

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 12/23/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444</p> <p>Based on interviews, and record review, the facility failed to ensure that all drugs and biologicals were accurately dispensed and administered to meet the needs of each resident when 1 (Resident #5) of 3 residents were reviewed for pharmaceutical services.</p> <p>The facility failed to ensure Resident #5 did not miss a dose of antibiotic medication that was to be administered on 12/21/24.</p> <p>This failure could place residents at risk of not receiving their medications as ordered by their physician.</p> <p>Review of Resident #5's Face Sheet, dated 12/23/24, reflected Resident #5 admitted [DATE] with paraplegia (paralysis in lower half of body) and right femur (large bone in upper leg) chronic osteomyelitis (bone infection).</p> <p>Review of Resident #5's Physician Order, dated 12/20/24, reflected an order for Vancomycin (antibiotic that treats infection caused by bacteria) intravenous (administer directly into a person's vein) solution 750 mg plus 500 mg = 1250 mg intravenously every 12 hours (at 09:00 AM and 09:00 PM) for osteomyelitis until 01/07/25.</p> <p>Review of Resident #5's Comprehensive Care Plan, dated 12/04/24, reflected Resident #5 had intravenous access and received antibiotics for osteomyelitis. One intervention was to administer the intravenous medications as ordered and flush lines/ports as ordered.</p> <p>Review of Resident #5's Quarterly MDS (tool used to assess health status) Assessment, dated 11/28/24, reflected Resident #5 was cognitively intact with a BIMS (tool to assess cognitive status) score of 15 and treated with intravenous antibiotics for a surgical wound.</p> <p>Record review of Resident #5's Medication Administration Record, dated 12/23/24, reflected Resident #5 did not receive the scheduled 09:00 PM dose of Vancomycin on 12/21/24. Resident #5's physician and infection disease doctor were notified of the missed dose and the ADON documented it in Resident #5's chart.</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 12/23/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/23/24 at 03:15 PM, the ADON opened Resident #5's medication administration record and stated Resident #5 did not receive the 09:00 PM dose of Intravenous Vancomycin on 12/21/24. The ADON stated the nurse on Resident #5's hall worked from 6:00 AM-08:00 PM on 12/21/24. She stated the nurse verified the medication counts and handed the facility keys to the unit nurse at 08:00 PM. When a telephone number was requested, The ADON stated the unit nurse works nights, and she calls the unit nurse at the facility when she needs to speak with her. The ADON stated the facility was short on staff over the weekend and the ADON worked the night shift on 12/21/24. She stated Resident #5 came to the nurse's station about 02:00 AM and stated he did not get his evening dose of Vancomycin. The ADON stated she told Resident #5 it was not in the window of time to administer the medication. She stated medications can be given an hour before or an hour after the prescribed time. The ADON stated she told Resident #5 he would receive the next dose at 09:00 AM that morning on 12/22/24. The ADON stated Resident #5's primary doctor was notified of the missed dose. She stated she also notified Resident #5's infectious disease doctor who was prescribing the Vancomycin dose. The ADON stated missing a dose of the prescribed antibiotic could delay the healing process and potentially cause more harm. She stated missed doses could result in the resident having to go back to the hospital. The ADON stated her expectation of staff was to administer all medication when it was due. She stated she would in-service staff about this failure.</p> <p>In an interview on 12/23/24 at 03:35 PM, the Regional Compliance Nurse stated her expectation was for all medications to be administered as ordered. She stated, we are taking action to be sure this doesn't happen again. She stated Resident #5's primary physician was notified of the missed dose. She stated the infectious disease doctor prescribing the antibiotic dose was notified as well.</p> <p>In a telephone interview on 12/30/24 at 12:25 PM, the Human Resources Director provided the unit nurse's cell phone number. An attempt to contact the unit nurse's phone revealed an automated message stating the person you are calling is not accepting calls at this time. We apologize for any inconvenience. The call was disconnected and there was no opportunity to leave a voicemail.</p> <p>Review of the facility's policy titled Medication Administration Procedures, revised 10/25/17, reflected defining the schedules for administering medications to maximize the effectiveness (optimal therapeutic effect) of the medication and The 10 rights of medication should always be adhered to:</p> <ol style="list-style-type: none"> 1. Right patient 2. Right medication 3. Right dose 4. Right route 5. Right time 6. Right patient education 7. Right documentation 8. Right to refuse <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 12/23/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9. Right assessment</p> <p>10. Right evaluation</p>