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	06/25/2024

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 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. 43843 Based on observation, interview and record review the facility failed to ensure the resident environment remained free of accident hazards as was possible for 1 of 1 smoking areas reviewed for accidents and hazards. The facility failed to ensure smoking residents were free of fire hazards, when a propane grill was stored on the smoker's court. The facility failed to ensure the smoking area was free of fire hazards. Findings include: Observation on 06/23/2024 at 1:00 PM of the resident smoking courtyard revealed residents sitting in patio chairs through the courtyard. Through the conference room window reflected a grill on the smoking court near the building . Observation on 06/23/24 at 1:13 PM, on the smoking courtyard, revealed a grill with 2 gas tanks outside in the courtyard one propane tank was attached to the grill and one was positioned behind the grill . Interview on 06/23/24 at 1:23 PM with the Activity Director revealed the residents sat all the way in the chairs in the courtyard. He said he did not do any cooking on the grill. He stated the maintenance man did the grilling for the facility . Interview on 06/23/24 at 01:40 PM with the Maintenance Director revealed, he arrived on the smoker's courtyard and immediately disconnected the propane tank from the gas line on the grill. He then picked up the second tank located behind the grill. He stated the tanks were empty. He was told to reconnect the tank to verify his statement that the tanks were empty. He connected the tank to the grill's gas line and pushed the ignite button. The grill immediately produced a flame. He then turned off the grill and again disconnect the tank from the grill's gas line where there was an audible sound of gas releasing from the line. He stated he felt the questions were leading and did not answer. He walked off the courtyard with both propane tanks. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA C on 06/23/2024 at 3:13 PM revealed the facility had a cookout on 06/19/2024 to celebrate nurse's week, the Maintenance Director grilled wienies . She stated the risk to the residents was it could blowup. Interview on 06/23/2024 at 3:08 PM with the Activity Assistant revealed she assisted the smoking residents. She stated she handed out cigarettes to the residents, then gave them a light. She stated there was only one lighter. Residents were allowed to walk and sit anywhere on the courtyard. She stated the risk was residents were not as cautious and they could ash it wrong and not put out the cigarette and it could cause a fire. Interview on 06/23/2024 at 3:22 PM with the Administrator revealed he was not sure when the grill was last used. He stated there was a facility event on Juneteenth, and it was possible the Maintenance Director grilled some hot dogs for residents. He stated the Maintenance Director would need permission to grill and the facility was aware of the grill being used. The risk to the facility and residents was a fire hazard. Interview on 06/23/24 at 3:33 PM with the DON revealed on the last day of CNA week the Maintenance Director was in charge of the grill. She stated it was the facility's grill. It was usually stored in the courtyard, but she didn't think the propane remained connected. The risk of the propane being connected to the grill was that it could explode . Record review of the facility's policy titled Fire Safety and Prevention, dated revised May 2011, reflected Flammable items: f. Store flammable liquids in a locked metal cabinet.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on record review and interview the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (Resident#19) of five residents reviewed for pharmaceutical services. The facility failed to specify blood pressure (BP) perimeters for Resident #19's order for Nifedipine 30 mg ER and Carvedilol 6.25 mg [both medications used to treat high blood pressure] when Resident #19's blood pressure reading was 105/72. MA A administered Nifedipine 30 mg and held Carvedilol 6.25 mg. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings Included: Record review of Resident #19's face sheet, dated 06/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included generalized anxiety disorder a condition of severe, ongoing anxiety that interferes with daily activities, breast cancer, depression, low vision in right eye, high blood pressure, high cholesterol, and a fracture of the lower legs. Resident #19 was her own responsible party. Record review of Resident #19's quarterly MDS, dated [DATE], reflected Resident #19 had a BIMS of 15out of 15, which indicated she was cognitively intact. Resident #19 could understand others and others could understand her. Record review of resident #19's order summary, dated 06/24/24, reflected Nifedipine ER Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine). Give 1 tablet by mouth one time a day related To Essential (Primary) Hypertension (I10) Do Not Crush. Coreg Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day related to essential (primary) hypertension (I10). (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medication observation and interview with MA A on 06/24/24 at 08:19 AM revealed MA A dispensed six medications in a medication cup for Resident #19. He then handed over the medications bubble packs to be recorded. Among the medications was the 30 mg Nifedipine tablet and the 6.25 mg Coreg tablet bot medications were documented on the med card as r/t high blood pressure (BP). The medication bubble card did not reflect a perimeter to hold medication. MA A then stated he needed to check Resident #19's blood BP. He locked the cup with the six medications in the med cart and went into Resident #19's room and checked her BP. The BP reading was 105/72 with a heart rate of 69 BPM. He returned to the med cart and retrieved the medication cup, and some eye drops for Resident #19. He then took the Coreg 6.25 MG tablet out of the medication cup and stated he would not administer it due to Resident #19's BP reading. He left the Nifedipine ER 30 mg in the cup, [which was also used to treat high blood pressure]. After administering the five medications to Resident #19, he stated he held the Coreg 6.25 MG tablet because the MAR on of Resident #19's noted BP parameters was to hold the medication if the BP was below 110. He stated he forgot that Nifedipine ER 30 mg was also a blood pressure medication. He stated the Nifedipine ER 30 mg should not have been administered to Resident #19 either because it could lower her blood pressure even more. MA A stated he should have verified the BP parameters with his nurse to be sure, but he did not. He stated not following medication parameters could cause adverse effects to the resident. He said he and the nurse would monitor Resident #19 to make sure her BP did not bottom out. In an interview with LVN C on 06/24/24 at 10:06 AM, she stated MA A informed her he administered Nifedipine 30 mg tablet and held the Coreg 6.25 MG tablet to Resident #19. She stated he should have asked her if he had any questions about any medications. She stated both blood pressure medications did not have any parameters to hold. LVN C stated she reached out to the physician and told him about missing blood pressure parameters. LVN C stated the nurse was responsible for inputting parameters in the MAR when they got an order for blood pressure medication and if they did not have the parameters then to reach out to the physician for clarification. She said the risk to the resident not having clear BP parameters was their BP could drop significantly. She stated she was monitoring Resident #19's BP and HR for any significant adverse effects. In an interview with the DON on 06/25/24 at 04:58 PM, she stated MA A should have administered both BP medications. She stated the 110 that MA A was referring to and he thought was a BP parameter, was the ICD number capital letter I and #10 which was the number for hypertension on the MAR. She stated it was the physician's preference to add parameters to blood pressure medications. She stated the physician did not add nor did not require the nursing staff to have BP parameters to administer BP medications to residents. The DON stated the pharmacists had also told her they do not need to check BP and HR before medication administration because residents did not even check their own BP at home before taking these medications. She stated had the physician added parameters to the orders, then she would expect the nursing staff to follow the physician parameters for BP and HR medication administrations. She did not state risk to resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Medical Director on 06/27/24 at 03:18 PM, he stated the facility notified him of the missing parameters for BP medications. He stated he put in place a standing blanket order with parameters for all BP medications as of Wednesday 06/26/24 [after surveyor intervention]. He stated he expected the nursing staff to add parameters when he gave them verbal orders and to ask him if the parameters were missing on orders. He stated it was best nursing practice to always check vital signs before administering medications that altered BP or HR. He stated residents who came back from the hospital with new BP medications may have missing parameters, however, he expected the nursing staff to notify him for clarification. He stated not checking vital signs before administering blood pressure or heart medication could cause adverse effects to the patient because you did not know the current vital signs whether it was too high or too low. He stated moving forward, he expected to be notified of missing parameters on orders. In an interview with the ADM on 06/25/24 at 06:05 PM, he stated he expected all staff to follow the medication administration policy when administering medications. Record review of the facility's Administering Medications, dated April 2019, read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . eight. if a dosage is believed to be inappropriate or excessive for a resident or the medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns .10. The individual administering the medication checks the label three times to verify the right residence, right medication, right dose, right time, right method, before giving the medication. 11. the following information is checked/verified for each resident prior to administering medication; allergies to medication and vital signs if necessary

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	455881	A. Building B. Wing	06/25/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for one (Resident #38) of five residents reviewed for storage of drugs and Biologicals. The facility failed to ensure MA B administered Amiodarone 200 mg (a medication used to regulate and lower heat rate) without checking vital signs or heart rate for Resident # 38 even with warning reflected on the medication bubble card to hold if heart rate was less than 60 BPM. These failure could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Record review of Resident #38's face sheet, dated 06/24/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (a condition of brain confusion due to chemical imbalance in the blood), left tibia (lower leg) fracture, left hip fracture, vision loss in both eyes, muscle wasting and dying muscle (atrophy), atrial fibrillation (an irregular heartbeat), type 2 diabetes (a condition of uncontrolled blood sugar), high blood pressure (hypertension), cataract in both eyes (an eye disease that causes vision loss) and kidney failure. Record review of Resident #38's quarterly MDS, dated [DATE], reflected a BIMS of 3 out of 15, which indicated severe cognitive impairment. Record review of Resident #38's order summary, dated 06/24/24, reflected Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 1 tablet by mouth in the morning for heart disease. During medication observation and interview with MA B on 06/24/24 at 09:20 AM, revealed MA B took the medication bubble pack which contained medication Amiodarone 200 mg, she popped 1 pill out and placed it in a medication cup with other medications. She then handed over the medication bubble packs to be recorded by surveyor. The medication bubble pack read Amiodarone TAB 200MG. Give 1 tablet by mouth one time a day for atrial rhythm abnormality. Hold if HR<60. Expiration 04/17/25. MA B administered all medications to Resident #38 without checking her BP and Heart Rate (HR). MA B said she did not know she had to check Resident #38's heart rate before administration of the Amiodarone 200 mg. She stated the bubble pack contained parameters from an old prescription given to Resident #38 before she went to the hospital. She stated she did not know the heart rate for Resident #38 prior to administering medication. She stated administration of heart medications without checking the heart rate could cause Resident #38's heart rate to drop lower and cause adverse effects. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN D on 06/24/24 at 09:54 AM, he stated MA B should have checked Resident #38's vital signs. He said he expected MA B to not just follow the MAR but also to remember when administering any blood pressure or heart medications to check vital signs. He stated MA B should have looked at the bubble pack and saw the parameters to hold medication when or if heart rate was less than 60. He stated the risk to the resident was an adverse effect of a low heart rate or even low blood pressure. He stated he checked Resident #38's vitals and notified the physician and RP. He stated the physician gave orders to hold all of Resident #38's blood pressure medications for the day. He stated he would continue to monitor Resident #38 and notify the physician. In an interview with the DON on 06/25/24 at 04:58 PM, she stated it was the physician's preference to add parameters to blood pressure medications. She stated the physician did not add nor did not require the nursing staff to have BP parameters to administer BP medications to residents. The DON stated the pharmacists had also told her they do not need to check BP and HR before medication administration because residents did not even check their own BP at home before taking these medications. She stated had the physician added parameters to the orders, then she would expect the nursing staff to follow the physician parameters for BP and HR medication administrations. She did not state risk to resident. In an interview with the Medical Director on 06/27/24 at 03:18 PM, he stated the facility notified him of the missing parameters for BP medications. He stated he put in place a standing blanket order with parameters for all BP medications as of Wednesday 06/26/24 [after surveyor intervention]. He stated he expected the nursing staff to add parameters when he gave them verbal orders and to ask him if the parameters were missing on orders. He stated it was best nursing practice to always check vital signs before administering medications that altered BP or HR. He stated residents who came back from the hospital with new BP medications may have missing parameters, however, he expected the nursing staff to notify him for clarification. He stated not checking vital signs before administering blood pressure or heart medication could cause adverse effects to the patient because you did not know the current vital signs whether it was too high or too low. He stated moving forward, he expected to be notified of missing parameters on orders. In an interview with the ADM on 06/25/24 at 06:05 PM, he stated he expected all staff to follow the medication administration policy when administering medications. Record review of the facility's Administering Medications, dated April 2019, read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . eight. if a dosage is believed to be inappropriate or excessive for a resident or the medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns .10. The individual administering the medication checks the label three times to verify the right residence, right medication, right dose, right time, right method, before giving the medication. 11. the following information is checked/verified for each resident prior to administering medication; allergies to medication and vital signs if necessary

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen . The facility failed to ensure items found in the reach-in refrigerator, were labeled with the name of container contents and the use by date, expired by date in the facility's only kitchen. The facility failed to ensure items found in the reach-in refrigerator was covered, tabled and dated. This failure could place residents at risk for food-borne illness and food contamination. Findings include: Observation on [DATE] at 9:01 AM revealed in the facility's only reach-in refrigerator the following items were not labeled or dated: Metal pot with shredded cheese covered with a ceramic plate. Styrofoam plate which contained potato chips and two sandwiches. Block of cheese covered in plastic wrap. Metal pan which contained meat pies covered with plastic wrap. Metal pan which contained sliced ham had no covering. Interview on [DATE] at 03:42 PM with the Dietary Manager revealed staff's outside food should not be stored in the facility refrigerator. She stated the shredded cheese in the pot was brought into the facility because of the nurse appreciation celebration. She stated food should be labeled and dated as soon as they got through with it so staff knew when it was opened and when it would expire. She stated the risk for storing outside food in the refrigerator was the staff didn't know where it came from. She stated the risk of not labeling and dating food was food borne illnesses . Interview on [DATE] at 4:58 PM with the DON revealed the expectation for dietary staff was that food stored in the reach in refrigerator was that all food would be labeled and dated, and properly covered . The risk to residents is food contamination or food poisoning. Interview on [DATE] at 6:14 PM with the Administrator revealed, per policy and procedure food should be labeled and dated. He stated procedures were missed because the kitchen staff was having trouble retaining staff. He stated when staff were disciplined about mistakes they would quit. The risk was infinite for resident safety . (continued on next page)

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	455881	A. Building B. Wing	06/25/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Food Receiving and Storage, dated 2017, reflected 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of ten residents (Residents #19) reviewed for infection control. 1. The facility failed to ensure MA A performed hand hygiene and wore gloves when administering eye medication to Resident #19. 2. The facility failed to ensure MA A did not use his bare finger to remove Coreg 6.25 MG tablet out of Resident #19's. medication cup before administering her medications. These failures could place residents at risk of infectious diseases and cross contamination. Findings include: 1. Record review of Resident #19's face sheet, dated 06/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included generalized anxiety disorder a condition of severe, ongoing anxiety that interferes with daily activities, breast cancer, depression, low vision in right eye, high blood pressure, high cholesterol, and a fracture of the lower legs. Resident #19 was her own responsible party. Record review of Resident #19's quarterly MDS, dated [DATE], reflected Resident #19 had a BIMS of 15 out of 15, which indicated she was cognitively intact. Resident #19 could understand others and others could understand her. Record review of Resident #19's order summary, dated 06/24/24, reflected: 1.Coreg Oral Tablet 6.25 MG (Carvedilol). Give 1 tablet by mouth two times a day related to essential (primary) hypertension. 2. Artificial Tears Ophthalmic Solution (Artificial Tear Solution) Instill 2 drop in both eyes two times a day for dry eyes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During medication observation and interview with MA A on 06/24/24 at 08:19 AM, revealed MA A performed hand hygiene with hand sanitizer, he dispensed six medications in a medication cup for Resident #19. Then he stated he needed to check Resident #19 BP and he took the medication cup and locked it in the med cart. He took the BP cuff and went into Resident #19's room to check her BP. The reading was 105/72 with a pulse rate of 69 BPM. He returned to med cart, placed the soiled BP cuff on top of med cart. He got the keys out of his pocket and unlocked the med cart. No hand hygiene was performed after checking the BP. He picked up the medication cup and retrieved the Artificial Tears Ophthalmic Solution medication box for Resident #19. He placed both items on top of med cart. With no hand hygiene performed and no gloves on his right hand, MA A reached into Resident #19's medication cup, and he took the Coreg 6.25 MG tablet out of the medication cup with his pointer finger. He placed the pill in the sharps, and he stated he would notify the nurse for holding the BP medication due to the vital sign reading. No hand hygiene was performed after touching the pill with his bare hand. MA A picked up the eye drops, medication cup and a soft tissue paper and went into Resident #19's room. He handed Resident #19 her pills and she took them. He then put two eye drops in each eye and wiped the excess with the soft tissue then he handed Resident #19 the soft paper tissue to wipe herself. He went back to the med cart, took keys out of his pocket, and unlocked the med cart and placed the eye drops back inside the med cart. MA A performed hand hygiene and he pushed the med cart to the next room. MA A stated he performed hand hygiene, and it was missed by the observer. He stated he was not aware he could not touch the pill with his bare finger. He stated he forgot to wear gloves when administering the eye drops to Resident #19. He stated the risk to the resident was to spread infection. In an interview with the DON on 06/25/24 at 04:58 PM, she stated MA A should have used a spoon or gloved hand to remove the pill from Resident #19's cup. She stated she expected all staff to perform hand hygiene before and after medication administration. She stated she expected staff to wear gloves when administering eye drops to residents. In an interview with the ADM on 06/25/24 at 06:05 PM, he stated he expected all staff to follow the facility policies of hand hygiene when administering medication and before and after resident care. Record review of the facility's Administering Medications, revision date April 2019, read in part, .24. Staff should follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for administration of medication as applicable. Record review of the facility's policy titled Standard Precautions, revision date October 2028, read in part .the facility's infection control policies and practices are intended to facilitate maintaining a safe, a sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . Policy Interpretation and Implementation . 4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities