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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 environment and to help prevent the development and transmission of communicable diseases and infections for one of eight residents (Resident #4) and the facility's water management system reviewed for infection control. 1. The facility failed to perform wound care by not covering Resident #4's right foot prior to leaving the room and being in common areas.2. The facility failed to identify situations that could lead to Legionella growth and to implement measures to prevent the growth of opportunistic waterborne pathogens (control measures), and how to monitor them. This failure could place residents at risk of cross-contamination, increased risk of infection and the spread of infection. Findings included: In an interview on 3/11/2026 at 02:20 p.m., the Maintenance Director stated he was not aware of a facility water management plan and he was unable to describe or provide evidence of identification of situations that could lead to Legionella growth, measure used to control the introduction and/or spread of Legionella, or documentation of implementation of these measures. He stated that the facility does not need to flush their water lines because they were on city water. He stated the facility's water system was not at risk for any bacterial growth because, we have water softeners. He stated he did not know what Legionella or Legionnaires' disease was and did not know of any risks of failing to have a water management plan. In an interview and record review on 3/11/2026 at 03:45 p.m., the DON when asked for the facility's water management program documentation provided the facility, undated, policy titled, Legionella Water Management Program as well as a list titled, Water Management Team with four names which included the name of the Administrator, the DON, Maintenance, and the Medical Director. A facility map was provided with areas highlighted and labeled, tankless, hot water heaters basement and water heater. The DON was unable to describe or provide documentation of a water management program which included identification of situations that could lead to Legionella growth, measure used to control the introduction and/or spread of Legionella, or documentation of implementation of these measures. The DON stated failing to have a water management program could place residents at risk of disease, breakouts, and respiratory issues. She stated the facility had not had any diseases, breakouts, or respiratory issues related to water management. In an interview on 3/12/2026 at 01:30 p.m., the Administrator stated water management was not an issue because the facility did not have any stagnant water and water temperatures were monitored. The Administrator stated the facility had two resident rooms which were not in use, one of which was out of commission. She stated residents' rooms were often moved around and housekeeping, when cleaning, turned on sinks and flushed toilets. She stated the facility had not had any outbreak of waterborne illness or Legionnaires' Disease. The Administrator stated she, the DON, the Maintenance Director, and the Medical Director were responsible for the water management plan. She stated the (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	risk of not having a water management plan would be Legionnaires' Disease. A record review of the facility's, undated, policy, , Legionella Water Management Program reflected, our facility has a water management program, which is overseen by the water management team, the water management plan included, the identification of situations that can lead to Legionella growth.specific measures used to control the introduction and/or spread of Legionella.the Maintenance Director or designee will perform weekly flushing for at least 10 minutes of all water source locations that are utilized on a less than daily basis. 2. Record review of Resident #4's admission Record revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted ton 10/16/2025. Resident #4 had a primary diagnosis which included Unspecified Atherosclerosis of native Arteries of Extremities Right Leg (indicates plaque buildup in the leg arteries, causing narrowing and reduced blood flow) Record review of Resident #4's Care Plan Report, dated 01/21/2026, revealed; Focus: skin issues r/t incontinence and impaired mobility AEB; Arterial wound to right foot; Interventions: Skin checks weekly per facility protocol, document findings. Focus: Behavior exhibits maladaptive behaviors r/t difficulty communicating h/o CVA mental illness, dementia (a decline in mental ability), cognitive impairments, verbal aggression toward others, refusal of care (cleaning/trimming nails/wound care, refuses eye exams, refuses meds at times, physical aggression toward others, places self on floor at times and crawls. Goal: will have fewer episodes of (yelling out behavior) Interventions: Allow choices within individual's decision-making abilities. Explain all procedures to the resident before starting and allow the resident time to adjust to changes. Focus: Resident 4 is on enhanced barrier precautions. Goal: there will not be any transmission of infection from or to the resident. Interventions: Gloves and gowns should be donned if any of the following activities are to occur; linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care. Focus: Resident #4 refuses treatment assessment and evaluations from providers and wound care NP. Wound care to Right Foot. Goal: Resident #4 will deal with his decision X 90 days. Interventions: Attempt to get other staff who he trusts to assist with resident compliance with treatment. Ensure pain is managed to attempt resident to be compliant with treatment, Staff will listen to resident concerns. Record review of Resident #4's Team Care Plan, dated 02/03/2026, revealed; Care Plan H160; Skin/Wound; skin remains intact within limits of disease process. Interventions; wound care performed daily by facility nurse. Normal saline used to cleanse the wound, pat dry and apply dressing. Record review of Resident #4's Minimum Data Set (MDS) Nursing Home Quarterly (NQ) Item Set dated [DATE] revealed; no BIMS score recorded No (resident is rarely/never understood). Record review of Resident #4's Treatment Administration Record, dated 03/01/2026, revealed; Apply Betadine to open areas of the right foot one time a day for wound care-D/C date 03/10/2026. Dates: 03/09/2026-2 (Drug refused Effective); 03/10/2026-2 (Drug refused Effective). Cleanse open areas to right foot with normal saline, pat dry, and Apply Betadine to the open areas of the right foot. Daily and PM. Apply bandage to draining areas and wrap with roll gauze. Every evening shift for Wound care. Date; 03/11/2026-Administered. During an observation on 03/10/2025 at 2:46 p.m., revealed Resident #4 was sitting up in his wheelchair self-propelling himself down the hallway in front of the dining room with his right foot uncovered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 03/10/2026 at 2:55 p.m. revealed Resident #4 was sitting up in his wheelchair in his room right foot was uncovered with subcutaneous drainage lower extremity edema onto the floor under Resident #4's wheelchair. During an attempted interview on 03/10/2026 at 2:55 p.m. revealed Resident #4 was verbally unresponsive to investigate questions. Resident #4 moved his foot and body away when attempting to observe the right foot. During an interview on 03/10/2026 at 2:57 p.m. with RN B revealed Resident #4 was not compliant with wound care. She stated he would refuse treatment. He would self-propel to smoke. RN B stated there was drainage from the right foot. She stated the risk was the foot could get infected. During an interview on 03/10/2026 at 4:04 p.m. with the Treatment nurse revealed she Resident #4 was non-compliant with wound care, when they tried to clean and cover the foot the resident would non-verbally refuse by becoming physical and showed resistance. Resident #4 was able to verbally say Akoo. She stated they made several attempts to provide wound care sometimes we get lucky and he would allow treatment. She stated his foot did not always drain. She stated someone usually took him to smoke and if drainage was noted, they cleaned it up with disinfectants. During an interview on 03/12/2026 at 2:55 PM with the DON revealed if Resident #4 had active drainage staff should clean it up with disinfection wipes. The risk was if he had an infection, it could spread to the other residents. Record review of facility policy, Skin Integrity Management, revised 10/05/16, revealed .minimize environmental factors leading to skin drying, such as low humidity .additional heel protection may be needed .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to residents with reasonable accommodations of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 12 (Resident #91) reviewed for call lights. The facility failed to keep Resident #91's call light off the floor and within his grasp so Resident #91 could communicate to staff when he needed assistance. This failure placed residents at risk for not getting their needs met and a diminished quality of life. Findings included: Record review of Resident #91's Face Sheet, dated 3-10-2026, revealed a [AGE] year-old male with an initial admission date of 8-29-2024 and a re-admission date of 7-26-2025. Resident #91 had a primary diagnosis of Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (a chronic disorder characterized by high blood sugar [hyperglycemia] that causes widespread damage to peripheral nerves.), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (an impairment in communication-including listening, speaking, reading, or writing-caused by underlying cognitive issues such as memory loss, poor attention, executive dysfunction, or impaired reasoning rather than a primary language or speech-motor deficit), PTSD (a chronic mental health condition triggered by witnessing or experiencing a terrifying, life-threatening, or violent event), and Acquired Absence of Right and Left Legs below the knee (An amputee of both legs below the knee). Record review of Resident #91's Quarterly MDS dated [DATE] reflected a BIMS score of 11, which indicated being mildly cognitively impaired. The GG-Functional Abilities Section revealed he was totally dependent on staff for toilet hygiene, maximal assistance where a helper lifts the trunk or limbs and provides more than half of the effort to transfer from chair to bed or bed to chair, and in need of moderate assistance where a helper lifts, holds, or supports trunk or limbs but provides less than half the effort to move from a lying position in bed or a sitting position to a lying position in bed. Record review of Resident #91's Care Plan, dated 8-30-2024, indicated Resident #91 had Hemiplegia/Hemiparesis (a neurological conditions causing one-sided body weakness or paralysis, usually resulting from stroke, brain injury, or tumor) and was a fall risk stating, be sure resident's call light is within reach and encourage him to use it for assistance.In an observation and interview on 3-10-2026 at 11:35 AM, Resident #91 was observed lying in his bed. Resident #91 was observed to be a double amputee in his legs from the knees down. Resident #91's call light was on the floor underneath his wheelchair next to the wall. Resident #91 said he did not know where his call light was, he used the call light to get help from the staff, but it did not bother him.In an observation and interview on 3-10-2026 at 3:20 PM, Resident #91's call light was observed to be in the same location as it was at 11:35 AM. The call light was still on the floor, underneath Resident #91's wheelchair, next to the wall. Resident #91 was observed coughing repeatedly and was unable to answer my questions. In an interview on 3-10-2026 at 3:25 PM, CNA A said she had worked at the facility for 6 months, worked the 2:00 PM-10:00 PM shift, and was responsible for the care of Resident #91 during the evening shift. CNA A said she had just arrived at work and did not know why Resident #91's call light had been on the floor for 4 hours. CNA A said CNA C had worked the 6:00 AM - 2:00 PM Shift and was responsible for Resident #91's care during that time. CNA A said the reason it was important for Resident #91 to have his call light within reach was because he would not be able to contact staff when he needed help. CNA A said they made rounds in the hallways, as much as they could, to ensure Resident's call lights were kept within reach. In an interview on 3-10-2026 at 3:30 PM, RN B said she worked the hallway responsible for Resident #91's care on the 6:00 AM-2:00 PM shift. RN B said every staff member who went into Resident #91's room was responsible for making sure his call light remained within his reach. RN B said, the risk to a resident, who was a double amputee, not being able to reach his call light was he would not be able to call for help when he needed it. RN B said she believed staff were just too busy to notice Resident #91's call light was on the floor. In an interview on 3-11-2026 at 3:30 PM, CNA C (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she had worked at the facility for 1 year, worked the 6:00 AM-2:00 PM shift, and was responsible for Resident #91's care. CNA C said the CNAs were responsible to ensure Resident's call lights were kept within reach and if a Resident could not reach his call light, he would not be able to call staff for help. CNA C said staff clip the call light onto the clothes of Residents when they were lying in bed to keep the call lights within reach. CNA C said she thinks she was just too busy yesterday to ensure Resident #91's call light was kept within his reach. In an interview on 3-11-2026 at 4:00 PM, the DON said she expected Resident's call lights to always remain within their reach when they were in their rooms. The DON said all staff were responsible for ensuring call lights remained within a Resident's reach. The DON said if a call light was not kept within a Resident's reach, it could cause him to not have his needs met. In an interview on 3-12-2026 at 2:10 PM, the Administrator said her expectations were for all Resident's call lights to remain within their reach. The Administrator said the CNAs and the nurses were responsible for ensuring call lights were kept in place for the hallways they were working in. The Administrator said if a resident could not reach his call light, he would not be able to call for help or assistance. In an interview on 3-16-2026 at 1:00 PM, the Administrator said the facility did not have a call light policy. Record review of the facility's undated policy titled Resident Rights stated: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure at the time each resident was admitted the facility had a physician order for the resident's immediate care for 1 of 5 (Resident #25) reviewed for residents receiving care and services upon admission. The facility failed to ensure Resident #25 had a current physician's order for use of oxygen after readmission to the facility. This failure could place residents at risk of not receiving necessary care and services. Record review of Resident #25's annual MDS, dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident #25 had diagnoses which included interstitial pulmonary disease (a group of over 200 disorders causing progressive inflammation and scarring [fibrosis] of lung tissue, making it difficult to breathe and transfer oxygen to the blood), end-stage renal disease (when kidneys no longer function well enough to meet a body's needs), and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs resulting in swelling and irritation). Section J1100 reflected Resident #25 had other health conditions such as shortness of breath or trouble breathing when lying flat. Resident #25 had a BIMS score of 15, which indicated Resident #25 was cognitively intact with high cognitive functioning. Record review of Resident #25's care plan, dated 12/11/25, reflected the resident had altered respiratory status, difficulty breathing, and shortness of breath anxiety. The care plan reflected: Goals: The resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review. Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Encourage sustained deep breaths by: Using demonstration (emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation); Using incentive spirometer (place close for convenient resident use); Asking resident to yawn. Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor for s/sx of respiratory distress and report to MD PRN; Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis (excessive sweating due to a secondary condition) ; Headaches; Confusion; Hemoptysis(coughing up blood from the lower respiratory tract); Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Position resident with proper body alignment for optimal breathing pattern. Provide oxygen as ordered. Use pain management as appropriate. Monitor/document side effects and effectiveness. Record review Resident #25's progress note, dated 03/09/26 at 10:53 PM, by LVN D, reflected: Resident readmitted from hospital to room . under the care of the Medical Director. Resident #25 is alert and able to make needs known. Oxygen at 2 lpm via nasal cannula. Record review of Resident #25's physician orders, dated 03/10/26, reflected no physician orders for oxygen. Observation and interview on 03/10/26 at 11:23 AM revealed Resident # 25 was resting in her bed and not feeling well. Resident #25 stated she did not feel like answering questions from the state surveyor. Observation revealed Resident #25 had an oxygen concentrator in her room that was set to 3.5 liters per minute, and Resident #25 was wearing oxygen tubing from the oxygen concentrator correctly. Observation on 03/11/26 at 2:59 PM of Resident #25 revealed Resident #25 was resting peacefully in bed with her eyes closed. The resident's oxygen concentrator was set to 3.5 liters per minute. Resident #25 was wearing oxygen tubing from the oxygen concentrator correctly. Observation on 03/12/26 at 12:20 PM revealed Resident #25 was resting peacefully in bed with her eyes closed. Interview on 03/11/26 at 4:21 PM with LVN D revealed she was the evening shift nurse (Monday through Friday) for Resident #25. LVN D stated Resident #25 had no order for oxygen upon admission when reviewed with the state surveyor. LVN D stated there should be an order for oxygen with its liters per minute from the physician based on Resident #25's admitting diagnoses. LVN D stated Resident #25 needed oxygen due to her low oxygen levels. LVN D also stated the admitting nurse should have contacted the physician and obtained an oxygen order for (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 upon admission. LVN D revealed the importance of getting an order for oxygen was to ensure the resident's oxygen was set to the correct liters per minute because too much oxygen was bad for a resident (LVN D did not know specifically how it affected the body). LVN D stated it was all nurses' responsibility to ensure residents had an order for oxygen which included the ADON, if they were using oxygen. LVN D concluded by stating their policy stated nurses were allowed to use nursing judgement and place oxygen on a resident using 2-3 liters per minute based on their admitting diagnosis. LVN D stated in Resident #25's case, she failed to contact the physician and obtain an order for oxygen at a 3.5 liter per minute rate when she admitted Resident #25 on 3/9/26. Interview on 03/12/26 at 9:01 AM with RN E revealed she was the dayshift nurse (Monday through Friday) for Resident #25. RN E revealed due to the resident's diagnoses of COPD, Resident #25 could experience hypoxia (low levels of oxygen in the blood). RN E stated upon admission, all residents' vitals should be taken including oxygen saturation. RN E stated if the saturation level was low, the supervisor should be informed. Then oxygen should be placed on the resident, and the physician notified to get an order for oxygen for the correct liters per minute. RN E stated Resident #25 should have an order for the correct oxygen liters per minute from her physician. RN E revealed it was the admitting nurse's responsibility to ensure the resident had an order for oxygen. RN E stated she should have checked the resident's orders as well to ensure the resident had an order for oxygen and it was set to the correct liters per minute. RN E stated if the nurse did not verify the physician's order for oxygen, the nurse could set it too high, and then the resident could get sick. Interview on 03/12/26 at 12:27 PM with the DON revealed the ADON was not available for interview. The DON revealed Resident #25 had a diagnosis of COPD. The DON stated it was the admitting nurses' responsibility to ensure residents' orders were received and entered correctly into the electronic health record. The DON stated the admitting nurse for Resident #25 should have notified the physician and received an order for oxygen and the appropriate liters per minute so the resident had adequate oxygenation due to her diagnosis. The DON stated if a resident received too much oxygen, it could depress the respiratory drive which could lead to exasperation and resident decline. Record review of the facility's, undated, Physician's Orders policy reflected: Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.Person responsible: Medical Records/Designee.Verbal or Telephone Orders by the Physician or Nurse PractitionerNurse will receive the order and read the order back to the prescriber to ensure it is correct.If needed, the nurse will contact the prescriber for any clarificationsThe nurse will enter the order into PCC for the resident and select either verbal or telephone, depending on how the nurse received the order .Preventing Verbal or Telephone Order Errors. 4. Ensure all elements of the order are included; being clear about the unit of measure for each dose and the frequency of administration.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of 12 (Resident #104) reviewed for ADLs. The facility failed to ensure Resident #104's shirt and pants were changed, which were covered in food, after being fed lunch on 3-10-2026. This failure could place residents at risk for low self-esteem and self-worth causing negative psychosocial outcomes affecting their health. Findings included:Record review of Resident #104's Face Sheet, dated 3-10-2026, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Parkinson's Disease (a neurodegenerative disorder that impairs motor function due to the loss of brain cells that produce dopamine) and secondary diagnoses of Type 2 Diabetes Mellitus (high blood glucose [sugar] levels, often stemming from insulin resistance. In this condition, the pancreas cannot produce enough insulin), Muscle Weakness, Unsteadiness on feet, Cognitive Communication Deficit (a difficulty with communications such as speaking, listening, reading, or writing-caused by underlying cognitive impairments rather than primary language or speech deficits), and Glaucoma (a group of eye conditions that damage the optic nerve-the vital connection between the eye and brain-often due to abnormally high eye pressure). Record review of Resident #104's Nursing Home Comprehensive MDS, dated [DATE], reflected a BIMS Score of 14, which indicated she was cognitively intact. The F - Preferences for Customary Routine Activities Section, of the MDS, revealed it was very important to Resident #104 to choose what clothes to wear and take care of her personal things. In the GG - Functional Abilities Section, of Resident #104's MDS, revealed Resident #104 needed partial/moderate assistance to dress and undress from the waist up and needed substantial/maximal assistance to dress and undress from the waist down. In the GG0115 - Functional Limitation in Range of Motion, of Resident #104's MDS assessment, revealed she used a wheelchair to ambulate. Record review of Resident #104's Care Plan, dated 2-25-2026, indicated Resident #104 had a communication difficulty requiring 1 staff member for assistance dressing and eating. Resident #104 had ADL Self Care Performance Deficient needing assistance choosing clothes to wear. In an observation and interview on 3-10-2026 at 3:37 PM, Resident #104 was observed having a substantial amount of food debris on the front of her shirt and in front of both pants legs while sitting in her wheelchair in her room. Resident #104 stated she had gotten the food on her while eating lunch in the dining room. Resident #104 said she wanted help changing into clean clothes as it made her feel dirty. In an interview on 3-10-2026 at 3:50 PM, RN B said Resident #104 should have had her clothes changed when she came back from lunch. RN B said it could be a dignity issue if residents needing ADL Care were left with dirty clothes on. RN B said the staff member who transported Resident #104 into the dining room should have been the one to change Resident #104 into clean clothes after lunch. In an interview on 3-10-2026 at 4:00 PM, CNA A said the nursing staff worked 8-hour shifts, she worked 2:00 PM-10:00 PM and was responsible for Resident #104's care. CNA A said it was the responsibility of the CNA, working the hallway where the Resident lived, to change the Resident's clothes when they got dirty. CNA A said if a resident's clothes became dirty at lunch time, it was the responsibility of the CNA working the 6:00 AM -2:00 PM shift to change her clothes. CNA A said if a Resident was left in clothes with food on her, it could be a dignity problem and make the Resident feel like staff did not care for her. In an interview on 3-11-2026 at 11:00 AM, it was revealed that CNA C brought Resident #104 to the dining room, in her wheelchair, for lunch on 3-10-2026 because Resident #104 was getting confused about eating lunch. CNA C said the reason Resident #104 was left with food on her clothes, on 3-10-2026 after lunch, was because she got busy and did not have time to change Resident #104. CNA C said not changing a Resident's clothes, when they had gotten food on their clothes, could make a Resident feel dirty. CNA C said she was responsible for ensuring Resident #104 (continued on next page)

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	03/12/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had clean clothes on after lunch. In an interview on 3-11-2026 at 4:00 PM, the DON said her expectations were that Residents who needed ADL Assistance got the help they needed in a timely manner. The DON said Residents who have spilt food on themselves should get help changing their clothes in a timely manner. The DON said the CNAs were responsible to ensure ADL dependent Residents got the assistance they needed as it could affect the Resident's dignity. In an interview on 3-12-2026 at 2:15 PM, the Administrator said she expected the Residents, who needed ADL assistance, not be left with food on their clothes after eating. The Administrator said the CNAs or nurses, who were working in the hallway where the Resident resided, were responsible for ensuring proper and timely ADL care was given. The Administrator said if an ADL dependent Resident was left with food on her clothes, it could make her feel bad because she would not be able to clean herself. Record Review of the EMR, for Resident #104 dated 3-10-2026, revealed CNA C assisted Resident #104 with eating lunch on 3-10-2026. Record review of the facility's undated policy titled Resident Rights without a date stated: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.