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	12/04/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 1 of 4 residents (Resident #5) reviewed for preadmission screenings. The facility failed to refer Resident #5 for PASRR Evaluation after a positive Level 1 PASRR 1 screening. This failure could place residents at risk of receiving inadequate care. The surveyor was unable to interview and observe Resident #5, as he was discharged on [DATE]. Record review of Resident # 5's face sheet dated 12/04/24 revealed that he was a 68 -year-old male who admitted to the facility on [DATE] and discharged on [DATE]. His active diagnosis included: cognitive communication deficit (difficulty communicating caused by cognitive impairment), anxiety disorder (fear and worrying) and depression disorder (mood of sadness). Record review of Resident #5's Admission MDS dated [DATE], reflected a BIMS score of 12 indicating that he was moderately impaired cognitively. Section D addressed the resident's depression and feeling down with a total severity score of 3, indicating minimal depression. Review of Section N addressed Resident #5's MD orders for anxiety and depression medications. Record review of Resident #5 's care plan dated 10/25/24 did not address his positive PASRR Level I for mental illness at the time of his admission. Record review of Resident #5's MD orders on 12/04/24 reflected a referral for Psychiatric assessment. There were no orders for therapy, medication management for depression and anxiety noted. Record review of Resident #5's Level 1 PASRR screening for dated 10/24/24 indicated he had a mental Illness on Section C0100, and it was not documented in Resident #5's electrical file at the time of his admission. At the time of investigation 12/03/24 there was no documentation addressing the resident PASRR process for PASRR Level 1 and PASRR Level 2. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's Trauma informed dated 10/31/24 completed by the SW reflected score of 40. 0 indicating he had a history of homelessness, mental disorders, anxiety, depression, Life threatening illness, serious accident resulting in limited mobility, fear, Got into some bad drugs, and believed I witchcraft., concluding that he had multiple life events that was affecting his mental status. Record review of Resident #5's consent for services with Psychiatric [NAME] Service dated 10-31-24 reflected A recommendation and referral for services has been made to Psychiatric Consult Service by your treating physician for specialized care of your emotional and mental health. Our office, according to your respective insurance carrier, will bill fees for services .With this understanding, I [Resident #5] give consent for services and request that payment under my medical signed by [Resident #5]. Indicating that Resident #5 was referred for mental health services based on mental health illness documentation from his positive PASRR, and trauma informed social history assessment dated [DATE]. The facility did not have an active social worker at the time of the investigation, therefore there was no interview. Interview with the ADM on 12/04/24 at 3:52 PM, she stated she was a licenses Social Worker, and she was covering social worker task until the position was filled. She was aware that Resident # 5 was diagnosed with bipolar disorder, and the facility was to notify the stated appointed local authority within 24 to 48 hours after admission of the positive PASRR Level 1. The ADM stated that she had not received any training on the PASRR process, and the MDS was responsible for all notifications and documenting information in the resident file of the completed task. The ADM said that the risk of not following the PASRR notification process, following up with third party referral, and documenting service task and timelines in the resident's file could result in untimely mental health treatment, increased anxiety and depression, and behaviors. The Administrator stated that it was her responsibility and the corporate nurse to ensure all clinical task were completed timely. Interview on 12/04/24 at 4:05 PM with the MDS Coordinator RN-L and LVN -A revealed that she was not aware of the timeline or the facility policy notifying state dedicated authority for positive Level I PASRR residents. She will go and review the policy. RN-L returned and stated that the facility policy states that the level 1 PASRR positive are uploaded by the MDS coordinator to Simple LTC and wait for the local authority to respond RN L said after reviewing her emails, she found an email correspondence dated 10/28/24, from the local authority that the PASRR email was received. RN-L said she did not follow up with the agency nor documented the email. RN-L said that the potential risk to a resident for not ensuring the referral process was documented and completed could result in resident not receiving the necessary services for mental illness. Record review on 12/04/24 of corresponding email provided by RN-L from HCDS dated 10/28/24 at 4:04 AM reflected Please provide me with the Face Sheet, order summary, Care Plan, MDS, and Clinical's (Hospital) for the following individuals in your facility: [Resident #5]. After receiving the above information, PASRR will try to schedule a time and date with the facility to come. The PE evaluation document was not filed in Resident # 5's medical records. Record review of RN-L dated 12/04/24 at 5:09 PM reflected below is the email communication with [local state authority] regarding scheduling of [Resident #5's] PE prior to his discharge. The PE evaluation document was not filed in Resident # 5's medical records. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the interview with RN-L dated 12/04/24 at 5:25 PM stated that as I was looking closer, [Resident #5] did indeed have the PE completed prior to discharging. I just didn't register it when I was looking in SIMPLE, I apologize. It was completed 11/01/24, and he was deemed negative. The PE is attached. Record review of Resident #5's PASRR Evaluation reflected that the MI evaluation was initiated on 10/30/24 completed by QMHP reflected in Section C that C0100 Primary DX of Dementia and C0200 severe Dementia Symptoms were answered no. C0600 was answered yes for Disruption in normal living situation requiring supportive services in the last 2 years. C0700 was answered yes for intervention by law enforcement. C0800 reflected based on the QMHP assessment, does this individual meet PASRR definition of mental illness, no. The date that this document was printed from https://secure.simpleltc.com/State/PL1/viewPE/1831208 dated 12/04/24 at 5:23 PM. This file was not in the resident medical records at the time of the investigation, and it was emailed prior to exit 12/04/24 at 5:45 PM. Record review of the facility's titled PASRR Maintenance in the Active Paper Medical Record dated January 2018. Policy: It is the policy of this facility to ensure all PASRR Related forms and communication is maintained in the Resident's Medical Record under the PASRR Tab of the chart or electronically stored in the LTC Portal. PASRR record retention is permanent until informed otherwise. Person Responsible: Medical Records Procedure. The following records will be filed under the PASRR Tab of the medical record: Referring Entity (RE) PASRR Level (PL1) Screen for all Positive and Negative suspicion of MI. This includes NF PL1 and RE PL1's. If the Residents is PASRR positive the following forms will follow: LA (Local Authority) PASRR Evaluation (PE) Form for all confirmed Negative or Positive PE Forms. (Obtained from the LA). LA 1014 or Individual Service Plan (ISP) Forms. (Obtained from the LA). IDT Meeting (Printed from Simple LTC along with any handwritten notes or the handwritten IDT form prior to data entered and submitted to Simple LTC) LA PSS (PASRR Specialized Service) (if applicable): Habilitative Therapy Communication Progress Notes: All communication to any outside entity regarding PASRR must be documented in PCC under Progress Notes, Printed and Placed in the MR under the PASRR Tab. This includes anytime communication occurs between the NF (Nursing Facility) and LA (Local Authority) or DME/CMWC (Durable Medical Equipment/Customized Manual Wheelchair) Vendors, the communication must be documented. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of state operations manager GUIDANCE S483.20(k)(1)-(3) The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities, and related conditions. This initial screening is referred to as Level I Identification of individuals with MD (mental disorder), ID (intellectual Disorder), (S483.128) and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identity individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility. Level II PASARR is a comprehensive evaluation conducted by the appropriate state designated authority that determines whether an individual has MD (mental disorder), ID (intellectual Disorder), or a related condition as defined above, determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs. The Level II PASARR cannot be conducted by the nursing facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review, the facility failed to develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care that was developed within 48 hours of resident's admission for 1 (Resident #5) of 4 residents reviewed for baseline care plans. The facility failed to ensure Resident #5's baseline care plan addressed his Level 1 PASSR, mental illness, anxiety, and depression within 48 hours of resident's admission. This failure could place the residents at increased risk of not having their individual needs identified, met and a decreased quality of life. Findings included: The surveyor was unable to interview and observe Resident #5, as he was discharged on [DATE]. Record review of Resident # 5's face sheet dated 12/04/24 revealed that he was a 68 -year-old male who admitted to the facility on [DATE] and discharged on [DATE]. He had an active diagnosis of cognitive communication deficit (difficulty communicating caused by cognitive impairment), anxiety disorder (fear and worrying) and depression disorder (mood of sadness) with an onset date of 10/24/24. In a record review of Resident #5's Admission MDS dated [DATE], reflected a BIMS score of 12 indicating that he was moderately impaired cognitively. Section D addressed the resident's depression and feeling down total severity score of 3 indicating minimal depression. Section N addressed the residents MD orders for anxiety and depression medications. In a record review of Resident #5 's baseline care plan and comprehensive care plan dated 10/25/24 reflected the had cognitive loss impaired cognitive function, interventions administer medications as ordered, communicate with resident/family/caregivers regarding resident capabilities and needs, dated 11/04/24. The care plan does not address resident did not address his positive PASRR Level I for mental illness, anxiety disorder, and depression disorder. The facility does not currently have a DON; therefore, an interview was not completed. In an interview on 12/04/24 at 3:52 PM with the ADM revealed due to the facility not having an onsite DON nurse or a dedicated nurse to complete care plans, all facility nurses, including herself were responsible for baseline care plan initiation and completion. The ADM stated that she expects the baseline care plan to be accurate and individualized to provide the necessary care to the resident to prevent a decline in abilities. The ADM stated that it was the responsibility of the DON, IDT meeting, and ADM to monitor and ensure that baseline care plans are completed timely. The ADM stated that the corporate nurse was visiting the building in the interim until a DON was hired. She has been using the MDS coordinator to assist with DON duties. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with MDS RN L on 12/04/24 at 4:05 PM, she stated that she was not responsible for monitoring care plans in the interim of DON hiring. She stated that she completed MDS assessments and occasionally answers nursing protocol clinically for the facility. She said the corporate nurse was visiting the building daily and remote to respond to daily clinical concerns. The corporate nurse was not interviewed as she was in a meeting off site. Record review of facility policy entitled Comprehensive Resident Centered Care Plans, undated Comprehensive Care Planning, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR and the resident's representative(s)-The resident's goals for admission and desired outcomes. Comprehensive Care Plans: A comprehensive care plan will be-Developed within 7 days after completion of the comprehensive assessment. Prepared and/or contributed to by an interdisciplinary team, that includes but is not limited to- The attending physician. A registered nurse with responsibility for the resident. A nurse aide with responsibility for the resident. A member of food and nutrition services staff. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation will be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.