

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/14/2025
NAME OF PROVIDER OR SUPPLIER  Dfw Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46403</p> <p>Based on observation, interview, and record review the facility failed to ensure residents had the right to be from abuse for 1 of 4 residents (Residents #1) reviewed for abuse.</p> <p>The facility failed to protect Residents #1 from a physical and verbal altercation on 01/22/25 with the Administrator. The Administrator pushed Resident#1, causing Resident#1 to fall. The incident was not reported or documented until after surveyor intervention on 01/23/25. The Administrator was not suspended until 01/23/25 at approximately 11:30 AM.</p> <p>An IJ was identified on 01/23/25. The IJ template was provided to the facility on [DATE] at 5:15 PM. While the IJ was removed on 01/25/25, the facility remained out of compliance at a scope of Isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems .</p> <p>This failure placed residents at risk of subsequent abuse, mental anguish, and emotional distress.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 01/23/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Schizophrenia (Serious mental health condition that affects how people think, feel and behave), Type 2 Diabetes Mellitus with Diabetic, Unspecified Psychosis not due to substance or known major depressive disorder.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 10/28/24, reflected Resident #1 had a BIMS of 12, which indicated cognition moderate impaired.</p> <p>Record review of Resident #1's care plan, revised 09/20/24, revealed the resident at risk for altered status due to a traumatic life experience while at a previous group home or [Nursing Facility]. Certain male figures in authority positions, with similar physical attributes or appearance at times trigger him. Interventions in place included: Administer medication as ordered, approach resident from the front and speak in a calm, unhurried manner .Identify cause/trigger for behavior and reduce factors that may provoke resident .Call [Family Member#1] if need to calm down or get him to comprehend the situation]</p> <p>.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Record review of Psychological Services Progress Note, dated 10/08/24 and completed by Psy services reflected, Resident#1 was negative for Trauma Informed Care.</p> <p>Record review revealed no incident/accident report was completed about the incident on 01/22/25.</p> <p>Record review of Resident#1 progress noted dated, 11/01/23 to 01/22/25 reflected: Resident#1 had other incidents with other staff but not the Administrator.</p> <p>Record review of Resident#1 progress notes revealed no documentation about the incident on 01/22/25.</p> <p>Record review of Resident#1 assessments revealed no documentation about incident on 01/22/25.</p> <p>Record review of Resident#1 incident provided to surveyor on 01/25/25 reflected: it was initiated on 01/22/25 with no completed/ locked date on the incident report. Incident description section reflected: This [LVN K] was notified by staff after the incident that [Resident#1] slapped [MA N] and physically attacked Administrator and [Resident#1] fell to the floor. Resident description reflected: [Resident#1] stated he was approached by Administrator, in what he felt was an aggressive manner so I just swung on his . Immediate action taken section reflected: [Resident#1] assessed for injuries. None noted, denied pain or any discomfort. Physician notified, In the agencies/people notified section reflected: no notification found,</p> <p>An interview on 01/23/25 at 10:20 AM Family Member#1 approached surveyor at the facility and stated the Administrator fought [Resident#1] last night. Family Member#1 stated that was wrong and he is elderly. Family Member#1 stated the Administrator was always picking on him when Resident#1 wanted to play his piano. Resident#1 did not speak to the Administrator when the Administrator would try to speak to him</p> <p>An in-person interview on 01/23/25 at 10:45 AM, the Administrator and MA N entered the conference room to explain the incident on 01/22/25. The administrator stated Resident#1 assaulted a medication aide around 7pm on 01/22/25. The Administrator stated the medication aide and himself went to Resident#1s room. Resident#1 was asked why he hit the medication aide. The Administrator stated Resident#1 started punching and kicking the Administrator and made threats. The Administrator stated he put his hands up to protect himself. The Administrator stated Resident#1 tripped over his own leg and fell . The Administrator stated [CNA J], [CNA L] and [LVN P] intervened and pulled Resident#1 away. The Administrator stated he was told by Resident#1 and Family member that he reminded Resident#1 of males from his past that made fun of him and were aggressive towards him because he was gay. The Administrator stated it did not have to be reported because it was an altercation between staff and a resident.</p> <p>An interview on 01/23/25 at 10:45 AM, MA N stated Resident#1 took snacks off the snack tray and hit MA N's face when she asked him what he was doing. MA N immediately reported to the Administrator who went to Resident#1 to ask what happened and Resident#1 hit the Administrator.</p> <p>An interview on 01/23/25 at 11:00 AM, the DON stated she was not made aware of the incident until after 10:15 AM on 01/23/25 when Resident#1 family member came into her office. The DON immediately called her nurse consultant and informed her of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview and observation on 01/23/25 at 11:05 AM of the camera in the Administrator office with the PD revealed, Resident was punching and kicking the Administrator. The Administrator open hand pushed Resident#1 face area and caused Resident#1 to fall. Observed a linen cart pushed between the Administrator and Resident#1. Observation of additional staff stepped in between Resident#1 and Administrator. Staff were observed holding the Administrator back and grabbing Resident#1. PD stated an incident would be put on file but no arrest or charges because the resident started the altercation. Surveyor did not recall observing a date and time on the footage.</p> <p>An interview on 01/23/25 at 11:30 AM, Ombudsmen stated she had not been notified about the physical altercation between the Administrator and Resident#1.</p> <p>An over the phone interview on 01/23/25 at 1:30 PM the Corporate Operations Manager and Nurse Consultant stated they were not made aware of the abuse allegation until 1/23/25 at approximately 10:30 AM. The Administrator (Abuse coordinator) was asked to go home until the investigation was completed. Both stated it did not have to be reported to State since there was not an allegation of abuse at the time of the incident. Operations Manager stated that is the company policy for all that when an investigation of abuse had been reported the staff member would be suspended until the investigation was completed. Corporate Operations Manager and Nurse Consultant both stated the Administrator was suspended until the investigation was completed. Both stated there was no risk to residents, as soon as they found out about the incident the facility took immediate action.</p> <p>An interview with Resident#1 on 01/23/25 at 2:15 PM he stated he would not feel safe in the facility if the Administrator returned. Resident#1 stated the Administrator hit him and he hit him back.</p> <p>An interview on 01/23/25 at 4:11PM CNA J stated it was chaos in the hallway and he did not see how the incident started. CNA J stated he saw Resident#1 kicking and hitting the Administrator. CNA J stated he tried to intervene but did not want to get hit by Resident#1 so, he pushed a linen cart between them. CNA J stated he did not see how the resident fell . CNA J stated he grabbed Resident#1 and took him outside to smoke.</p> <p>An interview on 01/23/25 at 4:20 PM LVN P stated he witnessed Resident#1 swinging both of his arms towards the Administrator LVN P stated they separated Resident#1 and the Administrator.</p> <p>An interview on 01/24/25 at 4:30 PM CNA L stated Resident#1 was kicking and hitting the Administrator in the hallway. CNA L stated he did not see how Resident#1 fell but, he jumped back up and continued to attack the Administrator. CNA L stated the Administrator and Resident#1 were separated.</p> <p>An interview on 01/24/25 at 4:50 PM DON stated the Administrator who is the abuse coordinator is responsible for completing and reporting investigation to corporate and State office. DON stated while the Administrator was suspended, she would be responsible.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled; Usual Occurrence Reporting revised 12/07 reflected: H. Other occurrences that interfere with facility operations band affect welfare, safety, or health of residents, employees or vistors.2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.</p> <p>Record review of facility policy titled; Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating revised 09/22 reflected:</p> <p>All reports of resident abuse . Are reported to local state and federal agencies add (current regulations) is thoroughly investigated by facility management . findings of all investigations are documented and reported . Policy interpretation and inflammation reporting allegations to the administrator and authorities upon receiving any allegations of abuse the administrator is responsible for determining what actions (if any) are needed for protection of residents . Investigation allegations 1. all allegations are thoroughly investigated the administrative initiates investigations any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete . 9. the investigator notifies the ombudsman that in abuse investigation is being conducted the ombudsman is invited to participate in the review process B. the ombudsman is notified of the result of the investigations as well as any corrective measures taken . follow up report #1 within 5 business days of the incident the administrator will provide a follow-up investigation report direct action number one all relevant professional and licensing boards are notified when an employee is found to have committed abuse #2 if the investigation reveals that the allegations of abuse are founded the employee is terminated #3 any allegations of its view in our files in the huge employees personal records along with any statement by the employee disputing the allegation if the employee chose make one .</p> <p>The Director of Nursing was notified that an Immediate Jeopardy situation was identified and record review request of ANE policy due to the above failure and provided with the Immediate Jeopardy template on 1/23/25 at 5:15 PM. A Plan of Removal was requested.</p> <p>The facility's Plan of Removal was accepted on 1/24/2025 at 1:50 PM and included:</p> <p>Plan of Removal:</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Resident # 1 was assessed by the Nurse on 1/22/25 . A thorough investigation was initiated by the Corporate Office and Director of Nursing Services.</p> <p>The Medical Director was notified by the DON at 3:33pm and The DON called and left a message for the Ombudsman 1/23/25, at 5:30PM. The RP was notified on 1/22/25 by the Administrator. The accused Team Member was placed on Administrative Leave pending investigation. The Police Department was called and arrived at the facility. The Incident Report was completed on 1/23/25. The SIMS was initiated on 1/23/25 at 2:30pm.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In-services have been done by the DON for: Completing Incident reports, Notifications to MD/Ombudsman, Reporting Abuse/Neglect, Abuse Policy including timeline for reporting and What to do When a Team Member is accused (investigation requires for Team Member to be placed on Administrative Leave until the investigation is concluded). De-escalation of aggressive behaviors and resident to staff altercations.</p> <p>The Post Test will be administered by the DON/designee after education is completed. Staff are required to pass at least 80%. Staff who do not achieve 80% passing rate will be re-educated and will retake the test.</p> <p>TEXAS Abuse hotline number, [PHONE NUMBER] posted in strategic areas within the facility, staff made aware of postings.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected. Supervisor Rounds have been started and will be completed by 1/24/25 to interview residents for issues related to care, respect and dignity. The rounding will be done by the Supervisors and the monitoring will be completed on the Supervisor Daily Rounds form.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>An in-service education program was conducted by the Director of Nursing Services and the Assistant Director of Nursing with all staff addressing circumstances that require reporting including appropriate timeframes, reporting to the Corporate Office, reporting to the Ombudsman, timely completion of Incident Reports and SIMS reports and policy regarding Team Member involvement will be completed by 1/24/25.</p> <p>The Corporate Nurse Team will conduct a Zoom meeting at 10 am on 1/24/25 with [Facility] Director of Nursing. The purpose of the in-service is to provide education for the following areas:</p> <p>Our Abuse/Neglect Policy as it relates to Reporting Timelines to Corporate/State/Law Enforcement/Ombudsman/Medical Director</p> <p>Steps to take when a Team Member is involved or is allegedly involved-Contact Corporate HR and place on Administrative Leave pending investigation of Abuse.</p> <p>Conducting Education and Training with all Departments</p> <p>Follow up and Monitoring that is required such as Rounding on Halls, Talking with Residents and Staff, Re-education with Staff to help Ensure There is No Breakdown in Communication</p> <p>Five day follow up with the State Office</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not reoccur:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any incidents or injuries are identified, properly investigated and reported to the appropriate entities.</p> <p>Findings of this audit will be reviewed in the Resident Council meetings.</p> <p>This plan of correction will be monitored at the monthly Quality Assurance meeting until such time the IDT determines consistent substantial compliance has been met.</p> <p>On 1/25/25 beginning at 3:00 PM the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by:</p> <p>Record review of pre/posttest had been completed by 1st, 2nd and 3rd shift nursing staff on ANE.</p> <p>Record review of Director of Nursing in-services by the Nurse on ANE</p> <p>Record review of the Administrator profile reflected, the Administrator was hired on 11/27/23 and terminated on 01/24/25.</p> <p>An observation of the facility on 01/25/25 at 2:00 PM revealed 1-800 HHSC hotline number for abuse was posted at the entry of the facility, social workers door, display board in hallway and employees break room.</p> <p>All staff were able to provide competency regarding in-service over ANE. All staff were able to provide policy, procedure, protocols, appropriate interventions, and when and who to report abuse to. All staff were to provide an example of ANE.</p> <p>Staff interviewed on 01/24/25 between 9:00 AM to 2:00 PM CNA A, CNA B, LVN C (overnight shift) and CNA G, CNA H, LVN I (1st shift) and CNA J, CNA L LVN K, RN O, LVN P (2nd shift).</p> <p>Staff interviewed on 01/25/25 3:40 AM to 3:00 PM: CNA D, CNA E, LVN F, RN N (Weekend shift) and laundry aide M.</p> <p>An interview on 01/25/25 at 3:45PM the Director of Nursing stated she was in-serviced by the Corporate Nurse on 01/24/25 at 10:00 AM. The Director of Nursing stated she is currently the abuse coordinator. The Director of Nursing stated staff have been in-service and pre/posttest have been completed.</p> <p>The Director of Nursing was informed the Immediate Jeopardy was removed on 01/25/25 at 3:00 PM the facility remained out of compliance at a scope of potential of minimum harm and a severity level of isolated, due to the facility's need to evaluation the effectiveness of the corrective systems.</p> <p>An interview on 02/12/25 at 9:30 AM, Resident#1 stated that he was doing good and did not have any concerns and wanted to stay at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An over the phone interview on 02/12/24 at 9:52 AM Family member stated she was going by what [Resident#1] told her (Previous admin would tell him to stop playing his piano and pick on him that way.). Family member stated the previous Administrator [Current facility] favored someone from [Resident#1] past, but the sister did not know exactly who and people in general would make fun of [Resident#1] because he was gay. Family member stated he was previously, in a group home and wanted to stay there but, he could not care for himself. Since, previous admin is gone there has not been any more issues. Family Member stated he came from a group home, and he was happy there and did not want to leave.</p> <p>Attempted to call PCP on 02/13/24 at 9:27 AM</p> <p>Attempted to call Psy services on 02/13/24 at 9:52 AM</p> <p>An observation and interview on 02/13/25 at 11:30 AM Resident#1 stated [Name] the Administrator hit him last week and he did not know why. Surveyor asked Resident#1 if he knew the previous Administrator name at the current facility that he stayed at and he said that was [Name] Resident#1 stated he felt safe and did not have any concerns.</p> <p>Record review of Psy Subsequent assessment dated [DATE] and completed by Psy services reflected,</p> <p>The provider asked the patient to tell him what transpired since the last few days. The patient replied nothing happened. The provider reframed the question and asked the patient if he had any altercation with anyone in the facility a few days ago. He replied someone pushed me. The provider asked the patient how the incident happened or what prompted the altercation. He replied, I do not know .</p> <p>Record review of Psychological Services Progress notes dated ,01/30/25 on Resident#1 completed by Psy services reflected, Resident#1 was negative for Trauma Informed Care.</p> <p>The Director of Nursing was informed the Immediate Jeopardy was removed on 01/25/25. The facility remained out of compliance at a scope of actual harm and a severity level of isolated, due to the facility's need to evaluation the effectiveness of the corrective systems.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46403</p> <p>Based on observation, record review and interview, the facility failed to immediately report failed to report abuse, neglect, exploitation, or critical incidents for 1 of 4 resident (Resident #1) reviewed for reporting.</p> <p>The facility failed to report an incident of resident to staff physical aggression/assault to HHSC.</p> <p>This failure could place residents at risk for abuse, neglect and incidents.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 01/23/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Schizophrenia (serious mental condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) Type 2 Diabetes Mellitus with Diabetic, Unspecified Psychosis not due to substance or known major depressive disorder.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 10/28/24, reflected Resident #1 had a BIMS of 12, which indicated cognition moderate impaired.</p> <p>Record review of Resident #1's care plan, revised 09/20/24, revealed the resident at risk for altered status due to a traumatic life experience while at a previous group home or [Nursing Facility]. Certain male figures in authority positions, with similar physical attributes or appearance at times trigger him. Interventions in place included: Administer medication as ordered, approach resident from the front and speak in a calm, unhurried manner .Identify cause/trigger for behavior and reduce factors that may provoke resident .Call [Family Member#1] if need to calm down or get him to comprehend the situation]</p> <p>.</p> <p>Record review revealed no incident/accident report was completed about Resident#1 incident on 01/22/25.</p> <p>Record review of Resident#1 progress notes revealed no documentation about the incident on 01/22/25.</p> <p>Record review of Texas Unified Licensing Information Portal on 01/23/25 at 12:00 PM reflected, the verbal and physical altercation between Resident#1 and Administrator was not uploaded.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident#1 incident provided to surveyor on 01/25/25 reflected: it was initiated on 01/22/25 with no completed/ locked date on the incident report. Incident description section reflected: This [LVN K] was notified by staff after the incident that [Resident#1] slapped [MA N] and physically attacked Administrator and [Resident#1] fell to the floor. Resident description reflected: [Resident#1] stated he was approached by Administrator, in what he felt was an aggressive manner so I just swung on his . Immediate action taken section reflected: [Resident#1] assessed for injuries. None noted, denied pain or any discomfort. Physician notified, In the agencies/people notified section reflected: no notification found,</p> <p>In an interview on at DON stated she did not find out about the incident until Resident#1 family member came into her office on 01/23/25 at 10:00 AM and stated the Administrator hit Resident#1. DON stated she called the Nurse Consultant to be advised on what to do.</p> <p>An interview over the phone on 01/23/25 at 1:30 PM, Nurse Consultant and Operation Manager stated they were not made aware of the incident between Resident#1 and the Administrator until 10:30 AM by the DON.</p> <p>An interview on 01/23/25 at 1:15 PM DON stated that she does not do the incident and reports, upload the information in Tulip or contact HHSC. DON stated the Administrator was responsible for doing the incident and accident reports. DON stated no incident or accident report for the incident on 01/22/25 between Resident#1 and the Administrator had been completed. DON stated by this information not do not know what interventions need to be put in place to prevent further abuse.</p> <p>An over the phone interview on 01/23/35 at 1:30 PM Nurse Consultant E and Operation Manager stated the Administrator had been suspended pending the investigation. Nurse Consultant stated she will work and trained the DON on how to do the incident reports.</p> <p>An observation on 01/23/25 at 7am revealed the Administrator was in the building at 7AM and did not leave the building until 12:00 PM.</p> <p>Record review of Administrator profile reflected: Administrator was hired on 11/27/23 and terminated on 01/24/25.</p> <p>Record review of the facility policy titled Unusual Occurrence Reports revised 12/07, reflected: Other occurrences that interfere with facility operations and affects the welfare, safety, or health of residents, employees .2. Unusual occurrences shall reported via telephone to appropriate agencies as required by current law and/ or regulations within twenty-four (24) hours of such incidents or as otherwise required by federal and state regulations.</p>		

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NAME OF PROVIDER OR SUPPLIER  Dfw Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46403</p> <p>Based on interview, observations and record review, the facility failed to ensure 1 (Resident#3) of 4 residents received adequate supervision and assistance devices to prevent accidents.</p> <p>The facility failed to provide Resident#3 with adequate supervision on 01/20/25 when he eloped from the facility.</p> <p>The non-compliance was identified as past non-compliance (PNC). The IJ began on 01/20/25 and ended on 01/20/25. The facility had corrected the non-compliance before the state's investigation began.</p> <p>These failures could affect all residents at risk of elopement.</p> <p>Findings included:</p> <p>Record review of Resident #3's face sheet dated 01/23/25 reflected Resident #3 was a [AGE] year-old male and was originally admitted to the facility on [DATE]. Resident #3 was readmitted to the facility on [DATE]. Resident #3 was diagnosed with Hyperlipidemia (high levels of lipoproteins in the blood), Schizophrenia (Serious mental health condition that affects how people think, feel and behave) -unspecified, Depression (mood disorder that cause persistent feeling of sadness and loss of interest) -unspecified, anxiety disorder(Repeat episodes of sudden feelings of intense anxiety and fear) (-unspecified, Parkinsonism-unspecified, Epilepsy (A neurological disorder that causes seizures or unusual sensations )and behaviors unspecified.</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 01/03/25, reflected his BIMS score was 08, which indicated moderate cognitive impairment.</p> <p>Record review of Resident #3's care plan, dated 05/09/24, reflected no wandering behaviors.</p> <p>Record review of Resident#3 incident report dated 01/20/25 reflected: night [CNA A] noticed the resident is not in building, notify the nurse. The nurse called code yellow and all staffs in the building looking for resident inside the building and in the smoke patio. Unable to locate resident. Notify Administrator, DON, and all management directors. Call 911 and notify PD of missing resident. Notify [Family Member] of resident. Instructed some of the staff to go outside and look in the surrounding area. Police came to the building to talk to the staff. One of the [CNA A] found resident and brought him back to the building. Resident was shivering and skin very cold to touch .Police immediately called 911 .transfer resident to ER.</p> <p>Record review of Hospital records dated, 01/20/25, reflected: Resident#3 was coughing, sneezing, shivering and had an oral temperature of 99.7 [Resident #3] blood pressure was elevated. [Resident#3] was diagnosed with a viral upper respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/24/25 at 12:55 PM ADON stated she had clocked in 5 minutes to 6:00 AM. She overheard the overnight [CNA A] state he could not find a resident. ADON asked who? and when was the last time he was seen? [CNA A] stated to ADON that Resident#3 was coming in and out of his room and the last time he saw him was at 5:10 AM. The ADON stated she called a yellow code. Staff started looking everywhere inside and around the building and he could not be located. The ADON sent out a text to management team, she called 911, called the Resident#1 family members. The ADON talked with DON over the phone. [CNA A] found Resident#1 outside not too far from the facility. The ADON stated Resident#3 looked very cold, was shivering and he would not talk. ADON instructed staff to put blankets on him. The DON was in the facility and was on the phone with the Administrator. The police arrived at the facility and called 911. The EMT transported Resident#3 to the ER. The ADON stated when she came in, she did not hear any alarms going off.</p> <p>Record review of temperatures on January 20, 2025, reflected: Temperatures at 6:00 AM range from 23 to 21 degrees.</p> <p>In an interview over the phone on 01/25/24 at 3:50 AM CNA A and CNA B stated Resident#3 was up walking around at 4:30 AM. Resident#3 tried to urinate in the trash at the nursing station and they walked him back to his room to use the bathroom. He did not want to go and continued to walk around. CNA's started last rounds at 5:10 AM. CNA B stated she could not find Resident#3. CNA A and CNA B searched the building for Resident#3. CNA A stated about 5:45 AM the ADON was made aware that Resident#3 was missing. CNA B stated staff searched outside and got in their cars to look for Resident#3. CNA A stated he was concerned for Resident#3 because he was barefoot, did not have a jacket on and it was cold. CNA A had to leave the facility at 6:45 AM. CNA A found Resident#3 three blocks from the facility. CNA A stated Resident#3 did not have any aggressive behaviors when he was asked to come back to the facility. CNA A transported Resident#3 to the facility.</p> <p>In an observation on 01/24/25 at 4:30 PM all exits doors were checked to ensure they were working properly. Three random residents with wander guards and Resident#3 wander guard was checked to ensure they worked properly.</p> <p>The non-compliance was identified as past non-compliance (PNC). The IJ began on 01/24/25 and ended on 01/25/25. The facility had corrected the non-compliance before the state's investigation began.</p> <p>The facility took the following actions to correct the non-compliance prior to the survey:</p> <p>Record review of incident/accident reports, from 11/01/24-01/23/25, reflected no other elopements.</p> <p>Record review of in-service titled Elopement, dated 01/20/25, reflected all staff were educated by the DON on elopement protocol and code yellow.</p> <p>Record review of Residents #3, EHR revealed his care plans and TAR were updated and had interventions to address all care needs.</p> <p>Record review of service invoice dated, 01/20/25 reflected: both side exits, and back exit was operating fine and egressing a timely manner. The front door, however, would stop annunciating after the egress had been activated .adjusted the dip switches in lock and tested to verify that it was annunciating after egressed. All systems are normal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, revised 01/20/25, reflected Resident#3 had an elopement on 01/20/25. Interventions included: alert staff to wandering behaviors, check wander guard was properly working every shift by taking to the door if not properly working notify DON and replace the wander guard, in-service staff elopement risk, monitor and document behavior, send to ER for evaluation, skin check every shift to area wander guard is in place and wander guard in place when [Resident#3] returns from ER (wander guard to right ankle).</p> <p>Staff interviewed on 01/24/25 between 9:00 AM to 2:00 PM CNA A, CNA B, LVN C (overnight shift) and CNA G, CNA H, LVN I (1st shift) and CNA J, CNA L LVN K, RN O (2nd shift).</p> <p>Staff interviewed on 01/25/25 3:40 AM to 3:00 PM: CNA D, CNA E, LVN F, RN N (Weekend shift) and laundry aide M. All staff were able to provide competency regarding in-service over elopement. All staff were able to provide policy, procedure, protocols, appropriate interventions, and when and who to report elopements to. All staff were to provide an example on what to do if a resident eloped.</p> <p>Record review of the facility's policy titled Wandering and Elopements revised 03/2019 reflected:</p> <p>3. If a resident is missing, initiate the elopement/missing resident emergency procedure:</p> <p>b. If the resident was not authorized to leave, initiate a search of the building(s) and premises.</p> <p>c. If the resident is not located, notify the Administrator and the Director of Nursing, the resident's legal representative, the attending physician, law enforcement officials.</p> <p>4. When the resident returns to the facility, the Director of Nursing services or charge Nurse shall:</p> <p>A. Examine the resident for injuries.</p> <p>E. Complete and file an incident report</p> <p>F. Document relevant information in the resident's medical records.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46403</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate incident/accident report for 1 (Resident#1) of 4 residents reviewed for incident reports.</p> <p>The facility failed to ensure Resident#1's incident report was completed on 01/22/25, which involved a verbal and physical altercation between Resident#1 and Administrator by LVN C.</p> <p>This failure could place residents at risk of inaccurate or incomplete information, resulting in the risk of abuse or neglect by staff.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, dated 01/23/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Schizophrenia (serious mental condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) Type 2 Diabetes Mellitus with Diabetic, Unspecified Psychosis not due to substance or known major depressive disorder.</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 10/28/24, reflected Resident #1 had a BIMS of 12, which indicated cognition moderate impaired.</p> <p>Record review of Resident #1's care plan, revised 09/20/24, revealed the resident at risk for altered status due to a traumatic life experience while at a previous group home or [Nursing Facility]. Certain male figures in authority positions, with similar physical attributes or appearance at times trigger him. Interventions in place included: Administer medication as ordered, approach resident from the front and speak in a calm, unhurried manner .Identify cause/trigger for behavior and reduce factors that may provoke resident .Call [Family Member#1] if need to calm down or get him to comprehend the situation]</p> <p>.</p> <p>Record review revealed no incident/accident report was completed about Resident#1 incident on 01/22/25.</p> <p>Record review of Resident#1 progress notes revealed no documentation about the incident on 01/22/25.</p> <p>Record review of Resident#1 assessments revealed no documentation of completed assessment on 01/22/25.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident#1 incident provided to surveyor on 01/25/25 reflected: it was initiated on 01/22/25 with no completed/ locked date on the incident report. Incident description section reflected: This [LVN K] was notified by staff after the incident that [Resident#1] slapped [MA N] and physically attacked Administrator and [Resident#1] fell to the floor. Resident description reflected: [Resident#1] stated he was approached by Administrator, in what he felt was an aggressive manner so I just swung on his . In the agencies/people notified section no notification found,</p> <p>An interview on 12/23/24 at 2:30 PM, LVN K stated she did not witness the incident between the Administrator and the Resident#1 that happened on 01/22/25 at 7:00 PM. LVN K stated she was told about the incident after it happened. LVN K stated she did the incident report on 01/23/25 after the DON D told her to complete it. LVN K stated the incident and accident report should have been completed in the EHR under the resident's name the same day of the incident before she left for the day.</p> <p>An interview on 12/23/24 at 3:30 PM, the DON stated the nurse who is over the resident was responsible for doing the incident/accident report. The DON stated the incident and accident report should be completed immediately after the incident or before staff leaves for the day. DON stated Resident could have delay treatment if there were injuries and/or abuse. DON stated no specific policy on documentation of incident reports in residents 'medical records.</p>		