complete. Resident #1 required substantial/maximal assistance with toileting. The resident's active diagnoses included non-traumatic brain dysfunction (acquired brain injury due to internal forces, such as lack of oxygen). Review of Resident #1's care plan reviewed on 04/27/24 reflected had cognitive function/impaired thought processes. Interventions included asking yes/no question to determine resident needs. Identify yourself with each interaction, face Resident #1 when speaking, provide necessary cues-stop and return if agitated. Resident #1 resides in the Secure Care Unit. Intervention included to allow resident to perform activities of daily living activities, notify physician of any changes. Resident #1 had Activity of Daily Living deficit. Interventions included toileting, personal hygiene, dressing required extensive assist by one person. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/24 at 5:21 PM with CNA A revealed she recently started at the facility working on the 2:00 PM-10:00 PM in the Memory Care Unit. According to CNA A, she completed training with CNA B, and during her training she heard CNA B be verbally aggressive with residents during their care. CNA A stated when CNA B would say something or give directions, residents would jump, or act scared when she would tell them to do something. CNA A stated you she could tell Resident #1 was uncomfortable being around CNA B. CNA A stated, When [Resident #1] refused to be changed, [CNA B] grabbed the back of his neck and held him down in a choke hold saying out loud 'you better get in there, now'. According to CNA A, she did not intervene, she did not say anything to CNA B about being verbally or physically abusive, and she did not report the incident to RN G or the Abuse Coordinator. CNA A stated she did not intervene because she was scared of CNA B stating she was a big girl and could beat me up. CNA A stated, I seen her speak loudly, aggressively and get up into staff face, and they have not done anything to her. They let her work here. CNA A stated from the time she started a week ago, she had observed CNA B's behavior and felt that this abuse had been going on before she arrived. She stated no one was doing anything about it. CNA A stated RN G had heard CNA B speaking rudely to residents but did nothing to protect the residents. CNA A stated CNA B had friends and family that worked in the facility, so she did not know who she could trust in the facility. CNA A stated she felt if she reported the abuse to staff, the facility would retaliate against her, and she would be terminated. According to CNA A, she discussed her observations of abuse with CNA E and Hospitality Aide F, and they encouraged her not to report to the facility but to an outside entity. CNA A stated she was aware abuse should be reported to the Abuse Coordinator; however, she feared retaliation. CNA A stated she recently had an in-service covering abuse and neglect, and she was aware she was supposed to report it. CNA A stated not reporting abuse placed residents at risk of harm and endangerment. Interview on 04/27/24 at 6:27 PM with CNA E revealed she was not aware of any abuse in the Memory Care Unit. CNA E stated CNA A did not tell her about seeing any abuse in the facility, nor had CNA A told her that CNA B abused Resident #1. Interview on 04/27/24 at 6:52 PM with Hospitality Aide F revealed he was not aware of any abuse in the Memory Care Unit by CNA B. Hospitality Aide F stated CNA A did not report she observed CNA B abuse Resident #1. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/27/24 at 7:05 PM with the Administrator revealed she had not had any allegations of abuse reported to her. The Administrator was not aware of the alleged incident involving Resident #1 and CNA B until surveyor inquiry on this date. The Administrator stated she recently completed an in-service over abuse and neglect. The Administrator stated both CNA A and CNA B had worked in the Memory Care Unit. She stated CNA A was a new hire, who started last week. The Administrator stated RN G was the charge nurse on the 2:00 PM-10:00 PM shift and had been a previous DON and worked as a nurse for several years and would not allow any abuse. The Administrator stated she recently spoken with CNA A to see how things were going in the facility and open the floor to report anything good or bad she had noticed in the facility. She explained this was part of their new hire process to follow-up with new hires, and CNA A did not report anything to her when she spoke with her. The Administrator stated it was her expectation for all staff to report observations of abuse immediately. The Administrator stated her phone number was posted outside her door, and if staff could not reach her in a timely manner, the expectation was to contact the Director of Nursing or on the weekend they were to contact the manager on duty. The Administrator stated the on-call phone was also available for reporting. The Administrator stated not reporting abuse placed residents at risk of weight loss, isolation, along with other negative effects. The Administrator stated upon hire it was revealed CNA A worked for their company in a sister-facility and was terminated due to CNA A making false accusations simliar to the ones she was now making. Record review of CNA E and Hospitality Aide F's time sheets revealed they were not in the facility at the time of the alleged incident. CNA E's shift ended at 2:30 PM on 04/24/24, and Hospitality Aide F was not scheduled to work on 04/24/24. Review of the facility's policy titled Abuse/Neglect, revised 03/29/18, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.