| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455651 | A. Building<br>B. Wing | 05/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Downtown Health and Rehabilitation Center | 424 S Adams St<br>Fort Worth, TX 76104 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury for 1 of 3 (Resident #2) residents reviewed for abuse and neglect.<br><br>The facility LVN A, LVN B, CNA C and CNA D did not report Resident #2's allegations of abuse and neglect to the Admin who was the abuse coordinator.<br><br>This failure could place residents at risk of injuries, abuse, and/or neglect.<br><br>Findings Include:<br><br>Record review of Resident #2'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: paraplegia unspecified (the symptom of paralysis that mainly affects your legs though it can sometimes affect your lower body and some of your arm abilities, too)., major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), single episode, unspecified, insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep) other chronic pain (lasts months or years and can affect any part of your body), neurogenic bowel (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function) and neuromuscular dysfunction of bladder.<br><br>Record review of Resident #2's quarterly MDS assessment, dated 04/12/25 reflected his BIMS score was 15, which indicated no cognitive impairment . Review reflected Resident#2 needed Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for toileting hygiene.<br><br>Record review of Resident#2's care plan, dated reflected Resident #2 had Paraplegia r/t Bicycle/MVA on 07/03/23. Goals Initiated on 07/03/2023 reflected, will have decreased likelihood of complications or discomfort related to Paraplegia. Intervention initiated on 07/03/2023 assist with ADLs/Mobility as needed. Review of Resident#2 care plan reflected bowel and bladder incontinence R/T paraplegia which initiated on 07/03/2023. Goals Initiated on 07/03/2023 reflected a decreased likelihood of skin breakdown due to incontinence and brief use. Intervention initiated on 07/03/2023 reflected incontinent care at least every 2 hours and apply moisture barrier after each episode.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of CNA D's time sheet reflected she clocked in on 05/11/25 at 9:47 pm and clocked out at 10:03 AM.<br><br>Record review of a self- report as of 05/14/25 reflected an incident report was created on 05/12/25 at 5:00 AM by the DON. The report revealed, Nursing Description: Resident reported that a CNA tried to strangle him. Resident Description: Resident stated that a CNA tried to choke him. He was waiting for a while to be changed . He found the CNA in the shower room with another resident and when he confronted her the CNA tried to put her hands on him . Immediate action taken reflected: CNA was suspended pending investigation resident interviewed. No injuries observed at time of incident and no injuries observed post incident.<br><br>Record review of Resident#2 progress note, dated 05/12/25 at 9:00 AM reflected: resident had alleged that a staff member had strangled him then he changed his story stating that the aide attempted to reach out to chock him. Resident has no signs of trauma around neck or to shoulders. No redness, bruising or swelling noted. Resident denies pain or any emotional stress at this time. completed by ADON.<br><br>Record review of Resident#2 progress note, dated 05/12/25 at 11:35 AM reflected: SW (Social Worker) and 200 Hall Unit Nurse spoke with resident his report of a staff member trying to strangle him around 3 a.m. Nurse asked What happened? Resident stated, he was wet and needed changed and was needing changed. He stated, he pushed his call light and when it was not answered then he rolled to the nurse's station and complained to the nurse staff. When he was asked to wait, someone would be with him. He seen an aide and rolled in front of the shower to ask about why he wasn't changed. The aide attempted to explain but he said she appeared to reach for him but did not touch him. Completed by the SW.<br><br>Record review of LVN A's signed electronic statement undated, is extremely difficult to read and understand. Please refer to LVN A over the phone interview on 05/14/25 at 8:30 AM.<br><br>Record review of CNA D's written statement , undated, reflected: To whom it may concern I [CNA D] was attending to other residents on May 13th at 4:30 AM when co-worker [LVN A] and [Resident#2] approached me at shower room and I was assisting another resident when he shouted that he had his call light for 3 hours and I personally neglected to render him service I put my hands up in my defense and asked if I could speak now at that moment she stated that he was going to call the police and make a report on me because the state told him that he could. As I was trying to deescalate the situation [LVN A] stated don't touch or say anything. But I kindly stated to him that I was making rounds since I clocked in at 9:45 pm. I haven't made it his vicinity because I been doing showers since I have documented on the floor. We also only had (2) assistants on the date stated. I let him know that I was doing the best I could possibly for each and every one .<br><br>Interview at 05/13/25 at 9:55 PM CNA C stated on 05/12/24 she was told by LVN B that Resident #2 on the 200-hall needed assistance and for her to go provide care. CNA C stated she was told by Resident #2 on 05/12/25 that CNA D choked him.<br><br>Interview on 05/13/25 at 11:00 PM LVN A stated she had not heard about or seen any residents complain of being physical or verbally abused by staff.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 05/13/25 at 11:30 PM CNA E stated she had heard from Resident #2 that CNA D was not answering the call light and he went to confront CNA E because he was wet for hours; and he had already called to the front and LVN B said they would be with him. Resident #2 stated staff tried to choke him and he cussed CNA D out when she tried to tell him why she had not answered the call light yet she touched his shoulder. CNA E stated it was no reason for staff to touch the resident and continue to agitate the resident. CNA E stated she worked PRN and Resident#2 told her what happened on 05/13/25.<br><br>Interview on 05/14/25 at 12:45 AM LVN B stated Resident #2 called the facility phone and stated CNA D did not answer the call light and he needed to be changed. LVN B told Resident #2 that the aide would be with him. LVN B was told that Resident #2 cussed at CNA D because she did not answer the call light for hours. LVN B stated he did not call the Admin or the DON about the incident. LVN B stated he did not complete an incident report. LVN B did not provide additional information.<br><br>Interview over the phone on 05/14/25 at 8:30 AM LVN A stated Resident #2 had approached her at the nursing station and stated his call light was on for a long time and CNA D had not come to help him LVN A stated that she went with Resident #2 to find the CNA D. CNA D was giving another resident a shower. LVN A stated, CNA D told Resident #2 that she was giving a resident a shower and would help him after she completed the shower. LVN A stated that CNA D put her hands up and the stop motion. LVN A stated CNA D tried to pat the resident's shoulder and resident pulled back at that point LVN A stated she told CNA D to go back to her work and to back off. LVN A stated she would find another aide to assist Resident#2. LVN A stated CNA D was not being threatening to Resident#2. LVN A stated that she did not think the incident needed to be reported to the Abuse Coordinator (Admin).<br><br>Interview on 5/14/25 at 8:50 AM Resident #2 stated the regular overnight shift were good about changing him every 2 hours. Resident #2 stated it was about 4:30 AM on 05/12/25 and he had his call light on for a couple of hours and he called the front desk. LVN B waited another 30 minutes before he wheeled himself to the nursing station to find CNA D. Resident #2 stated the nurse who was at the desk stated she did not know who the CNA was working because she usually worked on the unit. Resident #2 stated they went and found CNA D who was given a resident a shower. Resident#2 stated he felt like CNA D was reaching for his throat. Resident#2 stated that LVN A then told CNA D not to put her hands on him. Resident #2 stated CNA C came to change him. Resident #2 stated CNA D did not assist him anymore, but he saw here in the dining hall around breakfast time. Resident #2 stated he told CNA E and AD, about the incident. Resident#2 stated he had a meeting with his family member and the Admin, the SW and the ADON about the incident and other concerns on 05/12/25.<br><br>Interview on 5/14/25 at 9:47 AM the ADON stated she was informed on 05/12/25 by the AD that CNA D was accused of choking a resident. The DON and the SW went to talk to Resident #2, and he said CNA D tried to choke him and he told her not to touch him. The ADON stated they did an assessment on Resident #2 and found he was not in pain and had no bruises at that time. The ADON stated CNA D was sent home immediately. The ADON stated staff should walk away when a resident was being aggressive and come back later when the resident was calm. The ADON stated another aide came and provided incontinent care to Resident#2.<br><br>Interview on 5/14/25 at 9:59 AM the SW stated Resident #2 was cussing and upset because he was not changed and checked on for hours. SW stated Resident #2 stated CNA D raised her hand and it looked like her hands were going towards him. The SW stated another nurse aide provided care to Resident #2.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview one 05/14/25 at 10:10 AM the AD stated that he was informed by Resident #2 on 05/13/25 around 9:00 AM that CNA D was aggressive towards him, and he thought she was going to hit him. The AD stated abuse should be reported immediately to the Abuse Coordinator who was the Admin to prevent residents from being harmed.<br><br>Interview on 05/14/25 at 1:43 PM with the Admin, the DON and the CN stated they found out about the incident after the morning meeting on 5/12/25 and around 9:30 AM. The Admin stated CNA D was suspended immediately pending investigation. The DON stated they did an in-service with CNA D before sending her home. The Admin stated that abuse allegations were supposed to be reported immediately to them. The DON stated when staff were in-serviced staff were required to sign off on the in-service training sheet to show they had completed the in-services. DON stated staff are in-serviced to prevent abuse from occurring or reoccurring. The DON stated in-services were usually done at the beginning of shifts and when needed.<br><br>Interview ed on 5/14/25 at 3:35 PM the family member stated she is not sure what happened; she was told two different stories by Resident#2 and drove from out of state to the facility. The family member stated she had a meeting with staff and they addressed concerns that Resident #2's concerns.<br><br>Interview over the phone at 05/14/25 at 5:10 PM after exit, CNA D stated she was told to go to the Admin's office and she explained what happened. CNA D stated she did a written statement about the incident with Resident #2 before she clocked out on 05/12.25 . CNA D stated Resident #2 was outside the shower room cussing at her because he said he had his call light on for 3 hours and no one had come to change him. CNA D stated she put her hands up with open hands to explain that she was finishing a shower and had not made it to him yet. CNA D stated she did not touch the resident and was in-serviced 05/12/25 by the DON before she left the facility.<br><br>Record review of an in-service on abuse/neglect dated 05/12/15 completed by the [NAME] reflected LVN A and CNA D did not sign off on the completed training.<br><br>Record review provided after exit of an in-service on abuse/neglect/aggressive behaviors dated 05/12/25 completed by the ADON reflected only CNA D's signature.<br><br>Record review of in-service on 02/25/25 titled De-escalating taught by the DON reflected: Verbal de-escalation .Remember, reasoning with an enraged person is not possible. The first and only objective in de-escalation is to reduce level of resident arousal . Do not try to argue or convince Avoid overacting . Minimize body movements such as excessive gesturing, pacing, fidgeting, or weight shifting. These all indications of anxiety and will tend to increase agitation.<br><br>Record review of facility policy titled abuse/neglect, dated 03/18 reflected: E. Reporting<br><br>When a suspected abused, neglected, exploited, mistreated or potential victim of<br><br>misappropriation of property comes to the attention of any employee, that employee will make<br><br>an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | outside of normal business hours, the Abuse Preventionist and/or designee will be called. A. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (medication cart) of 1 medication cart on the memory care unit reviewed for pharmacy services<br><br>The facility failed to ensure discontinued medication were removed from the medication cart. Resident #1's Diazepam that was DC on 12/30/24 was in the narcotic box on the secure unit medication cart.<br><br>This failure could place residents at risk of unnecessary medication error and/or lead to possible harm or drug diversion.<br><br>The findings included:<br><br>Interview on 5/13/25 at 9:50 PM LVN A stated when medications were wasted, they should be crushed and disposed of and two people, 2 nurses, were to sign off on the narcotics sheet and document medication was wasted.<br><br>Observation and record review on 05/13/25 at 11:00 PM revealed a secure unit narcotic sheet that was not filled out completely for Resident #1's Diazepam 5 mg tablet. Review of Resident#1's Diazepam 5mg narcotic sheet reflected the 10th pill was given with no date and no signature. Further review revealed the 9th pill was removed on 4/11 /25and on 5/4/25 the 8th pill was marked off as wasted. Observation of Resident #1's Diazepam 5 mg package reflected the medication was still in the bubble pack for the 8th tablet. Observation of the Diazepam bubble package revealed medication was filled on 11/12/24. Review of the Diazepam narcotic sheet revealed the Diazepam was put on the medication cart on 11/14/25.<br><br>Record review of Resident #1's order summary revealed to give 1 tablet Diazepam by mouth every 6 hours as needed and not to exceed 3 daily until 12/30/24 for anxiety.<br><br>Record review of Resident#1's November MAR reflected Diazepam was administered on 4/11/24.<br><br>Record review of Resident #1's March 2025 MAR reflected Diazepam was not a listed medication.<br><br>Interview on 05/13/25 at 11:00 PM LVN A stated Resident#1's Diazepam was DC and the DON was responsible for coming to pick up the DC medication from the medication cart. LVN A stated when medication was wasted two nursing staff would sign off on the medication. LVN A stated narcotics were crushed and put in water.<br><br>Interview on 05/14/25 at 12:15 PM the DON stated she had not been informed of staff taking narcotic medications for personal use off the medication cart.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview and observation on 5/14/25 at 1:43 PM the DON stated Resident #1's 5mg Diazepam was DC on 12/30/24. She stated that DC medication needed to be brought to her as soon as possible. The DON stated that nurses was responsible for taking DC medications off the medication cart. The DON stated the pharmacy comes every other month to destroy medications. The DON stated residents are at risk of being given medications that are no longer needed. The DON stated when medications are wasted two nursing staff members are supposed to sign off. Observed the CN leave out of the DON, and she went to pull the DC medication off the secure unit cart. The CN stated the nurse must have written the number backwards instead of 04/11/24 it should have been 11/04/24.<br><br>Record review of the facility policy titled, Medication Administration Procedures revealed, 3. Open the unit dose package only when you are administering medication directly to the resident.<br><br>Record review of the policy titled Controlled Medication Disposal, undated, revealed, 3. Schedule II, III, IV and V medications remaining in the facility after the resident has been discharged , or the order<br><br>discontinued, are disposed either in the facility by legally authorized personnel, Director of Nursing, and Consultant Pharmacist .<br><br>Record review of the facility policy titled, Discontinued Medications, undated, reflected : Policy .When medications are discontinued by physician order, . the medications are marked appropriately and destroyed . Procedure 1. If a physician discontinues a medication .the medication container is marked the date discontinuance is indicated along with the initials of the nurse. 2. Medications awaiting disposal are stored in a locked secure area designated for that purpose until disposed of medications are removed from the medication cart immediately upon receipt of an order to discontinue avoiding inadvertent administration. 3. Discontinued medications are destroyed in accordance with destruction policy and procedure . |