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	10/28/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interviews and record reviews, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for 2 of 7 residents (Resident #1 and Resident #5) reviewed for Accuracy of Assessments. 1. Resident #1's discharge MDS assessment dated [DATE] did not accurately reflect his current and MD order for Hemodialysis treatment in Section O. 2. Resident #5's quarterly MDS assessment dated [DATE] did not accurately reflect his current MD order for continuous oxygen treatment in Section O. These failures could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Resident #1 Record review of Resident #1's face sheet dated 10/28/24 reflected he was a [AGE] year-old-male, admitted on [DATE] and readmission on 10/22/24. Resident #1's DX included: Chronic Kidney Disease Stage 3 convulsions dependent on dialysis (kidney failure). Record review of Resident #1's MD orders, dated 01/26/24 reflected an order for Dialysis on (Tuesday, Thursday, and Saturday) at 6:00 AM. Record review of Resident # 1's October 2024 TAR and progress notes reflected that Resident was transported and received Dialysis treatment on Tuesday,10/01/24; Thursday, 10/03/24; Sunday, 10/06/24; Tuesday, 10/08/24; Thursday, 10/10/24; Saturday, 10/12/24; Tuesday, 10/15/24; Thursday, 10/17/24; Saturday, 10/19/24; and Tuesday 10/22/24. Record review of Resident #1's discharge MDS dated [DATE] reflected he had a BIMS score of 11 indicating he was moderately impaired cognitively. Resident #1's treatment of dialysis after discharge to a new facility was not addressed in his MDS. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Care Plans dated 07/29/24 revealed Resident #1 a Focus area Resident has the potential for complications related to ESRD (End Stage Renal Disease, kidney failure) Dialysis on Tuesday, Thursday, and Saturday chair time . Communicate with Dialysis as needed re: medication, diet, lab results. Enhanced barrier precautions, monitor dialysis site q (every) shift for s/s infections, bleeding, swelling & other abnormalities, notify physician if noted &/or as needed .Free Transportation. Resident will remain free from discomfort or further complications related to ESRD through next review in 90 days. Administer related medication as ordered observing for effectiveness &/or side effects. Notify physician as needed. Check dialysis fistula (surgical connection between artery and vein for dialysis) to (right chest) for thrill & bruit q shift. Notify dialysis & physician if not thrill/bruit (a vibration/ sound in the skin caused by irregular blood flow) noted. Communicate with dialysis as needed re: medication, diet, lab results. In an interview with Resident #1 on 10/22/24 at 12:45 PM revealed he was transported to dialysis every Tuesday, Thursday, and Saturday morning for treatment by his insurance transporter. He denied missing any appointments or that his MD orders had been discontinued. Resident #5 Record review of Resident #5's face sheet dated 10/28/24 reflected he was a [AGE] year-old male, admitted on [DATE] with DX: COPD (Continuous obstructive pulmonary disease lung disease), Asthma (a disease affecting the flow of air to the lungs, CHF (Congestive Heart Failure.) Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 11 indicating he was moderately impaired cognitively. The MDS reflected active diagnosis: Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases). The MDS did not address Resident #5's MD orders for continuous use of oxygen treatments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#5's care plan dated 09/05/24 reflected Resident requires oxygen therapy r/t COPD . please document refusals every evening and night shift .Resident will have no signs and symptoms of poor oxygen absorption during this quarter. Assure call light always within reach so if assistance needed when having respiratory distress .Give medications as ordered, monitor/document side effects and effectiveness .Monitor for signs and symptoms of respiratory distress such as respirations, pulse oximetry device that monitors blood oxygen, increased heart rate, restlessness confusion, skin color Obtain O2 saturation (oxygen in the blood) q shift. Potential for respiratory difficulty/complications related to CHF . Related medication will be effective as evidenced by no s/s exacerbation of CHF. Review in 90 days . Lung sounds prn. Notify physician abnormalities noted &/or as needed. Monitor for changes in/development of s/s of breathing difficulty re: SOB, productive or non-productive cough, fever, chills, difficulty speaking, bluish skin color, changes in cognitive. Notify physician if noted .Monitor for edema & SOB q shift. Notify physician as needed abnormalities noted monitor for edema (fluid retention) q shift every shift for edema weekly weights .Give medications as ordered. Monitor/document side effects and effectiveness Monitor for s/sx of impending asthma attack: coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, wheezing (whistle sound in the lungs), shortness of breath, tightness of neck or chest muscles, fatigue .Monitor vital signs as ordered, skin color, pulse oximetry, airway functioning and degree of restlessness which may indicate hypoxia (area deprived from oxygen). O2 sats Q shift. Oxygen at 3L continuous shortness of breath Record review of Resident #5's MD orders dated 04/19/24 reflected Check O2 sat every shift every shift . Oxygen at 3L continuous. every shift. Resident review of Resident #5's August 2024 TAR reflected he was administered oxygen treatment continuously per MD orders 08/01/24 to 08/31/24. Resident review of Resident #5's September 2024 TAR reflected continuous oxygen treatment he was administered oxygen treatment continuously per MD orders from 09/01/24 to 09/30/24. Resident review of Resident #5's October TAR reflected he was administered oxygen treatment continuously per MD orders from 10/01/24 to 10/28/24. In an observation on 10/22/24 at 11:10 AM of Resident #5 revealed the resident with his nasal cannula in his nose and the oxygen concentrator powered on and in use. In an interview on 10/22/24 at 11:13 AM with Resident #5 he stated that he received oxygen treatment daily. Resident #5 stated that he had not missed any oxygen treatments while residing at the facility. In an interview on 10/28/24 at 1:14 PM with the MDS/LVN he stated he had worked at the facility for 6 years. He stated that he completed the MDS assessments for Resident #1 on 10/23/24 and Resident #5 on 08/29/24. The MDS/LVN stated that he missed documenting Resident #1's dialysis on his discharge MDS assessment. The MDS/LVN said that he missed documenting Resident #5's oxygen use on his quarterly MDS. The MDS/LVN said there was not a risk to the residents for MDSs being incorrect. The MDS LVN said he reviews the MDS, and the assessment was for state agency's audits and resident billing. The MDS/LVN said it was important for the MDS to be comprehensive of the resident's treatment and accurate for all residents at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/28/24 at 1:44 PM with the DON revealed that Resident #1 had an active order for dialysis treatment and Resident #5 has an MD order for continuous oxygen use to addressed related diagnosis. She stated that the MDS should reflect all treatments ordered by the MD for accuracy of care and consistent records to prevent the residents from missing care and treatments. In an interview on 10/28/24 at 1:49 PM with the ADM revealed that he was not sure if there was a risk to the residents when the comprehensive MDSs was not accurate and reflected needed treatments ordered by the MD. He provided no additional information when asked. Record review of the CMS's RAI Version 3.0 Manual dated 10/01/24 reflected The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.