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	04/01/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Residents #6) of four reviewed for adequate supervision. LVN R failed to complete a fall assessment and implement interventions for Resident #6 after a fall, to prevent reoccurrence. The facility failed to ensure an updated fall assessment was complete for Resident #6. This failure could affect residents by not having the necessary resources to ensure appropriate care, interventions, and supervision were provided. Findings included: Review of Resident #6's Face Sheet dated 04/01/2025 revealed the resident was a [AGE] year-old female was initially admitted on [DATE], and again on 08/20/2024. Relevant diagnoses were alcohol dependence with alcohol-induced persisting dementia, unspecified protein-calorie malnutrition, other reduced mobility, history of falling, other lack of coordination, unsteadiness on feet, muscle weakness (generalized), other abnormalities of gait and mobility, atherosclerosis of native arteries of extremities with intermittent claudication bilateral leg(buildup of fats, cholesterol and other substances in and on the artery walls), and unilateral primary osteoarthritis, right hip)the most common type of arthritis, characterized by the breakdown of cartilage in joints, leading to pain, stiffness, and reduced movement.) Review of Resident #6's Comprehensive MDS Assessment, dated 03/20/2024, revealed the resident had a BIMS score of 9, indicating she was moderately impaired cognitively. Section GG - Functional Abilities and Goals revealed Resident #6 requires set up and clean up for oral hygiene and upper body dressing. She requires supervision and touching assistance for toileting hygiene, lower body dressing, putting on and taking off footwear, and personal hygiene. She requires partial moderate assistance with showering and bathing. Section J900 revealed the resident had one fall with no injuries. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's Comprehensive Care Plan, dated 03/17/2025, reflected the resident had cognitive loss r/t impaired cognitive functional dementia with intervention. Keep the resident's, routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion .Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. limited physical mobility and the goal was the resident would be free from complications related to immobility including contractures and skin breakdown admitted to hospice due to a dx of lung cancer .Resident has had actual falls and remains at risk of falls . interventions included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Educate on use of walker, locking brakes on walker, and environmental check .Educate the resident family/care fall occurs .Hospital evaluation; Keep furniture in locked position: Provide visual cues in room. Record review of Resident #6's progress note dated 3/22/2025 at 11:45 AM reflected Resident had a fall this morning. Provider notified and other appropriate staffs also notified. Family will also be notified. Hospice also notified. Resident is oriented at baseline, knows her name and where she is but does not know what year it is. Neuro checks initiated. Resident found on the floor with knee twisted, Norco PRN given for reported pain-6/10. Further review of clinical records revealed that a fall assessment was not completed for Resident #6. In an observation and interview on 04/01/2025 at 12:38 PM with Resident #6 revealed Resident #6 sitting on her bed and denied falls or hospital transfers or injuries. She denied pain or recent injuries. There were no observations of skin tears, bruising or pain facial grimacing at the time of the observation. In an interview with the ADON on 04/01/2025 at 3:45 PM, the ADON stated that nursing staff were responsible for ensuring fall interventions were in place and followed, by checking during routine rounds. She stated that LVN R was trained upon being hired for PRN nursing. ADON was notified by LVN R that Resident #6's fell on [DATE]. ADON said this fall was unwitnessed. ADON contacted LVN R by phone on 03/23/2025 and requested that she return to complete the assessment for the fall. LVN R agreed to return to the facility and complete the nursing assessment. ADON said that she was unable to complete the fall assessment in LVN R's absence, due to all gathered such as, vital signs, pain, and other fall protocol task were completed by LVN R, so the ADON waited for LVN R to return and complete on 04/01/2025 at 2:00 PM for her shift. The ADON said that she met with LVN R and conducted education and coaching regarding nursing assessments and protocols. The ADON said failing to complete an assessment could lead to the resident not receiving adequate interventions, monitoring, and supervision during the first 72 hours of the fall. In an interview with the DON on 04/01/2025 at 4:04 PM, the DON stated the fall assessment should reflect the actual functionality of the resident. She said if the resident had fallen, an assessment should have been completed and mirrored the fall note 03/22/2025. If the residents were not assessed, the proper care and needs would not be met. The DON said the expectation was the residents were assessed not only after the fall but monitor every day to see if there was a change in condition, or resident acting different than usual. She said she would coordinate with the ADON Nurse to educate, audit, and monitor assessment timeliness for resident care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 04/01/2025 at 4:55 PM, the Administrator stated accurate assessments should be done to know what kind of care and services would be required. She said if the assessment were not completed, the needed care of the resident would not be met. She said the expectation was the residents would be assessed accurately to provide the appropriate care needed. She said he would coordinate with the DON and the ADON Nurse to educate, audit, and monitor resident assessments for timeliness and accuracy. Record review of facility policy, Fall Risk Assessments revised February 1, 2007, revealed Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. A Fall Risk Assessment will be completed on admission and after each fall. The assessment tool should be scored, and interventions implemented as indicated. Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall. Interventions will be designed to maintain the resident's privacy. The facility will be responsible for ensuring training and ongoing education to facility personnel regarding identification of residents who are high risk for falls. After risk is assessed, individualized plans of care will be implemented to prevent falls. The Charge Nurse will investigate all falls. The nurse will complete an event report and forward to the DON or designee. Falls resulting in sentinel event will be reported to the DON. The DON or designee will be responsible for investigating all resident falls on a concurrent basis. The nursing department will be responsible for submitting a fall trend report. Appropriate education will be provided to all staff members as needed on fall prevention.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #6) of 3 residents reviewed for Respiratory Care. The facility failed to ensure that Resident #6's nasal cannula and tubing was off the floor, properly stored when not in use, and her humidifier bottle water was dated. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Review of Resident #6's Face Sheet, dated 04/01/25, reflected the resident was a [AGE] year-old female was initially admitted on [DATE], and again on 08/20/2024. The resident was diagnosed with alcohol dependence with alcohol induced persisting dementia (cognitive decline from alcohol use), Chronic pain, History of falling, benign neoplasm of left bronchus and lung (non-cancerous tumor in the lung). Review of Resident #6's Comprehensive MDS Assessment, dated 03/20/2024, revealed the resident BIMS score was 9, indicating she was moderately impaired cognitively. Functional Abilities and Goals revealed Resident #6 requires set up and clean up for oral hygiene and upper body dressing. She requires supervision and touching assistance for toileting hygiene, lower body dressing, putting on and taking off footwear, and personal hygiene. She requires partial moderate assistance with showering and bathing. The Comprehensive MDS Assessment indicated the resident was receiving hospice care. Review of Resident #6's Comprehensive Care Plan, dated 01/15/2025, reflected the resident was on hospice. One of the interventions was to monitor for signs and symptoms of respiratory distress. Review of Resident #6's Physician's Order, dated 12/05/2024, reflected Admit to hospice for lung cancer. Review of Resident #6's Physician's Order, dated 12/05/2024, reflected Ipratropium-Albuterol Solution 0.5 - 2.5 (3) MG/3ML .3 milliliter inhale orally as needed for SOB or wheezing via nebulizer. Observation and interview on 04/01/2024 at 12:38 PM revealed Resident #6 sitting on the side of her bed, awake. The resident nasal cannula and tubing were observed on the ground, and the water bottle was not dated. on oxygen therapy via nasal cannula at 3 liters per minute and was connected to an oxygen concentrator. The resident said it was okay to open his drawer. Inside the drawer, was a nebulizer with a breathing mask connected to it. The breathing mask was not bagged. The resident said she was given a breathing treatment every morning. She said the nurse would put it on and the nurse would take it off when it was done. She said she was not aware where the nurse would put it after the breathing treatment. She said she did not notice the tubing on the floor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/01/2025 at 4:16 PM with LVN E, revealed LVN E was the charge nurse for the 2PM to 10 PM shift. She said all nursing staff are responsible for conducting rounds and monitoring resident treatment devices and equipment for safe operations and clean devices. All respiratory equipment should be dated, labeled, clean, and stored when not in use. She stated resident tubing found on the floor, or unbagged when not in use, should be removed, discarded, and installing new equipment and dating. She said the risk to the resident could result in respiratory infections or overuse of equipment. In an interview with the ADON on 04/01/2025 at 3:45 PM, the ADON stated the nasal cannula and tubing for respiratory equipment should be bagged when not in use. She said not bagging them could result in cross contamination and respiratory infection. She said the expectation was for the nursing staff to bag all the respiratory apparatuses used by the residents when not in use . She said she would coordinate with the DON pertaining to education and in-services about respiratory care. She said she would include checking on the respiratory apparatuses being bagged during her walk around and water bottles on the concentrator are dated. In an interview with the DON on 04/01/2025 at 4:04 PM, the DON stated the nasal cannula, tubing should be stored properly when not in use to keep them clean. She said if those breathing apparatuses were not bagged, were exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, and oxygen administration could be compromised. She said the nasal cannula and tubing should be discarded and replaced when found on the floor, undated, and not stored in a clean back with date. She said the nursing staff installing the humidifier bottles on concentrators should always be dated to prevent overuse. She said the staff should monitor during rounds and ensure the equipment was dated as soon as they saw it because they never knew when they could come back to the resident's room. She said moving forward, she would make an in-service and re-educate the staff about dating tubing, storing when not in use and ensure the bottle for the nebulizer was dated upon administering or replacing equipment. In an interview with the Administrator on 04/01/2024 at 4:55 PM, the Administrator stated everything that the residents were using should be kept clean to prevent infection. She said the expectation was for the staff to be trained proficiently, follow basic protocols, and ask if something needed clarification. She said they would monitor the staff and discuss the issue. Record review of facility's policy, Respiratory Policies and Procedures 2.0 Nasal Canula revised June 1, 2006, revealed Policy: Oxygen therapy via nasal cannula is administered as ordered by a physician .Oxygen is set up, delivered, and monitored by a licensed nurse or a respiratory therapist. Purpose: To provide oxygen concentrations (approximately 22-52%) at per minute Process: Replace entire set-up every seven day. Date and store in treatment bag when not in use If using a non-disposable humidifier, change bottle every seven days and change water every 24 hours to prevent bacterial contamination .date.