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	02/11/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on interviews, observations, and record review, the facility failed to ensure the residents' right to be free from abuse for one (Resident #2) of five residents reviewed for abuse. The facility failed to prevent Resident #2 from being abused by Resident #1 on the secure unit, who had a history of being verbally and physically aggressive to other residents. Resident #1 physically attacked Resident #2 which resulted in him being sent to the hospital and sustained a serious injury to his right eye on 12/29/24. The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 12/29/24 and ended on 12/29/24. The facility corrected the non-compliance before surveyor's entrance. This failure could place all residents at risk for abuse that could lead to serious injury, harm, impairment, or death. Findings included: 1. Record review of Resident #1's face sheet, dated 01/16/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses which included: Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skill), unspecified, unsteadiness on feet, cognitive communication deficit, personal history of transient ischemic attack (a short period of symptoms similar to those of a stroke), and cerebral infarction (stroke) without residual deficits and personal history of traumatic brain injury (a head injury causing damage to the brain by external force or mechanism. It causes long term complications or death). Record review of Resident #1's quarterly MDS assessment, dated /30/24, reflected his BIMS score was 08, which indicated moderate cognitive impairment. Resident#1 coded behavior for wandered daily. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, initiated 06/06/24 and revised 10/25/24, reflected: the resident was at risk for behaviors: [Resident#1] has a potential for maladaptive behaviors .Physical aggression toward others .Verbally aggressive. Interventions included intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Administer medication as ordered. Monitor/document for side effects and effectiveness. Record review of Resident#1 progress notes dated 05/09/24 to 01/16/25 reflected, Resident#1 had a history of being physically and verbally aggressive towards staff and residents. Progress notes reflected the incident on 12/29/24 was the first time a resident needed to be sent out to the hospital. On 07/04/24, LVN B reported: Resident verbally abusive with other residents calling them idiots and zombies On 07/09/24, LVN A reported: Ambulating in hall and stopped to yell at another resident that was confused On 7/12/24, LVN B reported: Resident yelling at other residents calling them idiots and stupid this nurse reminded resident that he needs to respect the other residents On 07/19/24, LVN B reported Resident yelling at another resident calling him a retard zombie resident redirected, resident walked away. On 08/12/24 LVN B reported Resident mocking other residents CNA explained to resident that he needed to stop that behavior . Resident yelling at resident from room [Resident#1] states I will kick his ass if he comes to my room . On 08/14/24, SSD reported SSD submitted referral to [Psy MD] for psych consult. On 08/20/24 LVN B reported On Gabapentin 300 for aggressive behavior, resident yelling at residents at dining room table. On 09/02/24, LVN B reported Resident verbally abusive with other residents On 09/04/24, SSD reported IDT team care plan carried out by [DON, DOR, ADON], . Family seeking possible admission to all male unit, wanting to stay localized, per family request . Referral sent to [Facility] per family request. On 10/20/24, LVN A reported [Resident#1] was observed unbuttoning and unzipping his jeans. He pulled his penis out and urinated on the floor. When ask to stop and go to his room he started yelling at staff. He was informed by this nurse . rest room. he was informed besides exposing himself to non-employees that it created a danger to residents staff. On 10/23/24, P Admin reported Resident observed displaying agitating and aggressive behavior towards staff and other residents. On 12/26/24, reported by LVN A [Resident#1] behaviors is getting worse and he is getting more aggressive both physically and verbally. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes and incident report in the EHR, dated 12/29/24 by LVN C , reflected: Nursing description: This nurse called to hallway when heard hollering and yelling, resident as on floor bleeding, when I approach him, he said he was ???? [sic]unable to comprehend, Full body assessment laceration on his head and eye area. Called 911 and police and advised admin and other in group text also called them, contacted [Family member], left message to call. Police came [PD #] to get report, and info. then EMS came and evaluated and took to [Hospital]. [Resident#1] stated he did nothing, the whole incident was witnessed by Housekeeping, had her write out a statement. Description of action taken: Immediately look to see where blood was coming from head and right eye. Record review of LA A's handwritten statement dated 12/31/24 reflected: To whom it may concern [LA A] was present when [Resident#1] was yelling down the hall he assaulted me. As [LA A] was putting linens in the closet on the unit. [LA A] looked down the hall and saw [Resident#1] push [Resident#2] down causing him to bleed. [LA A] yelled out for the nurse and she assisted [Resident#2]. Resident 21 was transported to hospital. Record review of police report, dated 12/29/24, reflected: injured persons report by [Resident#1] to [Resident#2]. Record review of Psy consults reflected: Record review of Psy consult, dated 10/28/24 reflected, Resident#1 increase Gabapentin for aggressive behavior. Continue Lexapro for depression. 10 mg, 1/2 tablet PO QD. Increase Neurontin 300 mg PO BID. Record review of Psy consult, dated 12/09/24 reflected Resident#1 started Depakote 250 mg, BID. Record review of Resident#1 January MAR reflected Resident#1 had received medication as ordered: Aricept Tablet 10 MG (Donepezil HCl) Give 1 tablet by mouth one time a day for Dementia. Depakote Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for Seizures and Aggressive Behaviors related to other seizures. Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for Aggressive behavior. 2. Record review of Resident #2's face sheet, dated 01/17/25, reflected an [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, muscle weakness (generalized), cognitive communication deficit, personal history of transient ischemic attack (a short period of symptoms similar to those of a stroke), and cerebral infarction (stroke) without residual deficits. Record review of Resident #2's quarterly MDS assessment, dated 12/30/24, reflected his BIMS score was 04, which indicated severe cognitive impairment. Resident#2 coded behavior for wandered daily. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan, revised 9/30/24, reflected Resident#2 had behavior problem r/t dementia. Physical aggression towards other. Interventions included: Administer medications as ordered. Monitor/document for side effects. Record review of Resident#2's hospital records dated 12/29/24 reflected: Resident#2 had right forehead with small laceration, large medial lower lid laceration. Lower puncta was displaced for temporally, past the midpoint of cornea. Resident#2 had to have right lower eyelid canalicular repair, repair of laceration on 01/02/25. Record review of Resident #2's December 2024 progress notes reflected: On 12/29/24, LVN C reported [Resident #2] Full body assessment laceration on his head and eye area. Called 911 . PD Incident report [number]. On 12/30/24, LVN C reported [Resident#2] returned from [Hospital] Resident has sutures to right eye and head from his injuries on 12/29/24. On 01/02/25 resident returned from surgery has instructions for eye care and next 2 appointments this month. In an interview on 01/16/25 at 1:21 PM, LVN D stated she worked at the facility for almost 3 weeks. Resident #1 was on Q15 monitoring since the incident on 12/29/24 with Resident#2. LVN D did not see the incident on 12/29/24. LVN D stated she has not witnessed any behaviors since the incident. In an interview on 01/16/25 at 1:25 PM, CNA E stated she has worked in the facility for 3 months and Resident #1 had been verbally and physically aggressive toward residents and staff. CNA E did not witness the incident on 12/29/24. Resident#1 has been verbally aggressive and physically aggressive towards staff and verbal aggressive to residents CNA E stated she would redirect residents and the nurse on duty documents the Q15 monitoring. CNA E stated in the secure unit staff had to pay attention and stay alert to care for the residents. In an interview on 01/16/25 at 1:45 PM, LA A stated she heard two residents yelling at each other and saw Resident#1 push Resident#2. Resident#2 fell face first and it was a lot of blood. LA A stated she called for help and the nurse came and provided help. LA A stated she had not witnessed more behaviors recently. LA A stated she would yell for help for a nurse when residents were being verbally/physically aggressive to each other. Attempted to call LVN C on 01/17/25 at 5:40 PM and voicemail box was full. Attempted to call LVN B on 01/17/25 at 5:42 PM and left voicemail. Attempted to call LVN A on 01/17/25 at 5:45 PM and left voicemail. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Abuse/Neglect, revised 03/2018, reflected in part the following: Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, Definitions . Abuse is the willful infliction of injury . Willful, as used in this definition of abuse, means the individual must have acted deliberately . C. Prevention The facility will provide the residents, families, and staff an environment free from abuse and neglect. The non-compliance was identified as past non-compliance (PNC). The IJ began on 12/29/24 and ended on 12/29/24. The facility had corrected the non-compliance before the state's investigation began. On 02/11/25 at 1:00 PM the Administrator, DON and Corporate Nurse were notified of the PNC IJ. The facility took the following actions to correct the non-compliance prior to the survey: Record review of incident/accident reports, from 12/19/24 to 02/11/25, reflected no other incidents involved Resident#1. Record review of in-service dated 12/29/24, reflected behavior management by DON to all staff members. Record review of Q15 monitoring dated 12/29/24 to 01/07/25, by LVN C and LVN D showed Resident#1 was checked on every 15 minutes and no behaviors were documented. Record review of order recap report dated 01/30/25 reflected, Depakote oral tablet delayed release 500mg (Divalproex Sodium) Give 1 tablet by mouth two times a day for Seizures and Aggressive Behaviors related to other seizures was increased by PCP. In an interview on 01/16/25 at 3:00 PM the Administrator and the DON stated the Administrator had worked in the facility since 12/29/24 and the DON had worked in the facility since 12/20/24. The and the DON stated Resident#1 had no aggressive behaviors since they started at the facility. The Administrator stated they were looking for placement for Resident#1. In an interview on 01/17/25 at 5:15 PM the Corporate Nurse and Administrator stated the facility had been searching for placement for Resident#1 and he has been denied placement because of his behaviors. The Corporate Nurse stated Resident#1 has not had behaviors since his Depakote has been increased. The corporate Nurse and Administrator stated Resident#1 was no longer on Q15 and he had no behaviors since the incident on 12/29/24. The corporate Nurse and Administrator stated Resident#1 was to be redirected when he displayed aggressive behavior, Resident#1 medications had been adjusted and Resident#1 was on Q15 monitoring for 72 hours. In an interview on 01/20/25 at 12:15 PM LVN D stated Resident#1 had not had any behaviors in the past month. Resident#2 was able to see out of his eye and has not wanted to come out of his room today. An observation on 1/16/25 at 1:30 PM both Resident#1 and Resident#2 were in their rooms asleep. Observation of the secure unit on 01/20/25 from 12:15 PM to 1:45 PM revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An attempted interview and observation on 01/30/25 at 12:30 PM, Resident#1 did not recall any incidents with the other resident. Resident#1 ate lunch and talked about his college. An observation on 01/30/25 at 1:15 PM revealed Resident#2 was in the bed asleep. An interview on 01/30/25 at 4:00 PM the Administrator stated Resident#1 had no behaviors since the incident and the facility was looking for placement for him and he was not accepted. In an observation on 02/11/25 in the secure unit from 5:30 AM to 9:00 AM revealed: In an observation on 02/11/25 at 5:40 AM revealed Resident#1 was no longer in the facility. In an observation on 02/11/25 at 6:30 AM revealed Resident#2 was awake in his wheelchair. Attempted to interview Resident#2 on 02/11/25 at 7:00 AM and he did not respond back. Staff interviewed on 01/24/25 between 9:00 AM to 2:00 PM with LA A, LVN C, LVN D, LVN F, CNA E (1st and 2nd shift) staff were able to provide competency regarding in-service over ANE and behavior management. All staff were able to provide policy, procedure, protocols, appropriate interventions, and when and who to report abuse to. All staff were to provide an example of ANE and how to care for resident with physical and verbal aggressions. An interview on 02/11/25 at 5:45 AM to 9:30 AM with LVN B (overnight shift) and SC G, AD H, DON And Administrator (1shift) staff were able to provide competency regarding in-service over ANE and behavior management. All staff were able to provide policy, procedure, protocols, appropriate interventions, and when and who to report abuse to. All staff were to provide an example of ANE and how to care for resident with physical and verbal aggressions. In an interview on 02/11/25 at 7:00 AM the Administrator stated Resident#1 was transported to the new facility on 02/10/25. Record review of Resident#2 follow-up appointment on 01/14/25 reflected: right eyelid laceration was healing well, no drainage. Continue current care, no change in current therapies. Forehead laceration was healed and no further treatment needed.