STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455881	A. Building B. Wing	03/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dfw Nursing & Rehab	900 W Leuda 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 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** 48177 Based on observation, interview, and record review the facility failed to provide services to residents with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents by not providing a call light system within reach for 1 of 25 (Resident #2) observed for call lights. The facility failed to ensure Resident #2 had a call light within reach so Resident #2 could communicate to staff he needed assistance. This failure affected residents by placing them at risk for not getting their needs met and diminishing their quality of life. Findings include: Record review of Resident's #2s Face Sheet dated 3-5-2024 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a primary diagnosis of Hemiplegia (paralysis) and Hemiparesis (loss of strength in limbs) following a cerebrovascular disease (condition affecting blood flow to the brain) affecting the right dominant side, unspecified visual loss, seizures, and dysarthria (difficult or unclear articulation of speech) following cerebral infarction (stroke). Record Review of Resident #2s medical record dated 3-1-2024, indicated a Brief Interview Mental Status (BIMS) Score of 10, indicating moderate mental impairment. Record Review of Resident #2s Care Plan, dated 2-26-2024, revealed Resident #2 was at risk for falls. Resident #2s Care Plan stated interventions were to assure call light is within reach and encourage Resident #2 to call for assistance as needed. In an observation/interview, on 3-5-2024 at 2:20 PM, Resident #2 was observed to be lying on his bed. Resident #2 was observed to be a right leg amputee. Resident #2 was observed to not have a call light within reach. Resident #2s call light was observed to be underneath his bed, on the floor, and out of the reach of the resident. Resident #2 stated he used his call light and could not see well. Resident #2 stated he did not know where his call light was, and the call light was not within his reach. Resident #2 stated that the aides were not very attentive to resident's needs at the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 3-5-2024, at 4:15 PM, Resident #2 was observed to still not have his call light within reach and it was on the floor underneath his bed. On 3-5-2024, at 4:17 PM, CNA-E was informed of Resident #2 not having a call light within reach. CNA-E got on the floor, found the call light, put the call light within reach, and attached it to Resident #2s bed. In an interview with LVN-A, on 3-9-2024, at 1:00 PM, it was revealed if a resident does not have a call light within reach, it is considered neglect. LVN-A stated she did not know Resident #2's call light was not within reach. LVN-A stated, in her opinion, staff answer call lights timely. The concern, if a resident cannot reach his call light, is the resident may need help and staff will not know it. In an interview with the DON, on 3-9-2024 at 3:49 PM, it was revealed that CNAs are responsible for ensuring resident's call light are within reach, especially those with needs of ADL assistance. CNAs should make rounds every 2 hours to ensure this expectation is met. CNAs should also check when they first come onto their shifts and when they are leaving their shifts, to ensure residents have their call lights within reach. In an interview with the Administrator, on 3-9-2024, at 4:10 PM, revealed that his expectations for residents who need ADL assistance, were for call lights to be placed within reach and keep them close to the nurse's station as possible. The Administrator stated he has high expectations that care plans be followed by staff. The Administrator stated that the DON is responsible to ensure call lights remain within reach to ADL dependent residents and to ensure care plans are followed. Review of the facility's call light policy, dated 9-2022, revealed under general guidelines: #5) Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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(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** 48177 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan 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 for one of 5 residents (Resident #2) reviewed for comprehensive resident centered care plans. The facility failed to ensure the comprehensive resident centered care plan for Resident #2 was implemented by not putting a fall mat in Resident #2's room. This failure could place residents, that are at risk for falls, to be injured by not putting interventions listed in resident's care plan. Findings include: Record review of Resident's #2s Face Sheet dated 3-5-2024 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a primary diagnosis of Hemiplegia (paralysis) and Hemiparesis (loss of strength in limbs) following a cerebrovascular disease (condition affecting blood flow to the brain) affecting the right dominant side, unspecified visual loss, seizures, and dysarthria (difficult or unclear articulation of speech) following cerebral infarction (stroke). Record Review of Resident #2's medical record, in Resident #2's MDS, dated [DATE], indicated a Brief Interview Mental Status (BIMS) Score of 10, indicating moderate mental impairment. Record Review of Resident #2s Care Plan, dated 2-26-2024, revealed Resident #2 was at risk for falls and at risk for injury due to having a seizure disorder. The care plan stated Resident #2 had a fall on 2-26-2024. Resident #2s care plan revealed that Resident #2 have a fall mat, in his room, while in bed. Record Review of Nursing notes for Resident #2, dated 2-24-2024 thru 3-5-2024, indicated Resident#2 was not offered a fall mat before 3-5-2024. In an observation/interview, on 3-5-2024 at 2:20 PM, Resident #2 was observed to be lying on his bed. Resident #2 was observed to be a right leg amputee above the knee. Resident #2 stated he had poor vison and had never been offered a fall mat nor has he ever had a fall mat in his room. In an interview on 3-9-2024, with LVN-A, at 1:00 PM, who was the charge nurse for Resident#2s hall, revealed she did not know why Resident #2 did not have a fall mat. In an interview with the DON on 3-9-2024, at 3:4 PM, revealed her expectation was for Resident #2 to have what his care plan called for. The DON stated if Resident #2's care plan indicated he should have a fall mat, while in bed, then she expected Resident #2 to have had it in place. The DON did not know why Resident #2 did not have a fall mat in his room. (continued on next page)

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(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	In an interview with the Administrator, on 3-9-2024, at 4:10 PM, revealed that he had high expectations that care plans be followed by staff and that the DON is ultimately responsible that care plans are implemented. Record Review of the facility's care plan policy dated 12-2016, revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .#8 the comprehensive, person-centered care plan will (b) describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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(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	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** 48177 Based on observation, interview, and record review the facility failed to provide residents who were unable to carry out ADLs the necessary services to maintain good personal hygiene for 1 of 25 residents (Resident #1) reviewed for showers. The facility failed to ensure Resent #1 received showers/baths on scheduled shower/bath days. This failure affected residents by putting them at risk for a diminished quality of life, hygiene, and self-esteem. Findings include: Record review of Resident's #1 Face Sheet dated 3-5-2024, indicated a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of type 2 diabetes mellitus, morbid obesity due to excess calories, cerebral infarction (stroke), and osteoarthritis. Record review of Resident's #1 care plan dated 6-21-2023, revealed he required extensive/total assist with ADL's due to morbid obesity and late effect CVA (an interruption in the flow of blood to cells in the brain) with hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscle). CNAs were to provide incontinence care in PAIRS, d/t resident's sexually inappropriate behaviors. Resident #1 had impaired cognitive function needing staff to sometimes use yes/no questions to determine Resident #1's needs. Resident #1 had impaired comprehension which required staff to speak distinctly and slowly while communicating. Resident #1 required checks every two hours for total care with toileting with disposable briefs. Resident #1 required cleansing of the right buttock shear with normal saline/wound cleanser and pat dry. Apply triad to the area daily and as needed for soiling. In an observation of Resident #1, on 3-5-2024 at 11:25 AM, in his bedroom, revealed a strong smell of feces coming from Resident #1s bed. In an interview with Resident #1, on 3/5/2024, at 12:20 PM, Resident #1 stated his problem was getting a bed-bath on a regular basis. Resident #1 stated he cannot get showers. Resident #1 stated he is supposed to get a bath on Mondays, Wednesdays, and Fridays. Resident #1 said sometimes he goes a week at a time without getting a bed-bath by staff. Resident #1 stated that sometimes CNAs will walk in the doorway of his room and tell him you're not getting a bath today. Resident #1 stated he does not always get bathed on scheduled days since he was admitted to the facility, and he has never refused a bed-bath. Resident #1 stated he uses a bed pan to have bowel movement in bed as he cannot get to the bathroom to use it. Resident #1 stated he is totally dependent on staff to clean/wipe him when he has a bowel movement or urinates. Resident #1 stated female staff have made fun of him before because of his obese size. This made him feel disrespected. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA-D, on 3-5-2024 at 1:20 PM, CNA-D stated working with Resident #1 has been difficult as he would be disrespectful, curse staff, and yell at them - if he does not get help instantly. CNA-D stated her work hours were 6:00 AM - 2:00 PM. CNA-D said, when she came to work on Sunday (3-3-2024), there was a shift meeting indicating a call light had been left on, for a long time, with no response on Saturday. CNA-D stated, for the facility to be fully staffed, there should be 4 CNAs and 1 shower aide. CNA-D stated that today, 3-5-2024, there was only 3 CNAs working and no shower aide. CNA-D stated Resident #1 used a bed pan for restroom use and today (3-5-2024) he received a bed-bath. In an interview with LVN-A on 3-9-2024 at 1:00 PM, LVN-A stated she has only worked at the facility for a month and worked in Hall B where Resident #1 was residing. LVN-A stated that the facility had a shower aide that gives the showers for the facility. The showers were documented in the shower logbook and not documented in the Point Care Click Electronic Medical Record System. LVN-A stated, as for as she knew, the shower aide, gives the showers to all the residents in Hall B. LVN-A stated she has not witnessed aides being rude to Resident #1. LVN-A stated that the nurse signs off on the shower log ensuring showers are given but the shower aide is responsible for giving the showers. In an interview with CNA-F, on 3-9-2024, at 2:35 PM, it was revealed CNA has worked at facility for [AGE] years. CNA-F stated that when a resident received a shower, it is documented in the shower logbook for each hall. Resident #1 is in Hall-B. Resident #1s shower sheets are in Hall-B's shower logbook. CNA-F stated the PCC may not be used when staffing is short. CNA-F stated that if a resident refused a shower/bath, it would have been documented in the shower logbook. CNA-F stated, because of Resident #1's sexual inuendoes, new CNAs might not have wanted to bath Resident #1. Record Review of the shower log, on 3-5-2024, for the B-Hall area, for Resident #1 revealed the last time Resident #1 took a shower was 2-28-2024. This shower log indicated it had been 6 days since Resident #1 had received a bed-bath or shower. The shower log for Hall B indicated that even number of resident's rooms were bathed or showered on Monday, Wednesday, and Friday. Resident #1s room was room [ROOM NUMBER]. There was no indication where Resident #1 ever refused a shower/bed-bath. In an interview with the DON on 3-9-2024, at 3:49 PM, it was disclosed that the DON is responsible for ensuring showers/baths are completed for residents. The DON stated that the CNAs gave the showers and sometimes they could have a shower aide who gave their showers. The shower sheets were where the shower/baths were documented when showers were given or refused. The DON revealed in Hall-B, showers were given in the evening time. The DON stated the CNAs were responsible for ensuring residents who needed ADL assistance get bathed/showered. In an interview with the Administrator on 3-9-2024, at 4:10 PM, it was disclosed that showers and baths were an issue at every nursing home. The Administrator stated the worst thing was for a resident to say the facility was not up to date on his/her showers. The Administrator stated residents should be offered a shower every other day and residents could tell him if they were not getting a shower. The Administrator stated he had zero tolerance for a resident not getting his/her shower or bath. The Administrator stated it is every staff member's responsibility to ensure residents get showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility's shower policy, not dated, on the shower log, indicated A-bed residents shower on 6 AM to 2 PM shift and B-bed residents will receive showers on the 2 PM to 10 PM Shift. The policy further revealed even numbered rooms will shower/bath Monday, Wednesday, Fridays, and odd number rooms will shower on Tuesday, Thursday, and Friday. The policy revealed every resident is offered a shower 3 times a week and are encouraged to take their shower on their scheduled day and time. Bed baths are an acceptable option, but the best practice is a full warm shower, so all areas of skin are cleaned .bed baths are good, but not as good or beneficial as a nice invigorating shower. Record Review of the facility's call light policy dated 3-2018, shows the purpose and guidelines are: .to ensure timely responses to the resident's request and needs.

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(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** 48177 Based on observation, interview, and record review the facility failed to must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 25 (Resident #2) observed for call lights. The facility failed to ensure Resident #2 had a call light within reach so Resident #2 could communicate to staff he needed assistance. The facility failed to enure Resident #2 had a fall mat next to the bed as indicated in Resident #2's care plan. This failure affected residents by placing them at risk for not getting their needs met and diminishing their quality of life. Findings include: Record review of Resident's #2's Face Sheet dated 3-5-2024 indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had a primary diagnosis of Hemiplegia (paralysis) and Hemiparesis (loss of strength in limbs) following a cerebrovascular disease (condition affecting blood flow to the brain) affecting the right dominant side, unspecified visual loss, seizures, and dysarthria (difficult or unclear articulation of speech) following cerebral infarction (stroke). Record Review of Resident #2's medical record dated 3-1-2024, indicated a Brief Interview Mental Status (BIMS) Score of 10, indicating moderate mental impairment. Record Review of Resident #2s Care Plan, dated 2-26-2024, revealed Resident #2 was at risk for falls and at risk for injury due to having a seizure disorder. The care plan stated Resident #2 had a fall on 2-26-2024. Resident #2s care plan revealed that Resident #2 have a fall mat, in his room, while in bed. Resident #2's Care Plan stated interventions were to assure call light is within reach and encourage Resident #2 to call for assistance as needed. Record Review of Nursing notes for Resident #2, dated 2-24-2024 thru 3-5-2024, indicated Resident #2 was not offered a fall mat before 3-5-2024. In an observation/interview, on 3-5-2024 at 2:20 PM, Resident #2 was observed to be lying on his bed. Resident #2 was observed to be a right leg amputee. Resident #2 was observed to not have a call light within reach. Resident #2's call light was observed to be underneath his bed, on the floor, and out of the reach of the resident. Resident #2 stated he used his call light and could not see well. Resident #2 stated he did not know where his call light was, and the call light was not within his reach. Resident #2 stated that the aides were not very attentive to resident's needs at the facility. (continued on next page)

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(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	In an observation/interview, on 3-5-2024 at 2:20 PM, Resident #2 was observed to be lying on his bed. Resident #2 was observed to be a right leg amputee above the knee. Resident #2 stated he had poor vison and had never been offered a fall mat nor has he ever had a fall mat in his room. In an observation on 3-5-2024, at 4:15 PM, Resident #2 was observed to still not have his call light within reach and it was on the floor underneath his bed. On 3-5-2024, at 4:17 PM, CNA-E was informed of Resident #2 not having a call light within reach. CNA-E got on the floor, found the call light, put the call light within reach, and attached it to Resident #2s bed. In an interview on 3-9-2024, with LVN-A, at 1:00 PM, who was the charge nurse for Resident#2s hall, revealed she did not know why Resident #2 did not have a fall mat. She stated if a resident does not have a call light within reach, it is considered neglect. LVN-A stated she did not know Resident #2's call light was not within reach. LVN-A stated, in her opinion, staff answer call lights timely. The concern, if a resident cannot reach his call light, is the resident may need help and staff will not know it. In an interview with the DON on 3-9-2024, at 3:40 PM, revealed her expectation was for Resident #2 to have what his care plan called for. The DON stated if Resident #2's care plan indicated he should have a fall mat, while in bed, then she expected Resident #2 to have had it in place. The DON did not know why Resident #2 did not have a fall mat in his room. In an interview with the DON, on 3-9-2024 at 3:49 PM, it was revealed that CNAs are responsible for ensuring resident's call light are within reach, especially those with needs of ADL assistance. CNAs should make rounds every 2 hours to ensure this expectation is met. CNAs should also check when they first come onto their shifts and when they are leaving their shifts, to ensure residents have their call lights within reach. In an interview with the Administrator, on 3-9-2024, at 4:10 PM, revealed that he had high expectations that care plans be followed by staff and that the DON is ultimately responsible that care plans are implemented. He stated his expectations for residents who need ADL assistance, were for call lights to be placed within reach and keep them close to the nurse's station as possible. The Administrator stated he has high expectations that care plans be followed by staff. The Administrator stated that the DON is responsible to ensure call lights remain within reach to ADL dependent residents and to ensure care plans are followed. Review of the facility's call light policy, dated 9-2022, revealed under general guidelines: #5) Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. Record Review of the facility's care plan policy dated 12-2016, revealed: (continued on next page)

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(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	A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .#8 the comprehensive, person-centered care plan will (b) describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.