

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 07/24/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507</p> <p>Based on interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 2 (Resident #10 and Resident #11) of 9 residents reviewed for ADL care.</p> <p>The facility failed to ensure Resident #10, and Resident #11 were provided showers as scheduled.</p> <p>These failures could place residents at risk of not receiving services and a decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #11's admission record, dated 07/23/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, end stage renal disease, muscle weakness, and dependence on renal dialysis.</p> <p>Record review of Resident #11's Quarterly MDS dated [DATE], reflected a BIMS score of 14, indicating intact cognition. Further review of the MDS revealed Resident #11 required partial/moderate assistance for showering/bathing.</p> <p>Record review of Resident #11's Care plan, undated, did not indicate resident refused showers.</p> <p>Record review of Resident #11's nurse notes from 03/30/2024 to 06/02/2024 did not indicate resident refused showers.</p> <p>Record review of Resident #11's April 2024 ADL sheets reflected shower days were Monday, Wednesday and Friday and pm. Resident #11 received 4 out of 12 showers in April 2024. Showers were given on 04/22/24, 04/24/24, 04/26/24, and 04/29/24. On 04/03/24 and 04/12/24 there were blanks on the ADL sheet. On 04/01/24, 04/05/24, 04/10/24, 04/15/24, 04/17/24, and 04/19/24, 8, 8 was entered on the ADL sheet indicating activity did not occur.</p> <p>Record review of Resident #11's May 2024 ADL sheets revealed Resident #11 received 4 out of 13 showers in May 2024. Showers were given on 05/06/24, 05/08/24, 05/10/24, and 05/27/24. On 05/01/24, 05/03/24, 05/13/24, 05/17/24 and 05/24/24 there were blanks on the ADL sheet. On 05/15/24, 05/20/24, 05/22/24, and 05/29/24 an 8, 8 was entered on the ADL sheet indicating activity did not occur.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #11's nursing progress note, dated 06/02/2024, revealed [Resident #11] discharge to home.</p> <p>Record review of Resident #10's admission record, dated 07/24/2024, revealed a [AGE] year-old-male who admitted to the facility on [DATE] with a diagnosis of paraplegia.</p> <p>Record review of Resident #10's Quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating intact cognition. Further review of the MDS revealed Resident #10 required supervision or touching assistance with showering/bathing.</p> <p>Record review of Resident #10's May 2024 ADL sheets reflected shower days were Monday, Wednesday and Friday and prn. Resident #11 received 2 out of 11 showers in May 2024. Showers were given on 05/01/24 and 05/29/24. On 05/17/24 there was a blank on the ADL sheet. On 05/03/24, 05/08/24, 05/10/24, 05/13/24, 05/15/24, 05/20/24, and 05/22/24 an 8, 8 was entered on the ADL sheet indicating activity did not occur.</p> <p>Record review of Resident #10's June 2024 ADL sheets revealed Resident #11 received 2 out of 12 showers in June 2024. Showers were given on 06/21/24 and 06/29/24. On 06/10/24, 06/14/24, and 06/19/24 there were blanks on the ADL sheet. On 06/03/24, 06/05/24, 06/07/24, 06/12/24, 06/17/24, 06/24/24, 06/26/24 and 06/28/24 an 8, 8 was entered on the ADL sheet indicating activity did not occur.</p> <p>Record review of Resident #10's July 2024 ADL sheets revealed Resident #11 received 7 out of 11 showers in July 2024. Showers were given on 07/03/24, 07/05/24, 07/10/24, 07/11/24, and 07/17/24, 07/21/24 and 07/22/24. On 07/12/24, and 07/24/24 there were blanks on the ADL sheet. On 07/01/24, 07/08/24, 07/10/24, 07/15/24, 07/19/24 an 8, 8 was entered on the ADL sheet indicating activity did not occur.</p> <p>Record review of Resident #10's nursing progress notes from 05/01/2204 through 07/23/2024 did not indicated refusal of showers.</p> <p>Interview on 07/24/2024 at 10:42 am, Resident #10 stated he does not get showers 3 times a week. He stated one of the CNA's will make sure he gets a bed bath when he works. Resident #10 stated his shower days were Monday, Wednesday, and Friday. Resident #10 stated the last time he had a shower or bed bath was on Monday (07/22/24).</p> <p>Interview on 07/24/2024 at 1:34 pm the ADON stated even numbered rooms had shower days on Monday, Wednesday and Friday and odd numbered rooms had showed days on Tuesday, Thursday and Saturday. The ADON stated 6a-2p shift provided A bed showers and 2-10p shift provided B bed showers. She stated the CNA's showered residents, and they documented in POC. She said if a resident refused a shower, the CNA was supposed to go back and try again 3 times, then inform the nurse so the nurse will ask the resident. She said if the resident still refused then the nurse would document the refusal in a progress note. She stated CNAs were required to document when a shower was given or when refused and the IDT team checks POC for documentation. She stated if any documentation was missing the IDT team would go back to the staff to remind them to document.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 07/24/2024 at 2:17 pm CNA C stated if a resident refused a shower she would document, let the nurse know and tell the ADON. When asked about the blanks on the ADL sheet for Resident #11, she stated the showers were not given. When asked about the 8 activity did not occur she stated that meant a refusal. She stated MDS provided training for the CNA's on how to document ADL care.</p> <p>Interview on 07/24/2024 at 2:35 pm, MDS Coordinator A stated they had done some training for CNAs on documentation related to ADL care. She said there was a different numbering system from 1-6, and CNAs would chart if the resident was independent, supervision, limited, extensive and total dependence, if activity did not occur or refused. When asked about the blanks on the ADL sheets, she stated she assumed the showers were not given. When asked about the code of 8 activity did not occur she stated she would talk with the other MDS Coordinator.</p> <p>Interview on 07/24/2024 at 2:47 pm, the DON stated his expectation was if the resident got a shower, CNAs was supposed to document they were given one. If the resident refused, the CNA needed to let the nurse know. He stated if the resident kept refusing, they had to care plan that. He said it was important to document showers were given or refusals for reference and to know if the shower was given. He said the unit manager monitored that showers were given, and documentation was done. The DON said they did not have a policy on showers, just the schedule.</p> <p>Interview on 07/24/2024 at 2:55 pm, MDS Coordinator B stated there should have been some documentation on the blank spots on the ADLS sheets. She said if the CNA coded it at an 8, it could have meant a number of things, like the resident refused or was out of the facility.</p> <p>Interview on 07/24/2024 at 3:00 pm, CNA D she did not give Resident #11 or Resident #10 showers. She said if a resident refused a shower, she would leave then come back and try 3-4 times before she told the nurse. When asked if she documents the refusals, she said it only gives you 2 options either the shower or refused. She stated it was important to document to explain whether the person refused or did get a shower.</p> <p>Record review of facility policy titled Bed bath, Complete undated, and Bath, Tub/Shower undated, reflected the procedure for a bed bath and shower, but did not reflect to document showers or refusals.</p>		

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<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>48122</p> <p>Based on observations, interviews, and record review the facility failed to ensure the resident environment remained free of accident hazards as was possible for 1 of 1 secured unit dining room reviewed for accidents and hazards.</p> <p>The facility failed to ensure residents who used the dining/activity room in the secured unit were free of hazards, when a window air condition unit cord was loose while plugged into a live extension cord coiled unsecured above a doorway.</p> <p>This failure could place residents at risk for accidents or injuries resulting from hazards in the facility.</p> <p>Findings included:</p> <p>Observation on 07/23/2024 at 12:22PM of the secured unit dining/activity room revealed approximately 22 residents who were seated at tables waiting on lunch trays to be served by staff. A table that was pushed against the wall by the door to the secure courtyard had three residents seated. The window unit was directly beside a resident chair with the loose cord hanging down near the floor and curved upwards attached to an extension cord that could be easily reached by residents. The extra length of extension cord was coiled and resting above the door while being plugged in to a live outlet. The extension cord was loosely secured to the wall by one piece of tape. The extra length of the extension was not secured in any way visible. There were two large temporary units in the main hallway by either entrance to the dining/activity room, with output tubes pointed towards the dining/activity room and vented through the central HVAC return air ducts that were in operation.</p> <p>Interview on 07/23/2024 at 1:33 PM with CNA E revealed that the window air conditioning unit had been installed for about a week in the dining/activity room due to the wall air conditioning unit going out. The window unit had been installed due to the high temperatures outside and rising temperatures in the dining/activity room. CNA E stated that there were no suicidal residents in the secured unit that she was aware of. When asked about potential hazards of unsecured or lose power cords or cables, CNA E stated that residents could have used to choke themselves or others or used to hit or injure themselves or others. CNA E reported that maintenance had removed the window unit and extension cord at 2:00 PM on 7/23/2024 and window was closed.</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 - Some</p>	<p>In an interview on 07/23/2024 at 4:25 PM with the ADM revealed that the secure unit had a temporary window unit installed by maintenance due to the wall unit not operating and temperatures rising in the dining/activity room. The ADM stated that the facility was waiting for the larger temporary air conditioning units to be placed in the secure unit and the window unit was to keep the area as cool as possible. The ADM stated during the interview that there were no suicidal residents currently on the secure unit however Resident 12 had threatened suicide when staff attempted to integrate off unit or offered lunch in the main dining room. When asked, the ADM stated that extension cords should not be used in resident areas of the facility. The ADM stated that every 2-3 Fridays the staff conducted a shake down of the facility for removal hazardous or prohibited items including extension cords. When asked about the window air conditioning unit extension cord in the secure unit, the ADM informed that she was aware the air conditioning unit had been installed however had not noticed the extension cord or lack of the cords having been secured for resident safety. The ADM stated that facility maintenance would have been responsible for installation of the window air conditioner and to monitor for proper working condition and safety. The ADM stated that safe resident environment was the responsibility of all staff and that any hazards should have been reported immediately when discovered.</p> <p>Interview on 07/24/2024 at 9:19 AM with CNA F revealed that there were no suicidal residents on the secure unit that she had been aware of. CNA F stated that unsecured cords or extension cords may have been a hazard as residents could have chewed on the live power cords and been electrocuted, used as a weapon, or could have become entangled in the cord and had a fall. CNA F shared that a resident who had a diagnosis such as dementia, impulse disorder, TBI (traumatic brain injury), or bipolar disorder could have been at a greater risk of injury from access to loose cords or cables.</p> <p>Interview on 07/24/2024 at 9:37 AM with CNA G informed that extension cords and loose power cables should have not been used or found in the secure unit. CNA G stated that residents with diagnosis such as dementia, bipolar disorder, or impulse disorders would have been at a high risk as it could not have been predicted what the resident would have been thinking or planning to do. CNA F stated that it was responsibility of all staff to watch for and report any hazards to residents.</p> <p>Interview with LVN H at 9:55 AM on 07/24/2024 revealed that loose cables and extension cords could have been a hazard to secure unit residents and that all employees of the facility were responsible to look out and report any hazard seen. LVN H said that residents with diagnosis such as dementia, bipolar disorder, or impulse disorder would have been at a higher risk for injury from loose cables or extension cords and that any cords or cables were to have been out of reach or inaccessible to residents.</p> <p>Interview on 7/24/2024 with MTNC I revealed that unsecured cables or extension cords were a hazard in the facility as they could have caused a trip/fall or choking injury. MTNC I expressed that use of extension cords or having loose cables in the secure unit would have been alerting since the people there may have dementia and may not know what they are doing or become confused and hurt themselves or someone else with the cord or cable. MTNC I stated that extension cords were not used very often in the facility due to risks and only used in this instance in the secure unit due to the air conditioning unit in the wall having malfunctioned and was a temporary fix due to the hot weather. MTNC I shared that the temperature in the dining/activity room of the secured unit had been getting over 75 degrees and the temporary window unit was used to prevent residents from becoming too hot with the summer weather outside reaching temperatures in the high 90s. MTNC I stated this was the first time a window air condition unit had needed to be used for the secure unit dining/activity room.</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 - Some</p>	<p>Interview on 7/24/2024 at 1:32 PM with DON revealed that loose cables or extension cords were a hazard to residents as there could have been an electric shock or a fall. The DON stated that staff were expected to remove any extension cords or secure as best could any loose cables or extension cords. The DON stated that staff should immediately report a hazard to maintenance and enter in the maintenance log at the reception desk the hazard after having secured the area. The DON stated that it had been a rare occurrence the facility used a temporary window air conditioning unit as they typically used the larger portable units in the hallways. The DON stated the temporary unit in the secure unit dining/activity room was due to the high heat and numerous windows in the room causing the room and residents to have been warm and there was to have been a staff member in the dining/activity room at all times to monitor residents utilizing the room.</p> <p>Record review of the facility's policy titled Resident Rights, undated, stated in section Safe Environment that a resident has a right to a safe, clean, comfortable and homelike environment . and b.the facility maximizes resident independence and does not pose a safety risk.</p>		