STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455891	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Park Multi Care Center	4252 Bryant Irvin Rd Fort Worth, TX 76109

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider for one (Resident #5) of 5 residents reviewed for hospital transfer. The facility failed to ensure a safe transfer for resident #5 after discharge from the ER back to the facility with a left clavicle fracture. These failures could place residents at risk of not receiving the necessary care and services to meet their physical and psychological needs. Findings included: Review of Resident #5's face sheet dated 04/18/24 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included chronic kidney disease, vascular dementia (this is a condition which affects memory, forgetful ness, confusion), muscle weakness, difficulty in walking, abnormal posture, communication deficit, history of falling, osteoarthritis, blood clots in lower extremity (DVT) and vitamin D deficiency. Review of Resident #5's Quarterly MDS assessment, dated 04/01/24, reflected the resident had a BIMS score of 03, which reflected the resident had severe cognitive impairment. Section of the cognitive patterns on the MDS reflected the resident had a memory problem. Resident #5 required moderate assistance with one person for bed mobility, transfer, and toilet use, extensive assistance with one person for personal hygiene, eating, dressing and locomotion on and off unit. The resident required physical help in part of bathing activity. Record Review of Resident #5 hospital record dated 04/07/24 at 4:31 pm, reflected resident arrived at the ED via EMS with left shoulder pain from the facility for a left clavicle fracture found on X-Ray at the facility on 04/06/24 at 3 pm. Resident #5 had an unwitnessed fall per facility. Resident was reported to be agitated and combative. Resident was discharged to home at 10:45 PM. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #5's family on 04/18/24 at 2:30 pm, revealed the family was very upset with the facility because they did not follow up with the resident while she was sent to the hospital. Resident #5's family said the facility was called by the hospital before discharge starting at 9:00 PM. The family stated she tried calling the facility multiple times, but no one picked up the facility phone. The family said the hospital told her that transportation could be arranged and could be available at 03:00 AM or 6:00 AM. The family said that Resident #5 was agitated being in the ER for a long time therefore, when the hospital told the family that the resident could be transported to the facility by family. Resident #5's family stated that she would transport Resident #5 back to the facility. The family stated that at 11pm she called the facility again and someone answered, and the family informed the person that answered the phone that Resident #5 was on her way back to the facility, and they needed help getting the resident out of the car. The family member could not remember the name of person but that her name began with S. Interview with LVN C on 04/28/24 at 3:57 pm, revealed that he was instructed by the DON to send Resident #5 to the hospital after the facility physician ordered an arm sling and a follow up with an orthopedics for Resident #5 due to a clavicle fracture. He said he called 911 to transport Resident #5 to theER on [DATE] around 4:00 pm. He said he gave a report to LVN B at end of his shift informing her that Resident #5 was sent to the hospital. Interview with LVN B on 04/18/24 at 4:34 pm, revealed Resident #5's family called the facility to let her know that she was on her way to the facility with the resident. She stated Resident #5's family told her to have someone meet her with a wheelchair at the font entry to the facility. LVN B said that she sent a CNA to meet the family at the entrance to facility. LVN B said she could not recall the time when Resident #5 returned but it was close to midnight. LVN B said it was possible she may not have heard the facility phone because she was in residents room providing care and administering medication. LVN B stated that Resident #5's family did not bring back any hospital discharge paperwork for the resident. LVN B said she was not aware of who would track the residents when sent to the hospital. She said that she did not call the hospital for a discharge report for Resident #5. She said that she should have called. She said she was in-serviced on answering the facility phone and on abuse and neglect. She said the risk to the resident was not having post hospital care orders. Interview with facility Liaison E on 04/18/24 at 5:55pm revealed she and Liaison D were responsible for obtaining clinical updates or discharge from the ER case manager. She said the facility used a texting system to communicate when residents were sent out to the hospital. She said that she must have missed the message that Resident #5 was sent to the ER. She said if a resident was admitted to the hospital, she would usually visit the resident while in the hospital. She said the usual process was the hospital care manager would notify her of any discharges that were returning to the facility, and she would alert the facility, so they were prepared to receive the resident back to the facility. She said that the nurses also notify her if they do not get a report from the hospital when a resident was sent to the facility. She said no one notified her about the return of Resident #5 or that facility nurse did not get report from the hospital. She said if she had known that she would have followed up with the hospital. Liaison E said that she would have checked in with the ER within 3-4 hours of Resident#5 being at the hospital ER. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 04/18/24 at 6:26 pm, revealed when a resident was sent out to the hospital, the physician was notified, she was notified, and family was notified. She said LVN C told her that the facility physician had ordered an arm sling and an orthopedic follow up for Resident #5 after X-ray review. The DON said because the facility did not have arm slings, she told LVN C to send Resident #5 to the ER. She said a text message was sent to the IDT team to notify them that a resident was being sent out to ER. The DON said the hospital, or the liaison would typically give them an ETA of residents return to the facility. The DON said she found out Monday 04/08/24 that Resident #5 returned to facility on 04/07/24 without any hospital discharge paperwork or new orders. She said that LVN B should have called the ER for reports and for orders. She said there were a lot of communication breakdowns and that put the resident at risk for follow through care after ER visit. She said Resident #5 family expressed her frustration with the ER visit and trying to bring resident back to the facility. The DON said she did an in-service on answering facility phone timely and she has in-serviced in the past for nursing staff to report to her or the liaison person if any resident is sent to the facility without report from the hospital. Interview with the Administrator on 04/18/24 at 6:42 pm revealed she expected the staff to use the group chat to communicate residents being sent out to ER. She said she did not expect the facility to follow up if a resident was in the ER but follow up only when the resident admitted to the hospital. She said the hospital should have called the liaison person to let them know that Resident #5 was returning to the facility. She said it was not an acceptable practice to send a resident back to facility without discharge paperwork. She said she expected the facility admitting nurse to obtain a report from the hospital. She said the risk to the resident was not knowing if they had new orders. Record review in-service titled Answering Phones- All Staff on Duty by ADON on 04/08/24 reflected all staff were responsible for answering phones or directing calls to the after-hours manager. 30 employees signed the in-service training. Record review of facility's Policy for Transfer and discharge date d 11/29/23 indicated: 1. The facility will evaluate and determine the level of care needed for the resident prior to admission to the facility's ability to meet resident's needs . a. Obtain a physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis .

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 48520 Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the state for 1 of 1 Activity Director, reviewed for qualifications of activity personnel. The facility failed to ensure the AD was licensed, or registered, and qualified to serve as the director of the activities program. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. Findings included: Interview on 04/18/24 at 5:11 PM with the AD revealed she had been working as an AD for two weeks but had been working at the sister facility, [Facility Name] on the weekends as a receptionist. She stated she had been doing activities with the residents such as bingo on Mondays, Wednesdays, and Fridays, word searches, daily chronicles, parachute, and music. The AD stated the previous AD trained her when the previous AD had to go on sick leave back in March. She stated the previous AD trained her for three days. She stated she was currently taking her AD certification course that started on 04/02/24 and had only one week of training left before taking the certification. She stated the training was a total of four weeks long. Interview on 04/18/24 at 6:26 PM with the DON revealed the AD had been in the facility for a few weeks and no residents complained about activities conducted. The DON stated she has observed the AD conducting activities such as baking activities, devotional services, and other group activities. She stated the AD had not taken the residents out of the facility and had completed abuse and neglect in-services . DON did not state how the failure could affect the residents. Interview on 04/18/24 at 6:42 PM with the Administrator revealed she could not remember the exact date the AD started working at the facility and would have to contact the sister facility in order to get the exact hire date of the AD. The Administrator stated the AD had been working for the facility since the previous AD quit about two weeks ago. She stated the AD was currently taking classes to get her licensure and had about a week left. The Administrator stated it was expected for staff to have a license before hire, however, the AD was not providing direct care to residents and followed company policy and procedures. The adminstrator said she did not see how this failure affected the residents. Record review of the undated team management roster, provided by the facility revealed the AD was listed as Activities Director. Review of the facility's Activities Director (Non-Recreation Therapist) Job Description, revealed . Must be a qualified activities professional who was licensed or registered, if applicable, by the State in which practicing; AND .Eligible for certification as an activities professional by a recognized accrediting body on or after October 1, 1990 .

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F 0925 Level of Harm - Actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for one (hallway 100) of two hallways checked for pest control, so that the facility was free of pests. The facility did not maintain an effective pest control program to ensure Residents #3, #4, and #2 were not bitten by horse flies and to ensure the facility was free of gnats and horse flies for Residents #1, #2, #3, and #4. This could place residents at risk for an unsanitary environment. Findings included: Record review of Resident #3's Face Sheet, dated 4-18-2024, revealed a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left non-dominant side and secondary diagnosis of urinary tract infection, inflammatory reaction due to indwelling urethral catheter, and morbid obesity. Record review of Resident #3's MDS, dated [DATE], revealed a BIMS score of 14, which indicated he was cognitively intact. In an observation/interview, with Resident #3, in his bedroom, on 4-18-2024, at 1:12 PM, revealed Resident #3 has been dealing with gnats and horseflies for 3 weeks. Resident #3 stated what bothered him the most, was while sleeping and using the toilet, the horseflies have bitten him. Resident #3 said when he has been bitten, it was painful. Resident #3 showed a mark on his left forearm stating it was from a horsefly bite. Resident #3 stated he has been complaining to the facility for a few weeks about the bugs, while residing in the room next door (room [ROOM NUMBER]), and just 3 days ago moved him into his current room next door. While speaking with Resident #3, a fly was observed crawling on Resident #3's pie, which was covered with a plastic lid. A video was captured of this observation. Record review of Resident #4's Face Sheet, dated 4-18-2024, revealed a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of urinary tract infection, and secondary diagnosis of Parkinson's disease, repeated falls, and cerebral infarction (stroke). Record review of Resident #4's MDS, dated [DATE], revealed a BIMS score of 15, which indicating he was cognitively intact. In an observation/interview, with Resident #4, on 4-18-2024, at 3:15 PM, revealed Resident #4 has been dealing with insects in his room since he admitted to the facility. Resident #4 stated that he has been bitten by the flies and it hurt. Observation of Resident #4's room revealed 4 gnats flying, and 1 horse fly. (continued on next page)

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F 0925 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #2's Face Sheet, dated 4-18-2024, revealed a [AGE] year-old male, admitted to the facility on [DATE], with a primary diagnosis of acute kidney failure, and secondary diagnosis of hypertension (high blood pressure), hyperkalemia (high potassium level in the blood), type 2 diabetes, and congestive heart failure. Record review of Resident #2's MDS, dated [DATE], revealed a BIMS score of 15, which indicated he was being cognitively intact. In an observation/interview with Resident #2, on 4-18-2024, at 12:48 PM, 4 gnats and 3 horse flies, were observed flying in Resident #2's room. One horse fly was observed landing on Resident #2's leg while he was talking. Resident #2 stated that he has dealt with the insect problem since he admitted to the facility. Resident #2 stated he has been bitten by a bug while he was in bed. Resident #2 said he has not told a staff member he has been bitten. Record review of Resident #1's Face Sheet, dated 4-18-2024, revealed a [AGE] year-old male, admitted to the facility on [DATE], with a primary diagnosis of displaced fracture of shaft of the left tibia (the larger of the two shinbones in the lower leg) and secondary diagnosis of fracture of the upper end of the left tibia, necrosis (death of body tissue) of the left femur, and alcoholic liver disease. Record review of Resident #1's MDS, dated [DATE], indicated a BIMS score of 15, which indicated he was cognitively intact. In an observation/interview with Resident #1, on 4-18-2024, at 12:20 PM, 3 gnats and 2 horse flies, were observed in Resident #1's room. Resident #1 stated he noticed a bug problem in his room, since he had admitted into the facility, and he wished he would have stayed home, and not been admitted to this facility. In an observation, on 4-18-2024, at 1:09 PM, in the 100-hall hallway, 8 gnats were observed flying around. In an observation, on 4-18-2024, at 1:10 PM, in room [ROOM NUMBER], in the 100-hallway, approximately 6 large horse flies were video recorded flying in the window and approximately 30-50 dead gnats on the floor. An observation was made, on 4-18-2024, at 2:20 PM, of 25 gnats in the hallway by the kitchen on floor one. In an interview with RN A, on 4-18-2024, at 2:45 PM, revealed RN A has worked at the facility since 3-28-2024. RN A stated the flies and gnats have been here since she started working at the facility. RN A said residents have complained about the bugs to her. RN A stated another nurse uses an electronic bug zapper to kill the bugs at times. RN A stated she has not witnessed anything being done about the bug problem. (continued on next page)

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F 0925 Level of Harm - Actual harm Residents Affected - Some	In an interview on 4-18-2024, at 3:40 PM, with the Administrator, revealed the facility did not have a Maintenance Director, but were seeking to hire one. The Administrator stated that the Maintenance Director would be responsible for ensuring the facility was free of insects. The Administrator stated the facility used the Maintenance Director from a sister facility. In a phone interview with the Maintenance Director, of a sister facility, on 4-18-2024, at 3:51 PM, it was revealed that a pest control company was contracted for the facility, and they come out to the facility every two weeks to exterminate it. The interim Maintenance Director stated the pest control company treats the facility for gnats, flies, ants, roaches, spiders, and rodents. In an interview with the ADON, on 4-18-2024, at 5:05 PM, it was revealed the facility has had a flying insect problem since December 2023. The ADON stated the pest control company comes out to the facility, but they still have a problem with insects. The ADON stated the potential risk, to the residents, was for infections to occur for the ones who have IV lines, wounds, and colostomy bags. The ADON stated everywhere one goes, there seems to be a fly following you around. The ADON stated that residents on the first floor have complained about the insect problem. In an interview with the DON, on 4-18-2024, at 6:10 PM, revealed that residents have been complaining about the insect problem for a while. The DON stated the first time she noticed the insect problem occurring was 2 months ago. The DON stated that a few residents stated they had been bitten by large horse flies. The DON stated the potential risk to residents having insects in the facility, in their food, and residents being bitten by insects, is infection control. The DON stated that her expectation was for the facility to be free from flies. The DON stated the person responsible for pest control was the Maintenance Director. The DON stated the facility did not have a Maintenance Director but were seeking to hire one. The DON stated they were using a Maintenance Director from another facility. In an interview with the Administrator on 4-18-2024, at 6:50 PM, revealed that her expectation was for the facility to be free from flies. The Administrator believed the insects were coming from a drain and she has plumbers working on the problem. The Administrator said left over food in a resident's room can attract flies. The Administrator stated if a resident has left over food in their room, they have an aide throw the food away. The Administrator stated if a resident gets bitten by an insect, it can cause a skin problem and infection control. The Administrator stated that the Maintenance Director was responsible for maintaining pest control in the facility, but they did not have one. The Administrator stated they were in the process of hiring a Maintenance Director but were using one from their sister facility. The Administrator stated that only one resident has complained about the insect problem in the facility and as soon as he complained, they moved him to another room immediately. The Administrator stated that the facility contracts with a pest control company and they are working on the problem. The Administrator stated that the risk for insects getting into a resident's food was they could get sick. Record Review of the facility's pest control log indicated: 3-8-2024 - 11:05 AM to 12:44 PM - Insect Maintenance Service given flies, gnats, ants, and rodents. (continued on next page)

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F 0925 Level of Harm - Actual harm Residents Affected - Some	4-9-2024 - 12:08 PM to 1:30 PM - Insect Maintenance Service given for flies, gnats, ants and rodents. Pest control company check in with Maintenance Director from sister agency and performed preventative treatment on the front entry way doors and in kitchen. Inspected 3 rooms and performed a treatment in drains in kitchen. Checked rodent traps and changed bait in bait stations. Removed a rat from a ceiling void in conference room. Record review of the facility's pest control policy, dated 6-4-2023, stated: The facility will maintain an effective pest control program that provides frequent treatment of the environment for pest so that the facility is free of pest and rodents. It will allow for additional visits when a problem is detected. 48520