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	04/23/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interviews and record reviews, the facility failed to immediately consult with the resident's physician and notify the resident representative when there was a significant change in the resident's condition or need to alter treatment significantly for one (Resident #1) of five residents reviewed for change of condition. -The facility failed to notify Resident #1's physician and responsible party when the resident had a fall on 3/27/24 and when the resident showed signs of increased lethargy and altered mental status as the week progressed. An Immediate Jeopardy (IJ) was identified on 04/22/24. An IJ Template was provided to the facility on [DATE] at 1:28 PM. While the Immediate Jeopardy was removed on 04/23/24 at 02:02 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place all residents at risk of not receiving immediate medical attention when there is a change in their condition. Findings included : Record review of Resident #1's face sheet, dated, 04/02/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: encephalopathy (change in brain function), sickle cell (blood disorder), type II diabetes, cerebral infarction (stroke), and cirrhosis of liver (chronic liver damage). Record review of Resident #1's EHR revealed she did not have a completed admission MDS assessment. Further review revealed Resident #1 had a BIMs of 11 which indicated moderate cognitive impairment. Record review of Resident #1's baseline care plan, dated, 03/27/24, revealed the resident's level of consciousness was lethargic and she was cognitively impaired. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's consolidated admitting orders, dated 3/25/24, reflected an order to make the family/resident/responsible party aware of the resident's conditions. Further review reflected a lack of documentation of an order to make the MD aware of Resident #1's conditions, besides new onset symptoms of COVID-19. Record review of Resident #1's discharge hospital records (prior to admitting to [nursing facility]), dated 3/11/24-3/25/24, reflected the following: Progress note at 3/14/24 1:30 PM: . Assessment/Plan: . -Place NGT if [Resident #1] is lethargic and is unable to take PO. . Discharge Summary at 03/25/24 7:06 PM: Principle Final Diagnosis: Acute hepatic encephalopathy . Test results pending at discharge: none. Follow-up appointments: none Summary of hospital course: Hepatic encephalopathy Known history of cirrhosis secondary to alcohol abuse . Physical therapy and occupational therapy consulted, recommending SNF. [Resident #1] was improving but 03/19/24 worsening in mental status; oriented to person only. Repeat ammonia on 03/20/24 up to 178. . Mental status has now returned to [Resident #1] baseline. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. Therapeutic diet, encourage PO intake. . Further review of discharge hospital records reflected no documentation that ammonia levels were rechecked on 03/20/24 or prior to discharge. Record review of Resident #1's hospital records, dated 3/31/24, reflected the following: [Resident #1 is a [AGE] year-old female with history of CKD, cirrhosis (liver damage), encephalopathy (change in brain function), CVA (stroke), diabetes, hypertension (high blood pressure), who presents via EMS from nursing home due to altered mental status and facial droop. Per EMS, [Resident #1] is GCS (scale that assesses consciousness) 15 (mild brain injury) at baseline and able to speak and follow commands. Last known normal was 2 days ago per EMS until noticing change in neurological status today. [Resident #1] was recently admitted on [DATE] for hepatic encephalopathy (loss of brain function due to liver damage). . Laboratory Results: . Ammonia, plasma-205 umol/L (severely elevated) . Imaging results (CT head): 1. No acute intracranial abnormality. Chronic atrophic and chronic ischemic changes (brain damage), similar to the prior. In an interview on 04/02/24 at 9:48 AM, Resident #1's family member stated Resident #1 admitted to the facility after being in the hospital for about two weeks where she was being treated for complications related to her diabetes to her knowledge. The family member stated Resident #1 was visited at the facility on 03/30/24 by another family member and they were upset because Resident #1 did not look good, and staff reported she had been sleeping a lot more. The family member stated she had not been informed of a change in Resident #1's condition by the facility. The family member stated Resident #1 had a fall on 03/27/24 and they were informed of that by the roommate. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/02/24 at 10:48 AM, RN A, who worked at the local hospital, stated Resident #1 was previously admitted to the hospital from 3/11/24-3/25/24 for altered mental status and hyperglycemia (high blood sugar), and returned to the hospital on 03/31/24 with similar symptoms. RN A stated Resident #1 returned with altered mental status, encephalopathy (change in brain function), and critically high levels of ammonia from liver failure. RN A stated Resident #1 has been sleeping and nonverbal since admitting and had to get a nasogastric tube placed to receive nutrition and medication. RN A stated Resident #1's CT scans only showed evidence of past stroke with no new changes. In an interview on 04/02/24 at 10:48 AM, LVN B stated she worked at the facility since 02/2024. She stated she worked weekdays, 6am-2pm, and worked with Resident #1. LVN B stated she worked with Resident #1 on the day she was admitted , and Resident #1 was alert x 2 (only aware of person and place) and could respond to her name and answer yes/no questions. LVN B stated Resident #1 was confused and required assistance with eating as she would not initiate eating or drinking on her own. LVN B stated Resident #1 always seemed to have low energy and did not speak most of the time, but one morning during rounds she heard Resident #1 saying she was hungry and wanted a hotdog. LVN B stated she was the nurse who received report from the hospital before Resident #1 admitted to the facility, and they reported that Resident #1 had an altered mental status, hyperglycemia, and encephalopathy (change in brain function). LVN B stated she last worked with Resident #1 on the morning of 03/29/24 and the resident seemed to be less responsive than she had been and now required touch for response; however, before she would respond to her name. LVN B denied that Resident #1 showed signs of a stroke. LVN B stated she was responsible for checking Resident #1's blood sugar every morning and she was a little more responsive during previous mornings. LVN B stated a resident being less responsive was something that would be reported to the MD. LVN B stated she did not notify the MD of the change because she thought Resident #1 could have been sleepy due to it being early in the morning. In an interview on 04/02/24 at 10:48 AM, CNA C stated she worked at the facility for 3 years. CNA C stated she worked 6am-2pm on different halls, but she worked with Resident #1 on 03/28/24 and 03/31/24. CNA C stated on 03/28/24, Resident #1 was alert and eating but was not talking. CNA C stated she worked with Resident #1 again on 03/31/24 and there was a significant change. CNA C stated Resident #1 would not eat and required total assistance with care. CNA C stated before, Resident #1 could help move herself slightly during incontinent care. CNA C stated Resident #1 was weaker and less responsive. She stated she reported it to LVN F on 3/31/24. In an interview on 04/02/24 at 10:48 AM, CNA D stated she worked at the facility for 4 weeks. She stated she worked 6am-2pm on weekdays and worked with Resident #1 on 03/26/24, 03/27/24, and 03/28/24. CNA D stated earlier in the week, Resident #1 was talkative and very feisty. CNA D stated as the week went on, Resident #1 started talking less and was sleeping more. CNA D stated on the last day she worked with Resident #1 she was still sleeping more and had to be woken up for meals. She stated she was able to get Resident #1 to eat some of her food, but she was eating less. CNA D stated this was reported to the nurse; however, staff were still learning Resident #1's baseline and she was not sure what to think about the change. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/02/24 at 01:19 PM, the DON stated she was not at the facility when Resident #1 admitted ; however, she was there the next day and poked her head in to speak to Resident #1 and she responded. The DON stated there were no reports of a significant change in Resident #1 until 03/26/24 when LVN E reported the resident being nonresponsive with a blood glucose level of 50. The DON stated the MD was notified on 03/26/24 regarding the resident's low blood glucose, and after giving Resident #1 emergency Glucagon (medication to regulate blood glucose) and juice, her blood glucose stabilized. The DON stated EMS had already been called out to the facility, but the DON and MD decided not to transport Resident #1 to the hospital since her vitals were stable. The DON stated she did not receive any other report of a significant change in Resident #1 until 03/31/24 when it was reported that the resident was not waking up, eating, or responding. The DON stated staff reported Resident #1 had not eaten a lot in a day or so. The DON stated she went to assess Resident #1 and she was sleeping. The DON stated she pinched Resident #1's skin and she appeared to be dehydrated. The DON stated she told LVN G to call the MD and he gave an order to send Resident #1 to the hospital. The DON stated Resident #1 admitted to the hospital with hyperglycemia and was always lethargic with little response from the beginning. The DON stated the staff were still getting familiar with Resident #1's baseline as she had only been at the facility for a week; however, if there was any change from the day she admitted , the expectation was for the staff to report it to the DON and MD. In an interview on 04/02/24 at 02:05 PM, LVN E stated she admitted Resident #1 to the facility on [DATE]. LVN E stated Resident #1 was unarousable and would not speak or open her eyes when she admitted . LVN E stated Resident #1's baseline remained the same throughout the week and she never saw the resident feisty or very alert. LVN E stated on 03/26/24 she had to call the MD after Resident #1's blood glucose dropped, and she received an order to give the resident Glucagon (medication to regulate blood glucose). LVN E stated Resident #1 then had a fall on 03/27/24 with no injuries and she did not notify the MD although it was protocol. LVN E stated she would normally notify the MD of falls; however, she just forgot to do so for this incident. In an interview on 04/02/24 at 02:53 PM, the MD stated he visited the facility every Wednesday; however, he did not see Resident #1 when he visited on 03/27/24. The MD stated he had been notified of Resident #1's low blood sugar the day prior (3/26/24), but no one reported any other significant change or brought it to his attention that Resident #1 needed to be seen that day. The MD stated he was also not notified that Resident #1 had a fall on 03/27/24. The MD stated it was the expectation for staff to notify him of falls, but if it was late at night with no injury or change of condition, they could report it the following morning. The MD stated with Resident #1 being a new resident and due to her condition, he would have expected staff to notify him of her fall and any other changes. In an interview on 04/02/24 at 03:30 PM, LVN F stated she worked at the facility for 2 weeks. She stated she worked with Resident #1 on 03/30/24 and 03/31/24. LVN F stated Resident #1 was sleeping most of the time and not eating much during both shifts. LVN F stated on 03/31/24 the aide reported Resident #1 did not look like she was going to make it. LVN F stated she went to assess Resident #1 and she was very weak and lethargic, but the resident would open her eyes when spoken to, respond to sternum rub, and her vitals were normal. LVN F stated Resident #1's face was not drooping, and she did not have any other signs of a stroke. LVN F stated she notified the MD on 3/31/24 that Resident #1 had been sleeping more the past two days, was unarousable, and eating less, and the MD ordered Resident #1 to be sent out to the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/02/24 at 04:00PM, Resident #2 stated Resident #1 was her roommate for about a week. Resident #2 stated Resident #1 would sleep most of the time and only wake up for medication and to eat. Resident #2 stated Resident #1 was not able to converse with her but would sometimes pick up words from the television and repeat them over and over. In an interview on 04/02/24 at 05:05 PM with the DON and the Administrator, the DON stated she expected staff to notify her and the MD of any significant change in a resident's condition. The DON stated the MD wanted to make it clear to Investigator that the facility received a resident who was not stable enough to leave the hospital. The Administrator stated reporting a change of condition was easier said than done, especially with a new resident when staff were not familiar with their baseline. In an attempt to further interview about expectations and risks to the resident, the Administrator stated, no comment. In an interview on 04/23/24 at 10:08 AM with the Regional Nurse revealed she understood the facility failed to notify the physician of significant changes in Resident #1 after multiple opportunities presented, including a fall and other changes in mental and physical status that indicated a decline in health. The Regional Nurse stated her expectation and the facility's policy for any significant incidents and change in condition to be reported immediately. The Regional Nurse stated the risk of not notifying the MD of significant incidents and change of condition could result in a resident having serious harm or death. Review of the facility's policy titled Notification of Change, undated, revealed in part the following: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. . Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: . 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health mental. Or psychosocial status [sic]. This may include: a. Life-threatening conditions, or b. Clinical complications An Immediate Jeopardy (IJ) was identified on 04/22/24 at 11:45 AM. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/22/24 at 12:35 PM, the Administrator and the DON were notified of the IJ. The IJ template was provided to the Administrator and a plan of removal (POR) was requested at that time. The POR was accepted on 04/23/24 at 10:11 AM. The POR reflected the following: Issue Cited: Failure to Notify the Physician of a Significant Change of Condition Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur. 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 4/22/24) o The DON or designee notified the facility Medical Director of the incident. o Nursing supervisors/designees completed physical assessments on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were/were not identified. (Provide details if concerns were identified from the physical assessments). 2. Actions to Prevent Occurrence/Recurrence: The facility took, the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 4/23/24) o All licensed nurses will be educated by the DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure. o Nurse aides will be educated by the DON/designee on change of condition regulations to promote their situational understanding and facilitate communication with licensed nurses. o Staff members are not permitted to work a shift until education was completed. o New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by human resources/designee. o The DON implemented a Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 04/23/24 (10:08 AM-1:43 PM) were conducted with DON, ADON, LVN B (1st shift), LVN E (2nd shift), LVN G (1st shift), LVN H (1st shift), CNA I (1st shift), MA J (1st shift), CNA K (1st shift), CNA L (2nd shift), LVN M (2nd shift), CNA N (3rd shift), LVN O (3rd shift), LVN P (double weekends). All interviewed aides were able to provide competency regarding in-services over monitoring for and reporting change of condition to the charge nurse. The aides stated they knew to monitor residents for any changes to skin, behavior, mental/physical status while performing care and to immediately report it to the charge nurse and/or DON. All interviewed licensed staff were able to provide competency regarding monitoring for and acknowledging reports of change of condition and reporting to the physician. The licensed staff stated they were responsible for monitoring resident for any signs of change in condition, assessing a resident after receiving reports of change in condition from the aides, and immediately reporting any concerns to the DON/MD/family. An Immediate Jeopardy (IJ) was identified on 04/22/24. An IJ Template was provided to the facility on [DATE] at 1:28 PM. While the Immediate Jeopardy was removed on 04/23/24 at 02:02 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.