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	07/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review 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 (Resident #1) of three residents reviewed for notification of changes.The facility nurses failed to notify Resident #1's physician of Resident #1's refusal of ten scheduled doses of Rifaximin 550 mg oral tablet ordered twice daily for cirrhosis during June 2025 and July 2025. The facility nurses did not notify Resident 1's physician of her refusal of 12 scheduled doses of Lactulose 30 milliliters ordered twice daily for cirrhosis in July 2025.These failures could place residents at risk of not receiving appropriate treatment.Findings include:A review of Resident #1's Face Sheet reflect Resident #1 was a [AGE] year-old female resident admitted to the facility on [DATE].A review of Resident #1's MDS dated [DATE] reflected Resident #1 had a BIMS score of 14 indicating intact cognition. Resident #1 had a diagnosis of nonalcoholic steatohepatitis (fatty liver disease unrelated to alcohol consumption) and metabolic encephalopathy (brain dysfunction due to an underlying condition). Other diagnoses included in part end stage renal disease (permanent kidney failure requiring dialysis of kidney transplant) with dependence on renal dialysis, diabetes mellitus (disease of inadequate control of blood sugar), and heart failure (the heart cannot pump enough blood to meet the needs of the body).A record review of Resident #1's Care Plan Report dated 4-01-25, reflected Resident #1 had been non-compliant with taking her lactulose and goals and interventions were identified. A review of physician orders by Physician F reflected Resident #1 was ordered Rifaximin 550 mg oral twice daily for cirrhosis with start date 5/12/25 and Lactulose (20 Grams per 30 milliliters) 30 milliliters by mouth twice daily for cirrhosis with start date 5/12/25.A review of July 2025 MAR reflected Resident #1 refused her scheduled Lactulose on 7/1/25 (once), 7/2/25 (once), 7/3/25 (once), 7/4/25 (twice), 7/5/25 (twice), 7/6/25 (twice), 7/7/25 (twice) and 7/8/25 (once). The July 2025 MAR reflected Resident #1 refused her scheduled Rifaximin on 7/1/25 (twice), 7/2/25 (once), 7/3/25 (once), 7/4/25 (twice), 7/5/25 (twice), 7/6/25 (once), 7/725 (once). A review of June 2025 MAR reflected Resident #1 refused her scheduled Rifaximin on 6/29/25 (once) and 6/30/25 (once).In an interview on 7/16/25 at 08:35 am, the ADM reported that Resident #1 had refused her Lactulose multiple times in July 2025. She stated that Resident #1 had also declined to have her Rifaximin refilled by the pharmacy and had not received multiple doses, and that the physician had not been notified of these medication refusals. She stated it was the responsibility of the nurses to notify the physician of medication refusals. She stated the risk to the resident of not reporting these medication refusals was that Resident #1's ammonia level could have increased. A record review of Resident #1's progress notes for June 2025 and July 2025 reflected no documentation that the physician or nurse practitioner had been notified that Resident #1 had refused her Rifaximin and Lactulose. In an attempted telephone interview on 7/16/25 at 1:40 pm, the primary physician for Resident #1, Physician F, could not be reached.In an interview on 7/16/25 at 2:21 pm and 5:40 pm, NP A reported that she had not been notified that Resident #1 was refusing her Rifaximin and her Lactulose until 7/08/25. She stated another provider may have been notified. She stated she had noted documentation in the medical record that Resident #1 had received teaching on the risks of refusing her medications and had signed a statement acknowledging these risks. She reported that the facility nurses should have notified her of the medication refusals but that it would not have changed her orders or treatment in the case of Resident #1. She reported that she could not relate any symptoms experienced by Resident #1 to the refusal of these medications as Resident #1 had multiple comorbidities which could all cause similar symptoms. She reported that the possible risk of not reporting medication refusal to a provider was that the resident could have gone without needed treatment.In an interview on 7/16/25 at 2:07 pm, MA B reported there had only been one day that he had worked with Resident #1 that he did not give Resident #1 her Rifaximin because it was not available. He stated he notified an agency nurse on duty but was unsure of the nurse's name. He reported that the risk of not notifying the nurse of an unavailable medication would be that the patient could miss their medication or be harmed.In an interview on 7/16/25 at 02:22 pm, LVN C stated she had provided care for Resident #1 in June and July of 2025, but she was not notified by the medication aides and was not aware that Resident #1 was refusing her Lactulose. She reported that she would have notified the nurse practitioner of this refusal if she had known. She reported that the risk to Resident #1 was that it could have caused a change in her condition.In a telephone interview on 7/16/25 at 4:09 pm, RN D reported that on 7/05/25 and 7/06/25 the