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	05/08/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents, (Resident #1) reviewed for care plans. 1. The facility failed to address Resident #1's multiple refusals of care and services on the comprehensive care plan This failure could place residents at risk of not receiving the necessary care and services. Findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female, with an admission date of 07/11/24. Resident #1 had diagnoses of Multiple Sclerosis (chronic disease that affects the brain and spinal cord), Cognitive Communication Deficit (communication difficulty), and History of Transient Ischemic Attack (brief interruption of blood flow to the brain). The face sheet noted a discharge date of 09/17/24. Record review of Resident #1's Admitting MDS Assessment, dated 07/17/24, reflected Resident #1 had a BIMS score of 11, which meant Resident #1 had a moderate level of cognition. The MDS noted the resident did not exhibit any behaviors. Record review of Resident #1's care plan with an initial date of 07/12/24, reflected no interventions for Resident #1's multiple refusals of wound care, perineal care, medication administration, or showers. Record review of the progress notes on Resident #1's electronic record, dated, 05/08/25, reflected the following: 07/19/24 15:36 (3:36 PM)- Resident #1 refused wound debridement after multiple attempts, application of Nystatin Powder (antifungal medication for skin infections), application of Hydrocortisone External Cream (medication used to treat skin conditions) for wound care 07/23/24 at 16:17 (4:17 PM)- Resident #1 refused the application of Nystatin Powder for wound care (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/24/24 at 12:20 PM- Resident #1 refused the application of Hydrocortisone External Cream 08/01/24 at 9:38 AM- Resident #1 refused Pro-Stat AWC (protein drink for wound healing) 3 times 08/02/24 at 8:31 AM- Resident #1 refused Pro-Stat AWC 3 times 08/09/24 21:47 (9:47 PM)- Resident #1 refused a blood sugar check 08/10/24 at 8:37 AM- Resident #1 refused the application of Nystatin Powder and Hydrocortisone External Cream for wound care, cleansing of wound, and dressing change 08/10/24 at 8:45 AM- Resident #1 refused a shower 08/10/24 at 13:21 (1:21 PM)- Resident #1 refused a blood sugar check In an interview on 05/08/25 at 2:30 PM, the DON stated she did not work at the facility when Resident #1 was living there. She stated the refusals should have been addressed and interventions should have been in place to encourage Resident #1 not to refuse care. The DON stated the risk of refusals not addressed was a possible decline in health. In an interview on 05/08/25 at 2:40 PM, the Administrator stated she was not working at the facility last year when Resident #1 lived there. She stated the refusals should have been addressed so staff would know how to best assist the resident. She stated the risk would have been Resident #1 not receiving the services she needed. Record review of the facility's undated policy, titled, Comprehensive Care Planning, reflected the following: 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 - o The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and o the right to refuse treatment 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. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure residents were free of any significant medication errors for one (Residents #1) of four residents reviewed for medications. 1. Resident #1's Lisinopril and Metoprolol (medications used to lower blood pressure) were not held per physician's order on 07/13/25, 07/21/25, 07/23/24, and 07/25/24 when the resident's blood pressure was below parameters. These failures could place residents at risk of not receiving their medications as ordered or possible illness. Findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female, with an admission date of 07/11/24. Resident #1 had a diagnoses of Multiple Sclerosis (chronic disease that affects the brain and spinal cord), Cognitive Communication Deficit (communication difficulty), Essential Hypertension (high blood pressure), and History of Transient Ischemic Attack (brief interruption of blood flow to the brain). The face sheet noted a discharge date of 09/17/24. Record review of the active physician's order dated 07/11/24, reflected the following: Lisinopril Tablet 2.5 MG give one tablet one time a day by mouth for hypertension hold for SBP <110, DBP <60, HR <60 Metoprolol Succinate ER Oral Tablet 50 MG Give one tablet by mouth one time a day for HTN hold for SBP <110, DBP <60, HR <60 Record review of Resident #1's Medication Administration Record dated July 2024 reflected that Lisinopril and Metoprolol were both given by RN A on 07/13/24 when Resident #1's SBP was 106, outside of the ordered perimeters. RN A also administered both medications outside of the ordered perimeters to Resident #1 on 07/21/24 when Resident #1's SBP was 104 and DBP was 59. Both medications on both days were marked as given. Record review of Resident #1's July 2024 Medication Administation Record reflected on 07/23/24 and 07/25/24 LVN B administered both medications outside of the ordered perimeters when Resident #1's SBP was 98. Both medications on both days were marked as given. Record review of the progress notes on Resident #1's electronic record reflected no documented adverse effects. Record review of the Employee roster reflected RN A and LVN B no longer worked at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/08/25 at 2:30 PM, the DON stated she was not working at the facility at the time Resident #1 lived there. She stated the two medications should have not been given outside of the perimeters. She stated all physician orders should be followed. The DON stated the risk of not following the physician orders and giving the medications outside of the perimeters was a sentinel event or hypotension (low blood pressure). In an interview on 05/08/25 at 2:40 PM, the Administrator stated all physician orders should be followed and the risk of not following orders was adverse effects. Record review of the facility's policy titled, Medication Administration Policies, dated 10/25/15, reflected the following: 13. When ordered or indicated, Include specific item(s) to monitor (e.g., blood pressure, pulse, blood sugar, weight), frequency (e.g., weekly, daily), timing (e.g., before or after administering the medication), and parameters for notifying the prescriber. 20. The 10 rights of medication should always be adhered to 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 9. Right assessment 10. Right evaluation

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #2) of 3 residents reviewed for infection control. 1. The Treatment Nurse failed to discard contaminated gauze after performing wound care on Resident #2 on 05/07/25. This failure could put residents at risk of infection from cross contamination. Findings included: Record review of Resident #2's face sheet dated 05/08/25, reflected a [AGE] year-old female, with an admission date of 05/05/25. Resident #2 had diagnoses of Chronic Venous Hypertension with Ulcer of Bilateral Lower Extremity (damaged leg veins that causes blood pressure build up and skin breakdown), and Type 2 Diabetes with foot ulcer (body cannot regulate blood sugar levels). In an observation and interview on 05/08/25 starting at 8:40 AM, the Treatment Nurse was observed as she provided wound care to the toes and heel of Resident #2. The Treatment nursed wiped the toes of Resident #2, put her gloved hand into the package of clean gauze, took a few out, wiped the toes of Resident #2, then put her gloved hand back into the package of clean gauze to get a few more out. The Treatment Nurse was observed as she closed the package of remaining gauze and placed the package back in the drawer of the treatment cart and locked it. The Treatment Nurse stated she had a few more residents to treat on 05/08/25. In an interview on 05/08/25 at 11:39 AM, the Treatment Nurse stated she was not aware she put the gauze back on the treatment cart after she put her gloved hand into the package. The Treatment Nurse stated that was something she would not normally do. The Treatment Nurse stated the risk of putting her gloved hand into the package after touching Resident #2's wounds, then putting the gauze back on the treatment cart was infection. In an interview on 05/08/25 at 2:30 PM, the DON stated all employees were trained on infection control, but the staff get nervous when The State is in the building. She stated the Treatment Nurse was probably nervous during the observation. The DON stated the Treatment Nurse putting a contaminated hand in the gauze package and placing the gauze back on the treatment cart was contamination and infection. In an interview on 05/08/25 at 2:40 PM, the Administrator stated the risk of the Treatment Nurse putting her gloved hand into the gauze package during wound care was infection being spread to other residents. She stated all employees were trained on infection control. Record review of the facility's policy titled, Infection Control Plan: Overview, dated 03/2024, reflected the following: Infection Control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.