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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interview and record review, the facility failed to ensure that a resident received care, consistent with professional stands of practice, to prevent pressure ulcers for 1 of 4 residents (Resident #95) reviewed for quality of care. 1. The facility failed to implement interventions to prevent Resident #95 from developing a stage 3 pressure injury to the sacral area. The facility did not assess Resident 95's skin to determine if she had pressure ulcers due to resdient refusal and did not identify a Stage III pressure ulcer to her sacrum which was identified when she was transferred to the hospital and was infected. Resident #95 was diagnosed with sepsis at the hospital. 2. The facility failed to accurately assess the skin of Resident #95. RN A did an incomplete skin assessment and documented Resident #95's skin was intact with no skin issues. 3. The facility failed to document Resident #95's refusal of skin assessments. An Immediate Jeopardy (IJ) situation was identified on [DATE] The IJ template was provided to the facility on [DATE] at 12:14 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopordy and a scope of Pattern due to the need for monitoring of corrective measures and the effectiveness of its corrective plan. These failures could place residents at risk of inaccurately assessing resident's condition, preventing pressure injuries, a decreased quality of life, hospitalization , and death. Findings included: Review of Resident #95's admission record, dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of colon (cancer of large intestine), systemic lupus erythematosus (autoimmune disease), Parkinson's disease (a movement disorder of the nervous system) and neuralgia (nerve pain) and neuritis (nerve inflammation). Review of Resident #95's admission MDS, dated [DATE], revealed occasional urinary incontinence. (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

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #95's quarterly MDS dated , [DATE], revealed a BIMS score of 15, indicating intact cognition. Further review of the MDS revealed Resident #95 was at risk of developing pressure ulcers/injuries, had pressure reducing device for bed and turning/repositioning program and did not have pressure ulcers/injuries. The MDS section GG functional abilities revealed Resident #95 was independent with eating, toileting, transferring and required supervision with showering/bathing self. Review of Resident #95's care plan, dated [DATE] revealed Resident #95 was at risk for unavoidable pressure injury development or decline of skin integrity with a goal to maintain intact skin with no skin breaks. Interventions included: Clean and apply moisture barrier after each incontinent episodes . Educate resident/family/caregivers of causative factors and measures to prevent skin injury . Encourage/Assist with turning and repositioning . Pressure redistribution mattress . Weekly skin checks . Review of Resident #95's weekly skin assessment, dated [DATE], comleted by LVN X, revealed the following: no alteration in skin; skin color was normal, skin temperature was warm, skin moisture was normal, and turgor was fair. Review of Resident #95's weekly skin assessment, dated [DATE], completed by LVN y, revealed the following: no alteration in skin; skin color was normal, skin temperature was warm, skin moisture was normal, and turgor was good. Review of Resident #95's weekly skin assessment, dated [DATE], completed by RN A, revealed the following: no alteration in skin; skin color was normal, skin temperature was warm, skin moisture was normal, and turgor was good. Review of nurse note dated [DATE] at 08:50 AM, written by LVN P (Agency Nurse) revealed, nurse was notified by CNA that resident was needing extensive assistance to transfer to w/c. nurse came into patients room and noticed that she was lethargic. Ask resident if she was in any pain and she stated 'no'. Vitals were taking at this time ,d+[DATE] B/P, p103, t 98.6, r16, O2 93. Family was visiting in facility and wanted [Resident] to be sent out. Explained DON and Doctor would need to be notified and they would decide transfer. While monitoring O2 sat pulse was noted as elevated to 130 bpm. DON and Doctor was notified and the OK to send patient to hospital. [Family members] of resident was notified. They requested resident to be sent to [Hospital Name]. Resident was able to verbally respond to nurse. She was unable to dress herself and two watery stools were notated by staff. EMS was called and resident sent to hospital. Review of Resident #95's Nursing Home to Hospital Transfer From dated [DATE] completed by RN F, revealed reason for transfer: unresponsive. (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #95's hospital admission history and physical, dated [DATE] revealed mild discomfort in her buttocks. Review of Resident #95's hospital records dated [DATE] revealed problem list included Sepsis (a serious condition in which the body responds improperly to infection) due to methicillin resistant Staphylococcus aureus (MRSA - bacteria that has become resistant to many antibiotics) with acute renal (kidney) failure and tubular necrosis (damage to tiny tubule cells of the kidneys) without septic shock, lactic acidosis (buildup of lactic acid in bloodstream), diarrhea of presumed infectious origin, pressure injury (a sore that develops under pressure) of sacral region stage 3, and cellulitis (bacterial skin infection) and abscess (a painful, collection of pus) of buttock. Review of Resident #95's hospital Admission History and Physical dated [DATE] revealed in part: The patient is a [AGE] year-old female who presents with diarrhea and acute renal failure with possible buttock cellulitis. She reports experiencing diarrhea but has not had any episodes today. She also reports no associated symptoms of fever or chills. There have been no instances of vomiting. Additionally, she mentions mild discomfort in her buttocks. Negative for fever, chills, or vomiting. Review of Resident #95's hospital CT abdomen and Pelvis WO contrast results, dated [DATE], revealed in part: Addendum #1 Also noted on the exam but not mentioned in the exam report is considerable asymmetric edema (swelling) involving the right labial area without soft tissue gas or drainable abscess. This is an asymmetric finding in the labial region. Very subtle fat-containing direct inguinal hernias (a bulge or lump that occurs in the groin region) also evident previously and currently but not significant. Also history included symptoms of right and left lower abdominal pain .Impression .7. New superficial subcutaneous mass like density in the posterior left inferior buttocks area which could represent fibrotic or active inflammatory sequelae of a left decubitus ulcer. No soft tissue gas or ulceration evident. 8. Diffuse reticular edema throughout the subcutaneous tissues of the posterior buttocks areas and in the presacral pelvic cavity areas could relate to a left inferior buttocks decubitus ulcer but no drainable fluid or abscess noted. Review of Hospital records wound care flow sheet revealed in part: Wound - Date First Assessed:[DATE] Time First Assessed:1515 Primary Wound Type: Other (comment) Properties Group inflamed and tender Side: Right Location Specific: buttocks Drainage amount: scant Drainage Characteristic: blood, bright Odor: Odor (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Current Dressing: none; open to air Dressing Applied: ABD pad; gauze fluffs (Kerlix Fluffs) Dressing Appearance: clean, dry and intact Wound Base: edematous; moist; pink; red Periwound Area: edematous; redness; moist; swelling Wound Edges: Open . Date First Assessed:[DATE] Time First Assessed:1517 Location Specific: labia Drainage amount: small Drainage Characteristic: purulent; tan; thick Odor: none Current Dressing: ABD pad; gauze fluffs (Kerlix Fluffs) Dressing Applied: ABD pad; gauze fluffs (Kerlix Fluffs) Dressing Appearance: clean, dry and intact Wound Base: edematous; red; ecchymotic; moist Periwound Area: ecchymotic; edematous; redness; swelling; moist Wound Edges: Open . Review of Resident #95's hospital records revealed, Consult notes dated [DATE] [AGE] year-old with staph sepsis now with tachycardia. admitted 3 days ago with abdominal pain and diarrhea. She is found to have cellulitis. Blood cultures positive for MRSA. She has had a sinus tachycardia since admission. She was being taken for debridement this afternoon and noted to have a heart rate of 200. Telemetry suggestive of SVT. No EKG performed. Surgery has been postponed. Heart rate improved. No chest pain or shortness of breath. Review of Resident #95's hospital discharge summary dated [DATE] revealed in part: Discharge diagnosis: Bacterial pneumonia, unspecified (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Acute hypoxemic respiratory failure secondary to PNA and volume overload Septic shock secondary to PNA Perineal wound, POA SSTI secondary to MRSA, POA MRSA bacteremia secondary to perineal wound, SSTI, POA Acute exacerbation of diastolic CHF AKI Acute lactic acidosis . Briefly, this is a 79 y.o. year old female who presented with on [DATE] with a perineal wound. Blood cultures were positive for MRSA. She underwent I&D on [DATE] and [DATE]. Additionally, she underwent robotic colostomy placement on [DATE]. On [DATE], she was noted to be more hypoxemic requiring escalation to HFNC. CXR demonstrated worsening bilateral pleural effusions. TPCCC was consulted for acute hypoxemic respiratory failure. Her antibiotics were escalated but her hypoxemia continue to worsen. She was eventually placed on BPAP and transferred to the ICU because of hypotension. Vasopressors were initiated. She remained DNR and her clinical deterioration was discussed with the[family members] at bedside. They elected to transition to comfort care. Condition at the time of discharge: deceased . A phone interview on [DATE] PM at 12:26 PM with CNA D revealed Resident #95 did pretty much everything for herself and staff just brought her meals. CNA D stated Resident #95 would sometimes go to the dining room and walk or take herself in her w/c and was very independent. She said when Resident #95 was in the bathroom she would offer her help and Resident #95 would say no. CNA D stated she did not see Resident #95's skin because the resident would not allow it. An interview on [DATE] at 12:51 PM, RN F stated he only worked weekends downstairs on the rehab hall. RN F stated he admitted Resident #95 before she went upstairs for long term care. RN F stated on [DATE], the DON had asked him to go upstairs because the restorative aide had gone to do restorative with Resident #95, and she was lethargic and had a change of condition. RN F stated when he got upstairs, LVN P had called the doctor. RN F stated he did not see Resident #95 and helped with the transfer paperwork then went back to work downstairs. An attempted phone interview with LVN P (agency nurse) was unsuccessful on [DATE] at 12:58 PM. (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on [DATE] at 1:01 PM, the DON stated facility nurses did their own wound treatments and went through training with herself or another nurse, and she had done in services on wound care, infection control and wound stages. The DON stated the risk to residents if wound care was not done was infection, they could become septic, and it would be harmful to the resident. She stated nurses were supposed to assess skin weekly and they were trained through Lippincott's which taught them wound care. The DON stated she also trains the nurses and would bring in the nurse during an assessment and explain what they were supposed to do, and when to notify the wound care doctor. She said nurses reported to her any skin changes because it was a change in condition, an incident report would be completed, and she would contact the wound Doctor and he then took over from there. The DON stated the CNA's were to report skin changes to their nurse. The DON stated she hired a wound care treatment nurse today because they had wounds and she felt like they could keep an eye on the skin, and the skin assessments would be consistent with one person doing them. She said everybody is going to document different and it would be consistent with a would care nurse. The DON stated Resident #95 was alert and oriented x 4 and did everything for herself. She said Resident #95 would shower herself and staff did set up and got towels. She said Resident #95 was modest and because of her culture would not staff look at her skin. The DON stated Resident #95's refusals were documented and should be in the EHR. She said the day the agency nurse worked the day Resident #95 was sent out did a paper progress note because she could not get logged into the EHR. The DON stated she was not at the facility when Resident #95 was sent out but LVN P had called her and she had called RN F to go help with the transfer. The DON stated LVN P described Resident #95 as lethargic and was not herself according to the CNA. The DON stated she asked for Resident #95's vitals and told LVN P to contact the Doctor. The DON said there was no change in Resident #95's condition the day before ([DATE]) and she had come down to the Christmas Party and got her gifts. The DON stated Resident #95 was not acting different and did not make any complaints. An interview and record review on [DATE] at 2:12 PM with RN A revealed the weekly skin assessment dated [DATE] indicating skin intact with no issues was not based on an actual assessment but what Resident #95 would report to her. The ADON stated she saw Resident #95 every day. On [DATE] Resident #95 was getting off the toilet, and normally did not need help. The ADON stated she talked with Resident #95 about the pain in her feet and when Resident #95 stood up she pulled up her pants and did not have anything on her skin or redness to her left. The ADON demonstrated where she could see Resident #95 skin and stated Resident #95 only had her lower back exposed. The ADON stated she did not wipe Resident #95 because she did not need the help. The ADON stated she could not see Resident #95's buttocks or peri area because Resident #95 was ready to pull her pants up, and she would not have even seen that. Interview on [DATE] at 2:37 PM, Resident #95's family member stated they were not aware Resident #95 refused skin assessments and stated facility staff did not inform them of refusals. (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on [DATE] at 1:03 PM with CNA G revealed she was a restorative aide, and the other CNAs and the nurses would sometimes ask her to help them out. CNA G remembered it was morning, because she was going to get Resident #95 to go work out in the gym, where she normally went to do her exercises, and that was when CNA I asked her to help with the resident. She said CNA I told her that Resident #95 was weak, had had loose bowels, and she needed help with her. CNA G said they did not normally need to help Resident #95, and she knew as soon as CNA I asked for help with her, something was wrong. She said she was surprised when she saw her and knew something was not right with her. CNA G said on Saturday ([DATE]), Resident #95 was sitting in her chair, slouching, when normally she was sitting upright in her chair, and reading, or praising God. The resident told CNA G she didn't feel good. CNA G told her she was there to help clean her up. Resident #95 agreed to let her help. She immediately went and told LVN P (an agency nurse) to come right now because the resident had a big change in condition. She said that LVN P went to Resident #95 and took her vitals. Resident #95 normally did her own care, but she looked bad and she was weak and had BM on her. Soiling herself was something Resident #95 never did. CNA G said she had never seen Resident #95 naked, because normally she just got her set up for her shower and she stood outside the door while she showered herself. She said Resident #95 would shower, dress, and come out, then CNA G would go and clean up the shower. CNA G said when Resident #95 came to the facility initially, she was weak, but therapy got her better and she was self-caring after that. CNA G said she thought CNA I asked her to help on a Saturday, but on the Friday before ([DATE]) she was up, and moving around, but she did mention to her that she thought she might have a flu or something, because she was not feeling well, and she thought someone tested her for the flu. CNA G said before that Friday ([DATE]) Resident #95 was fine, and was in activities, singing along, and she had only complained on that Friday. CNA G said she saw Resident #95 playing bingo earlier that week, and she was functioning as she normally did, and carrying on her daily routine. She said the resident went from that, to on Saturday ([DATE]) too weak to care for herself. CNA G said she and the other CNA put Resident #95 on the bed to clean her up, because she was so heavily soiled. She said they tried to assist her to stand, but she could not even do that, so they laid her down, and cleaned her the best they could. She said the skin looked intact, nothing that would be a red flag to alarm them, like redness or excoriation. She said that Resident #95 was more comfortable with her than she was with most people, but nobody was getting up in there. because Resident #95 was so modest she would never allow them to spread her legs, to get to everything. CNA G said because the resident would not allow them access to her entire body she could not be 100% sure Resident #95 was 100% clean. CNA G stated Resident #95 would not let anyone clean her peri area. She said LVN P got orders to send Resident #95 to the hospital, and everyone expected her to come back. She said when the staff learned she passed away, they were shocked, and it brought everyone down. She said everyone loved Resident #95, and she missed her. CNA G said normally if someone would not let you do care, or wouldn't let you do it right, you would tell the nurse, and the nurse would document it in the notes. She said she was sometimes present when the DON did skin assessments, and she was able to describe what she herself looked for when doing care, and what the nurses did for a skin assessment, and that they documented in detail about the skin, and contacted the physician. She said when she assisted nurses, she held up legs, and all of the other body parts, any skin folds, genitalia, breasts, so the nurse could see into all of their cracks and crevices. She said if they did not report a skin concern to the nurse, something the size of a pea could turn into a big problem, and a wound could lead to a serious infection if it was not treated and could kill someone. (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of facility policy Nursing Documentation Issued: [DATE], Reviewed: [DATE], reflected 1The medical record must contain an accurate representation of the actual experience of the resident-and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. Review of the [NAME] Procedures adopted as facility policy for Documentation: Long-Term Care retrieved on [DATE] at 9:59 AM from https://procedures.lww.com/lnp/view.do?pId=4139796&disciplineId=7169 , reflected Introduction: (.) Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of that care, and the treatment and education that the resident still needs. It also decreases the risk of miscommunication and errors and promotes continuity of care. Documentation helps demonstrate that a nurse has applied nursing knowledge, skills, and judgment according to professional nursing standards. (.) These records must also be complete, accurate, readily accessible, and systematically organized and must provide documentation of the resident's assessments and the care plan and services provided. (.) Implementation: (.) Document only the care actually provided. Don't document care, treatments, or medications that you intend to administer. (.) Special Considerations: Never tamper with documentation or any part of the clinical record. Tampering includes (.) inserting inaccurate information in the record (.) Review of the policy Refusal Care or Treatment, Issued: [DATE]; Reviewed: [DATE], reflected: Policy: It is the policy of the facility to allow the resident to be informed and made aware of the risks, benefits and procedures to be used in providing treatment as well as alternatives, any, and to give Informed consent or refuse treatment. This includes the initiation of treatment and the continued application of treatment. (.) Procedure: (.) 4. If a resident refuses medication or treatment, the facility will notify the resident and/or the resident representative of the risks versus benefits of the refusal. a. The facility should explore the reasons for the refusal and possible alternatives with the resident and/or resident representative. (.) 6. If the resident refuses other care activities such as bathing, the facility should speak with the resident and/or resident representative to determine if the preference or tolerance for this care activity has changed. The interdisciplinary team should work with the resident and or resident representative to develop alternative options to provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. 7. Documentation of the refusal and (.) notifications should be present in the resident's medical record. Review of the facility policy Skin Integrity & Pressure Ulcer/Injury Prevention and Management, Effective Date: [DATE]; Revised: [DATE], reflected: Policy: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards (.) Procedure: (.) 2. Per regulation a standardized risk assessment tool should be completed upon (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	admission/readmission, weekly for 4 weeks, quarterly, and as needed based upon each resident's specific needs. The standardized risk assessment tool being used is the Braden Scale (.). The score and additional risk factors are documented on the tool. 3. A skin assessment/inspection should be performed weekly by a licensed nurse. a. Skin observations also occur throughout points of care provided by CNAs during ADL care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the Nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed. Review of the [NAME] Procedures adopted as facility policy for Skin Assessment: Long-Term Care retrieved on [DATE] at 10:05 AM from https://procedures.lww.com/lnp/view.do?pld=4138690&disciplineId=7169, reflected Critical Notes! (Facility Corporation Name) has approved the following information as an addendum to the Lippincott procedure. Please reference the Skin Integrity & Pressure Ulcer/Injury Prevention and Management policy and include the following information: - Skin inspections are performed frequently by CNAs during ADL care. Any changes or concerns are reported to nursing. -Showers may be optimal time for coordinated skin inspections. Introduction: Skin inspections offers [sic] insight into a resident's physical condition. Visual inspection of the resident's skin provides objective data; information gathered during the interview process directly from the resident or a family member in their own words, including thoughts and observations on the resident's health, provides subjective data. Physical assessment focuses on inspection and palpation. During inspection, the exposed area should be observed for color, moisture, texture, and the presence of lesions. (.) Implementation: (.) Assist the resident with putting on a resident gown to gain access to the resident's skin and to facilitate assessment. (.) Inspecting and palpating the skin: - Expose the resident's skin adequately to facilitate assessment. (.) Documentation: Document your assessment findings, including the risk assessment score and identified risk factors as well as findings communicated to other health care providers. Document teaching provided to the resident and family (if applicable), their understanding of that teaching, and any need for follow-up teaching. An Immediate Jeopardy (IJ) was identified on [DATE] at 12:14 PM due to the above failures. The facility Administrator, DON and Regional RN were notified. The Administrator was provided the IJ template on [DATE] at 12:14 pm and a plan of removal was requested. An interview on [DATE] at 12:14 PM with the Administrator, Regional RN, and DON revealed they had been expecting an IJ to be called, and where near completion on their Plan of Removal (POR.) The DON stated that they could ask a resident if they had skin issues, and that Resident #95 was fully alert and oriented, and able to say if she was having any pain. The DON likened asking an alert and oriented resident if they had any pain to a physician asking an alert and oriented patient if they were having any issues with their skin at an appointment. The Administrator stated she could give documentation from [DATE] that the resident had a wound, but it was not a DTI or a pressure ulcer. The Regional RN stated she also reviewed the documents from [DATE], and the diagnoses contraindicated each other, and she saw the photo from before Resident #95 died . The DON stated that if Resident #95 was having pain, she would have alerted someone. She said she understood the nurse should have done the full assessment, and did not do it, but Resident #95 did not want her to, and they could not, if she did not want them to. The following plan of removal submitted by the facility was accepted on [DATE] at 2:56 PM. Plan of Remediation: [Facility Name] (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Re: Pressure Ulcers Failures: o The facility failed to identify and implement interventions for a pressure ulcer, that was identified in the hospital after she had been transferred to the hospital Corrective Action for Those Found to Have Been Affected by the Deficient Practice: o Identified resident no longer resides in the facility o Education will be completed regarding conducting thorough skin assessments, Braden assessments, updating care plans, documenting of refusal of resident care, and implementing resident specific interventions related to pressure ulcers. This education will be provided to all licensed nursing staff by the Director of Nurses or Regional Nurse Consultant. This training will be completed prior to staff working and by [DATE]. Identification of Other Residents Having the Potential to be Affected: o On [DATE] Infection Prevention Nurse, Director of Nurses, Staff nurse and Regional Nurse conducted a skin sweep on all residents in the facility o No negative outcomes identified o All residents that reside in the facility will have a completed skin data collection tool, Braden and updated care plan by the Infection Nurse, Director of Nurse, Staff nurse or Regional Nurse this will be completed by [DATE] Measures/Systemic Changes to Ensure the Deficient Practice does Not Recur: o The DON and IP nurse and Regional Nurse began immediate in servicing on [DATE] of current licensed nursing staff on the following and will be completed on [DATE] or prior to the staff working shifts: o Completion of a thorough skin assessment upon admission within 24 hours by charge nurse weekly o Completion of Braden assessment upon admission and then weekly X4 weeks and then monthly. o Completion of care plan upon admission and updated on any significant change o Completion of implementation of interventions upon identifying any wound areas o How to Document refusal of skin assessments by residents, notifying DON of any skin assessment refusals immediately Current licensed staff will not be allowed to work until completion of education as noted above and completed by [DATE] (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ongoing Monitoring: o Director of Nurses, Infection Nurse and Regional Nurse will complete the following until substantial compliance has been achieved and maintained: o Review and documented audits for completion of weekly skin assessments for residents o Review and documented audits for completion of refusal skin sheets o Review and documented audits for completion of Braden assessments audits o Review and documented audits for care plans for residents with pressure ulcers identified o Review and documented audits for interventions for residents with pressure ulcers identified o The facility will continue to provide on-going in-services as noted above to newly hired licensed nursing staff, annually and as needed. o All components of this plan of correction will be submitted to the facility QAPI meeting and additional recommendations will be made until substantial compliance has been achieved. The Medical Director was notified and agrees with the plan of correction. The Executive Director, Director of Nurses, IP nurse, Regional Nurse and RVP are responsible for the corrections and continued monitoring. Completion Date: [DATE]. Surveyor Monitoring: Interviews with RN B, RN F, LVN J, LVN L, RN M, LVN T, RN V, LVN W on [DATE] between 12:15 PM and 6:00 PM revealed nurses had been in-serviced on how to perform head-to-toe skin assessments, the Braden Scale (a tool for determining pressure wound risk), who to notify, and what to document, which included description of skin issues, and documenting refusals or partial skin assessments. The nurses were able to talk surveyors through a detailed description of how they would perform a skin assessment. Nurses confirmed that they knew that asking even an alert and oriented, independent resident about their skin did not constitute a skin assessment. All nurses were able to express understanding of the risks of not performing thorough skin assessments. (continued on next page)

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	02/28/2025

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on [DATE] at 4:53 PM with RN A revealed she was in-serviced on [DATE] on skin, wound care, and abuse and neglect. She described the head-to-toe skin assessment in detail, including how to look at areas of the body which were normally not exposed. RN A stated she would look for anything abnormal about the skin, which could include rashes, raised skin, redness, pressure injuries, wounds, darkened areas, and would include inspecting bony prominences and low blood flow areas. She said it would be documented in the EHR, with the size, any signs of infection or odor, location on the body, who was notified, and any new orders. She said they were to notify the physician and DON and would notify the family of any findings and new orders. She said she would then care plan it the skin issue. She said they did skin assessments weekly at this facility, as well as on admission, and with any change. She said the CNAs knew how to use the skin data sheet, and the nurses followed up on any findings they had, as well. RN A said if the resident refused the assessment, that was to be documented, and if they allowed only a partial assessment, they would document which specific parts of the body were assessed, and which were not, then notify the physician of the partial skin assessment. She said the procedure was the same for any resident, regardless of how oriented and independent they were, and any verbal information a resident gave about their skin was subjective data and would not be considered reliable information to replace a skin assessment, and would not be documented as such. RNA said the risk of not doing thorough skin assessments was not finding skin problems in [TRUNCATED]

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	02/28/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 (Resident #143) of 2 residents reviewed for enteral nutrition. RN R failed to check g-tube placement before administering medication. RN R pushed medication and water with a syringe and plunger instead of using gravity gentle flow (this is a method used by attaching a feeding syringe without the plunger to allow water, medications, and food to enter the stomach via G-tube gently without force of pushing) to administer medications and water via G-tube for Resident #143. This deficiency practice would affect residents who receive tube feedings by not receiving the appropriate nutrition and causing G-tube complications. Findings included: Review of Resident #143's face sheet, dated 2/27/2025, revealed that resident was a [AGE] year-old female admitted on [DATE] with diagnoses of Anterior displaced type 2 dens fracture (fracture of the C2 bone of the spine), Type 2 diabetes, Chronic kidney disease, Acute cholecystitis (inflammation of the gallbladder). Review of Resident #143's physician orders, dated 2/25/2025, revealed that Resident #143 has Enteral feed order to verify position of Enteral Access Device by comparing the documented length or numerical marking at the exit site of the device to the previously documented length. Review of Resident #143's Care plan, dated 2/19/2025, showed that the resident was care planned for tube feeding. One of the interventions documented on 2/25/2025 stated feeding tube length 8.4cm from feeding port cover to stoma. Observation on 2/27/2025 at 09:20am, RN R was preparing PRN pain medication (Oxycodone) to administer to Resident #143. After crushing medication, preparing water, RN R performed hand hygiene, put on PPE and went in Resident #143's room. RN R lifted Resident #143's shirt to expose g-tube site which showed dressing labeled 2/26/2025, RN R paused continuous feeding. Without checking for g-tube placement, RN R proceeded to use the syringe plunger to flush the g-tube line with 10mL of water. He then drew the medication mixture from the medication cup using the same syringe and proceeded to push medication mixture directly in the g-tube. He flushed the line with 10mL of water, closed the port and restarted the continuous feeding. He performed hand hygiene before exiting the room. In an interview on 2/27/2025 at 09:30AM, RN R stated that pushing medication directly to the line has been the method he has been using. He does not use gravity method. He did not know which method was the correct method. (continued on next page)

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	02/28/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/27/2025 at 1:00PM, the DON stated that gravity was the only method to administer medication via g-tube, the nurses should never force the medication in the tube. She stated that the risk of peritonitis can happen if medication is forcefully pushed into the tube. She also stated if the nurses notice medication does not flow down the line while using gravity, they should notify the physician to get the tube changed. She also stated that the nurses have been trained to measure the g-tube length with the measuring tape and they should do it every time they are giving medication. Review of facility's procedure called Medication Administered through an Enteral tube, revised on 11/15/2024, revealed that the staff administering medication should confirm feeding tube placement per facility policy. The procedure guide also stated the procedure is done by inserting medication syringe into the appropriate port and pour each medication through the syringe, . Allow the drug to flow by gravity. If the medication does not flow easily, reposition resident and milk the enteral tube or give gentle boosts with the plunger. Do not forcibly push medications through the tube.

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	02/28/2025

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 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. 45507 Based on observation, interview, and record review, the facility failed to distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure the Dietary Manager wore a beard restraint while in the kitchen on 02/25/2025. This failure could place residents at risk for food contamination. Findings included: Observation and interview on 02/25/25 between 8:53 AM to 9:07 AM in the facility kitchen revealed the Dietary Manager was not wearing a beard restraint. He was observed walking through the kitchen when the Surveyor walked in. He stated he was not required to wear a beard restraint because he was not cooking food and it was required if he was cooking. He stated hair could get in the food if hair restraints were not worn. Interview on 02/27/25 at 12:07 PM, the Administrator stated her expectation was employees follow the company wide uniform policy. She stated if hair restraints (including beard restraints) were not worn, hair could contaminate the food. Record review of the facility's policy, titled Associate Conduct and Dress Code revised 04/30/2024 revealed in part: .Hair Restraints/Jewelry/Nail Polish - Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food . Procedure 1. Associates present a neat and clean appearance at all times. This would include; e. All facial hair including moustaches and beards should be trimmed and covered . 3. The Food and Nutrition Services associates wear a hair covering, which covers all unpinned hair, including all facial hair while on duty .

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	02/28/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 1 (Resident #23) resident personal refrigerators reviewed for food safety. The facility failed to ensure Resident #23's personal refrigerator was cleaned, and items discarded per facility policy. This failure could place residents at risk of not having an environment that is clean/comfortable. Findings included: Record review of Resident #23's admission record, dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #23's Quarterly MDS assessment revealed a BIMS score of 15 indicating intact cognition. Observation and interview on [DATE] at 10:07 AM in Resident #23's room revealed a personal fridge on top of a nightstand next to the bed. Inside the fridge were protein shakes, small yogurt cups and an ice tray on a shelf. Above the ice tray was a small white box with a temperature control knob. A rounded buildup of ice was attached from the bottom of the white box to the ice tray. Inside the ice appeared to be grapes and a paper towel. Resident #23 stated staff did not clean her fridge. Interview on [DATE] at 6:05 PM, CNA O stated CNA's were responsible to check resident's personal fridges and the temperatures. Interview on [DATE] at 12:07 PM, the Administrator stated housekeeping cleaned all resident personal fridges. She stated if they had to defrost the fridge, the CNA's would remove the food and put the food in the nutrition room. She said if the CNA's saw food that was expired, they should take the food out and let housekeeping know to go in and clean. The Administrator stated if the resident's fridges were not cleaned out it the risk could be infection control and the residents could get sick. Record review of facility policy titled, Resident Refrigerators revised [DATE] revealed in part: Procedure 1. Residents who choose to maintain refrigerators in their rooms will be provided with a copy of this policy and procedure upon admission and agree to the terms and conditions . 5. Facility staff will check individual food items for expiration dates and discard outdated food promptly from the residents' personal refrigerator. (continued on next page)

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	02/28/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Food will be labeled and dated to monitor for food safety . d. Food items in unmarked or unlabeled containers should be labeled with contents, and the date the food item was stored. e. Any food suspected to be contaminated or with visible signs of contamination should be discarded immediately .

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	02/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control measure designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 9 (Resident #143 and Resident #115) residents reviewed for infection control. RN R failed to perform hand hygiene and use clean gloves while providing wound care on Resident #143. Facility staff failed to ensure visitors for Resident #115 followed facility infection control policy during COVID19 outbreak. These deficient practices could place residents and nursing staff at risk of transmission of communicable diseases and infections. Findings included: Review of Resident #143's face sheet, dated 2/27/2025, revealed that resident was a [AGE] year-old female admitted on [DATE] with diagnoses of Anterior displaced type 2 dens fracture (fracture of the C2 bone of the spine), Type 2 diabetes, Chronic kidney disease, Acute cholecystitis (inflammation of the gallbladder). Review of Resident #143's physician orders, dated 2/16/2025, revealed that resident has right heel DTI (Deep tissue injury), the order stated to paint with betadine and apply dressing in the morning. Observation on 2/27/2025 at 9:00 am revealed, RN R, ADON, and MA S provided wound care to Resident #143. All staff performed hand hygiene before entering room, put on PPE. ADON and MA S assisted in holding Resident #143's right leg up to expose her right heel. RN R removed old dressing, which was labeled 2/26/2025, proceeded to open 2 packs of betadine sticks to paint on wound. RN R then applied border gauze dressing to wound and labeled 2/27/2025. RN R did not change gloves after old dressing was removed and did not perform hand hygiene after touching soiled dressing. He only performed hand hygiene before leaving Resident #143's room. In an interview on 2/27/2025 at 9:30am, RN R stated he only used one pair of gloves while providing wound care. He stated he did not know why he forgot to change gloves. He stated the risk of not changing gloves and performing hand hygiene was transmission of infections. In an interview on 2/27/2025 at 9:35am, ADON agreed RN R should have removed soiled gloves, perform hand hygiene and put on a new pair of gloves. She stated the risk of not doing that was infection. She stated the DON provided in-services monthly for infection control & hand hygiene. (continued on next page)

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	02/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/25/2025 at 12:09 PM outside Resident #115's room revealed a visitor wearing an N95 mask entered the room, came back out of the room to fill a water pitcher from down the hall, and returned to the room. Visitor did not use hand sanitizer before entering or when leaving the room and did not put on PPE before going into Resident #115's room. Signage posted on the door read Droplet Precautions Everyone must: clean their hands, including before entering and when leaving the room . and Contact Precautions Everyone must: clean their hands including before entering and when leaving the room . Record review of undated list provided by the facility on 02/25/2025 revealed 9 of 10 residents on Transmission Based Precautions were positive for COVID19. In an interview on 02/26/2025 at approximately 6:30 PM, the ADON stated when a resident was on Transmission Based Precautions for COVID, gowns, masks, eye protections and gloves were required for staff. She stated they encourage family members to wear gowns and gloves and dress out, but unfortunately could not catch them all. In an interview on 2/27/2025 at 1:00pm, the DON stated that RN R did not follow infection control procedure by not changing gloves and washing hands after he touched the soiled dressing. She stated since the facility does not have a treatment nurse, nurses do their own wound care. She stated the nurses go through trainings provided by the DON, including those that are related to wound care and infection control. She stated residents who were positive for COVID19 required droplet and contact isolation which was posted on the resident's door and family members or visitors could see. The DON stated she expected for visitors to wear masks and encouraged them to wear gowns, but it was their choice. She said Resident #115's visitor/family should not have gotten ice, and she should have asked someone. She stated the risk of not practicing infection control are infection, sepsis, harm to residents. Review of facility's Hand hygiene procedure, last revised on 7/15/2022, showed that Associates perform hand hygiene (even if gloves are used) in the following situations: a. Before and after contact with the resident b. After contact with blood, body fluids, or visible contaminated surfaces c. After contacts with objects and surfaces in the resident's environment d. After removing personal protective equipment, .