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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455891 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Renaissance Park Multi Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview, and record review, the facility failed to 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 disease and infections for one (Residents #1) of seven residents reviewed for infection control.</p> <p>LVN A failed to change gloves and perform hand hygiene during wound care for Resident #1.</p> <p>LVN A failed to follow wound care procedures that prevented spread of infection and cross contamination when he reused same gauze to wipe wound three times and placed the soiled items on the bed next to Resident #1's wound area during wound care.</p> <p>This failure could place residents at risk of cross contamination and spreading infections.</p> <p>The finding included:</p> <p>Review of Resident#1's face sheet dated 06/18/24, reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included stroke, history of falling, pubic bone fracture, fracture of the pelvis, wedge compression fracture of T1 and T11-T12 of the vertebrae, sepsis is an infection in the whole body, seizures, high blood pressure, elevated white blood count, sleep disorder while sleeping (obstructive sleep disorder), macular degenerative is an eye disease that causes vision loss and legal blindness.</p> <p>Review of Resident #1's quarterly MDS dated [DATE], reflected a BIMS of 6 which indicated severe cognitive impairment. Resident #1 required partial/moderate assist with the helper does less than half the effort. The helper lifts or holds, or support trunk or limbs and provides more than half the effort to roll left and right for bed mobility. The MDS indicated that Resident #1 skin treatments were a pressure reducing device bed and it indicated Resident #1 had no open wounds.</p> <p>Review of Resident #1's order summary dated 06/18/24, reflected Santyl Ointment 250 UNIT/GM (Collagenase) Apply to open area to sacrum topically every shift for wound care. Before applying, clean with Normal Saline. Cover with border dressing. Change dressing daily. Order active 05/31/24.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #1 care plan on 06/18/24, reflected Resident #1 had been at risk for break in skin integrity r/t impaired bed mobility and incontinence. Goal was to maintain intact skin with no skin breaks through next review. Interventions included to clean and dry skin after each incontinent episode. Care plan initiated on 04/16/24.</p> <p>Observation of wound care on 06/18/24 at 12:14 PM, revealed Resident #1 in bed with family at bedside. LVN A washed his hands then wore blue gloves pulled from out of his bag. He then gathered wound care supplies for Resident #1 provided by LVN B. The supplies contained some wax papers, wet five-by-five inches of white gauze, a couple of five-by-five inches of dry white gauze, Santyl wound ointment with two application sticks inside a small medication cup, dated dressing, and a clear bull eye wound measuring tool and placed them on a side table next to Resident #1's bed. The side table contained a clipboard with papers and pen, a cup, and socks on top of it. LVN A did not clean the side table and placed the wound care supplies on the wax paper next to the items on the side table. LVN A positioned himself on the left side of the bed. He attempted to position Resident #1 by pulling the sheet underneath her bottom to turn her on her right side but Resident #1 barely moved her body to the right side of the bed. LVN A then positioned his hand on her pelvic bone/hip area and pushed her to expose her band aid wound on the sacrum. LVN A held his left hand on Resident #1 left buttock to stabilize her in place. With his right-hand, he removed the old wound dressing on Resident#1's sacrum. He then placed the old, soiled dressing on the bed next to Resident#1 right buttock. He reached with his right hand on the side table and took the wet gauze and wiped Resident #1's wound 3 times with same gauze. He placed the soiled gauze on the bed next to Resident#1's right buttock. He then reached again on the side table and took one of the dry gauze and pat dry the wound. LVN A then placed the used gauze on the bed next to Resident #1's right buttock. LVN A did not change his gloves nor perform hand hygiene. At this time Resident #1 could not hold in place and slightly lied on back with the soiled dressing and gauze touching her left buttock. LVN A then adjust Resident #1's position. He took the measuring tool with his left hand and positioned it on Resident #1 wound on the sacrum. He used his right hand to hold the wound measuring tool and reached on the clip board with his left hand and took a pen. He then proceeded to measure the wound. Resident #1 was uncomfortable, and she expressed herself to LVN A. He then let go of Resident #1 and she laid on her back on top of the soiled items. LVN A again attempted to adjust Resident #1's position. He placed his hand again on her left buttock pushing her and reached on bedside table for the Santyl wound ointment and with both application sticks he took one scope and applied it to the wound and then went back into the cup with the Santyl wound ointment and applied more to the wound. He then placed the application sticks and cup on the wax paper next to the clean outer dressing. He let go of Resident #1 and she rolled on top of soiled wound items. With both hands, LVN A removed the plastic cover from the sticky part of the dressing and then with right hand he pushed Resident#1 on her right side. He attempted to apply the dressing, but the dressing rolled on the edges due to Resident #1 being unstable in position. He let go of Resident #1 and with both hands he unrolled the dressing. He then pushed Resident #1 on to the right side. At this time the resident was very uncomfortable and family at bedside asked if it was meant to go this way. LVN A continued to push Resident #1 more on the right side and applied the dressing.</p> <p>In an interview with LVN A on 06/18/24 at 12:48 pm, he stated he should have asked for assistance during wound care. He stated had he gotten help, he could examine Resident #1's wound better, he would have measured the wound correctly and applied the Santyl wound ointment correctly. He stated he was busy focusing on holding Resident #1 in place that he did not think about infection control or cross-contamination during the wound care. He stated he was an experienced nurse, and he should have known better. He said the risk to the resident was that her wound would get worse due to infection.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview with LVN B on 06/18/24 at 1:29 PM, he stated he had asked LVN A if he needed assistance with wound care, but LVN A declined stating that he was comfortable performing the wound care on Resident #1 by himself. He stated the risk to the resident for improper wound care was spread of infection and cross contamination. He said that it may cause resident's wound to get worse.</p> <p>In an interview with the cooperate DON on 06/18/24 at 5:10 PM, she stated LVN A was not employed by the facility. She said he was contracted from an agency for hospice. She stated she had banned LVN A from coming back to the facility. She stated facility would start checking off competencies and training before agencies can provide patient care. She stated she expected all nursing staff to follow infection control policy. She also stated she expected LVN A to have asked to assistance for resident's safety. She stated the risk to Resident #1 was spread of infection and cross contamination.</p> <p>In an interview with the ADM on 06/18/24 at 5:10 PM, she stated she expected all staff to follow the facility's infection control policy.</p> <p>Review of the facility's policy dated November 9, 2022, and titled Standard Precautions revealed .Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .hand hygiene is performed with soap (anti-microbial or non-antimicrobial) or alcohol-based hand rub before and after contact with the resident .</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe environment for residents, staff, and the public for one (Dining room [ROOM NUMBER]) of two dining room and one of one employee restrooms reviewed for physical environment.</p> <p>The facility failed to ensure the ceiling in the dietary department's employee restroom was free from unknown stains.</p> <p>The facility failed to ensure the ceiling tiles outside the dietary department in the dining room were not stained.</p> <p>The facility failed to ensure the walls outside the dietary department in the dining room were not damaged with drooping, sagging, and bubbled paint.</p> <p>This could place residents at risk for an unsafe environment.</p> <p>Findings included:</p> <p>Observation on 06/18/24 at 11:00 a.m revealed walls in dining room outside the dietary department had several drooping, sagging, and bubbled paint. The ceiling tiles above the wall were stained and brown from a leak.</p> <p>Interview on 06/18/2024 at 11:00 a.m. with the DM revealed there was an unidentified black substance in the dietary department's employee restroom. Observed the unidentified black substance in the employee restroom inside above, the door facing and on the ceiling. The color was scattered specks of a black substance. The DM revealed the area was treated by the Maintenance Director. The DM revealed the Maintenance Director informed her there has been a water leak from the air conditioner.</p> <p>Interview on 06/18/2024 at 11:15 a.m. with the Maintenance Director revealed he had been employed at the facility for one month. The MD revealed that he had treated the outside the dietary department area with [mold spray]. The MD revealed the mold was gone. Surveyor revealed to the MD the black substance was still in the dietary department's restroom. The MD revealed the area would be treated.</p> <p>again. The MD revealed the air conditioner had been leaking and causing moisture to form in the wall. The MD revealed the damage to the wall was there when he started work at the facility. The MD revealed he thought the Administrator was going to hire contractors to repair the wall. The MD revealed he had not completed any testing or observed any black substance on the wall.</p> <p>Record review of the Maintenance Repair Log, there was an entry dated 05/28/2024 informing AC Leaking in Dining Room, requesting repair by the Administrator.</p> <p>(continued on next page)</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the policy/procedure for Preventative Maintenance Services dated 01/11/2023 revealed Coordinate adequate resources and complete the required preventive maintenance on time. The facility must be designed, constructed, equipped, and maintained to protect health and safety of residents, personnel, and the public. The Plant Operations/Maintenance Department will respond to and correct identified problems within the scope of their operations or arrange for the correction by a qualified individual in a timely manner.</p> | | |