

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2024
NAME OF PROVIDER OR SUPPLIER FT Worth Southwest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Alta Mesa Blvd Fort Worth, TX 76133	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one (Resident #1) of eight residents reviewed for abuse.</p> <p>The facility failed to protect Resident #1, who was unable to give consent for sexual activity, from sexual abuse after Resident #2 was discovered in her bed with his pants off and buttocks exposed, laying behind her on 06/30/24.</p> <p>The facility failed to put interventions in place to protect Resident #1 after allegations were made that Resident #2 placed his penis in her mouth on 06/30/24.</p> <p>An IJ was identified on 07/03/2024. The IJ template was provided to the facility on [DATE] at 5:32 PM. While the IJ was removed on 07/04/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.</p> <p>These failures could place all residents at risk for abuse and psychosocial harm.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet dated 07/03/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: unspecified sequelae cerebral infarction (stroke), cognitive communication deficit (trouble participating in conversation), aphasia (loss of ability to understand or express speech, caused by brain damage), dysarthria and anarthria (motor speech disorder), bipolar disorder (mental disorder causing unusual shift in mood, energy, and concentration), and major depressive disorder, recurrent, severe with psychotic symptoms (depression along with loss of touch with reality).</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675817
		If continuation sheet Page 1 of 33

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's quarterly MDS Assessment, dated 06/25/2024, reflected no BIMS score, indicating it was not able to be completed. She had short- and long-term memory problems, cognitive and daily decision-making skills reflected moderately impaired - decisions poor, cues/supervision required. Signs and symptoms of delirium reflected and altered level of consciousness. Resident #1 exhibited no behaviors and used a wheelchair to ambulate. She was totally dependent for toileting, showering, dressing, transfers, and personal hygiene.</p> <p>Record review of Resident #1's BIMS assessment dated [DATE] and signed by the Social Worker reflected, severely impaired cognition.</p> <p>Record review of Resident #1's Care Plan dated 11/28/2023 - Present, reflected, Problem: [Resident #1] The resident has impaired cognitive function or impaired thought processes. Goal: will be able to communicate basic needs on a daily basis through the review date. Problem: The resident has a communication problem r/t aphasia. Intervention: Anticipate and meet needs. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Problem: [Resident #1] has an ADL Self Care Performance Deficit. Intervention: requires 1 staff participation to use toilet and all ADLs.</p> <p>Record review of Resident #2's Face Sheet dated 07/03/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses included: encephalopathy (group of conditions that cause brain disfunction), major depressive disorder (mental health condition that causes persistent depressive mood), intermittent explosive disorder (repeat sudden bouts of impulsive, aggressive outbursts), type 2 diabetes (problem in the way the body regulates and used sugar as fuel), hypertension (pressure in blood vessels is too high), and schizoaffective disorder (combination schizophrenia and mood disorder displayed by manic moods and hallucinations).</p> <p>Record review of Resident #2's quarterly MDS Assessment, dated 05/30/2024, reflected a BIMS score of 15, which indicated no cognitive impairment. No behaviors were exhibited. He was independent for all functional abilities and ADLs.</p> <p>Record review of Resident #2's Care Plan dated 06/14/2024 - Present, reflected, no prior sexually inappropriate behavior. The care plan was updated on 07/03/2024 and reflected, Problem: Behavior: Sexually inappropriate AEB: noted to have sexual urges at the facility. Date Initiated: 07/03/2024. Interventions: [Resident #2] to remain on one-on-one watch until further notice, Date Initiated: 07/04/2024. Report incidents of target behavior to charge nurse, Date Initiated: 07/03/2024. Staff to be in-serviced on behavioral approaches designed to effectively manage unacceptable sexual advances (avoid self-disclosing personal information), Date Initiated: 07/04/2024.</p> <p>Record review of the facility incident report, dated 07/03/2024 at 10:51 AM and signed by the DON, reflected, It was reported to this writer that [Resident #2] allegedly put his penis in [Resident #1's mouth. When asked if anyone touched [Resident #1] she indicated No. When asked if anyone placed their penis in her mouth she indicated No. Head to toe assessment completed with no visible injuries noted. Resident sent out to the ER for SANE evaluation. MD notified. Local law enforcement notified. Attempted no notify family but number is not working.</p> <p>Record review of the facility's transfer record dated 07/03/2024 at 2:30 PM and signed by ADON A, reflected Resident #1 was transferred to hospital.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Psychological Services Progress Note, dated 07/03/2024, reflected, Intervention: Discussed a recent incident in which the pt was discovered in a female resident's room with his pants removed. Utilized open-ended questioning to investigate patient's version of events and potential precipitating factors. Identified inappropriate sexual behavior and processed patient's feelings of guilt and shame. Provided psychoeducation in the importance of maintaining boundaries to protect his own safety and the safety of others. Response to Intervention: Saw pt in a private area to discuss a recent incidence of sexual misconduct. Pt presented as anxious with a blunted affect. He was fully cooperative and expressed remorse regarding his behavior. Pt admitted to entering the female resident's room and removing his pants. He vehemently asserted that there was no sexual conduct during the encounter. Pt claimed that he was walking by the room when he heard a voice call his name. Pt indicated that he was aware that the female resident in question was nonverbal and hypothesized that the voice was a hallucination. In response to the voice, he entered the female resident's room. Pt alleged that the female resident made sexual advances after he entered the room (touched his leg, moved her head toward his groin area). He stated that he removed his pants because the female resident indicated her intention to provide oral sex. Pt then stated that he changed his mind prior to sexual contact and was attempting to pull up his pants when a staff member discovered him. Pt responded positively to therapeutic interventions and admitted that his behavior was inappropriate. He said that he felt guilty about the entire incident and said that he intended no harm. Pt was also receptive to psychoeducation on maintaining boundaries and stated that he would not enter a female's room again. Pt demonstrated understanding of the importance of boundaries in maintaining his safety and the safety of others.</p> <p>In an interview on 07/03/2024 at 9:17 AM, Resident #1, was not able to answer questions with words. She did not make any gestures of verbal comments that reflected her understanding of questions asked of her regarding the incident.</p> <p>In an interview on 07/03/2024 at 9:49 AM, the DON stated Resident #2 had no previous history of any sexual behaviors. He said when LVN D called him on 06/30/2024 at about 9:30 AM to inform him that Resident #2 had been found in bed with Resident #1, he wanted to find out whether Resident #1 invited Resident #2 into her bed. He stated Residents #1 and #2 were friends and often watched television together in the television room. The DON stated LVN D did not complete an incident report and he did not immediately start an investigation about regarding the incident. The DON stated Resident #1 had a BIMS of 0 but that was related to her inability to speak clearly. He said Resident #1 was able to understand and could give consent to a sexual act. He said when LVN D called him, he got on the phone with LVN D and Resident #1, and Resident #1 was able to say some words and responded yes / friend when asked if she wanted Resident #2 in her room. He said he did not ask if Resident #1 wanted Resident #1 in her bed with her but did not feel the need to immediately investigate the incident further. He stated on 07/01/2024, he asked the Social Worker and ADON A to speak to Resident #1. He said they completed a verbal BIMS Assessment on Resident #1, which resulted in no score, which indicated severely cognitively impaired. He said Resident #2 had a BIMS of 15 which indicated no cognitive impairment. He stated he and the Administrator talked to Resident #2 and he denied any type of sexual inappropriate behavior. The DON said he did not refer Resident #1 to the hospital for a SANE exam and did not contact the police.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 10:50 AM, Resident #2 stated, on 06/30/2024 at about 9:30 AM, he was walking past Resident #1's room and she was in bed and waved him into her room. He said she waved at everyone in that way, but he felt she wanted him to come in. He said he knew Resident #1 because they occasionally watched television together in the day room. He said he did go into Resident #1's room because he was looking for a blow job, [oral sex]. He said he took his pants off and got into bed with Resident #1. He said when he was in bed with her, he started to feel bad and was about to get out of the bed when CNA G entered the room and saw him in bed with Resident #1. He said CNA G did not say anything and left the room and closed the door. He said he got up and put his pants on and heard CNA G call for LVN D. Resident #2 said he left the room and returned to his room. He denied he had done this with any other residents in the facility. Resident #2 said he did not place his penis in Resident #1's mouth and denied any penetration of any kind. He stated the Administrator talked to him about the incident on 07/01/2024 and told him if this type of behavior happened again he would call the police.</p> <p>In an interview on 07/03/2024 at 11:16 AM, CNA F said she heard from LVN D the Resident #2 was found in Resident #1's room, with his penis in Resident #1's mouth on 06/30/2024. She stated that in a similar incident involving different residents, a few years ago, the facility managers immediately sent the offending resident out of the facility and called police. CNA F stated she felt that should have occurred this time but had not. She said the Administrator and DON should have placed Resident #2 on some kind of supervision while they investigated the incident to ensure the safety of all residents in the facility. She said if what she heard was true, Resident #2 had access to Resident #1 and all other residents until today when he was placed on 1:1 supervision. She said she has worked at the facility for [AGE] years and was familiar with the facility's abuse policy because she received training on the policy almost weekly. She stated she did not report the incident to the Abuse Coordinator and was not sure if LVN D reported it. She stated she assumed it was reported.</p> <p>In an interview on 07/03/2024 at 12:00 PM, the DON stated the alleged incident between Resident #1 and Resident #2 was not discussed in the manager's stand-up meeting. He said not every manager needed to know about every incident that occurred. He said after the stand-up meeting on 07/01/2024, the Social Worker and ADON A interviewed Resident #1 and reported to him that Resident #1 answered no when they asked if Resident #2 did anything to her. The DON stated, [Resident #2] did not tell him any intentions to get oral sex from Resident #1. He stated at the time, he did not feel there was any sexual abuse so there was no need to report to police or the state. He stated he did not investigate further because he felt there was no evidence the incident was of a sexual nature and therefore did not move Resident #2. He said, Looking back, we did not get the full truth from [Resident #2] and [Resident #1's] BIMS does limit her ability to consent. He said, We should have called police to follow up with a SANE exam and placed Resident #2 on 1:1 supervision to ensure all residents' safety. He stated Resident #1 was sent to hospital, police have been called, Resident #2 was placed on 1:1 supervision, and the incident was reported to state today.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 12:10 PM, the Regional Director of Operations (RDO) stated the incident between Residents #1 and #2 should have been thoroughly investigated. He said Resident #2 should have been put on 1:1 supervision to ensure the safety of all residents, Resident #1 should have been sent to the hospital for examination, law enforcement should have been called, the incident should have been reported to the state agency, and a facility investigation started. He said based on Resident #1's BIMS, it was not clear she could have consented to anything, and the facility's policy was in place to ensure the safety of all residents during an investigation of any allegation of abuse. He stated, We should have confirmed what we observed was what happened through investigation in order to ensure the safety of [Resident #1].</p> <p>An observation and interview on 07/03/2024 at 12:40 PM revealed Resident #2 in his room sleeping on his bed. CNA I was observed outside the room. CNA I stated she was directed to supervise Resident #2 and document wherever he when in the facility.</p> <p>In a telephone interview on 07/03/2024 at 12:54 PM, LVN D stated she was at the nurses' station on 06/30/2024 at about 9:30 AM, when CNA G called her to Resident #1's room. She stated when she went down the hall she saw Resident #2 leaving Resident #1's room. CNA G told her she opened Resident #1's room door and saw Resident #2 in bed with Resident #1. She stated Resident #1 was facing the wall and Resident #2 was in the bed behind her also facing the wall. LVN D stated CNA G did not say she witnessed Resident #2's penis in Resident #1's mouth. She said CNA G told her Resident #2 told her he was talking to his friend. She said she observed Resident #2 with clothes on when he left Resident #1's room but did not observe Resident #2 in the bed. LVN D said she observed Resident #1 in bed with her clothes on. LVN D said she asked Resident #1 what happened, and Resident #1 only nodded no. She stated Resident #1 was not crying and did not appear in distress. She said Resident #1's brief was on and did not appear to be tampered with. LVN D said she felt like Resident #1 could give consent but could not verbalize the consent. LVN D said she could not be sure if she consented to any sexual act of to have Resident #2 in her bed. LVN D said she called the DON when the incident occurred and was instructed to do an emotional assessment. She stated she talked to Resident #1 and she seemed to have her normal demeanor. She did not appear to be afraid and did not behave differently from how she normally did. She said she did not document any assessment of Resident #1 and did not complete an incident report, she said she did not know why she did not document the incident. She said Resident #2 was not on 1:1 watch at the time of the incident on 06/30/2024 but looking back believed he should have been to ensure the safety of all residents while the incident was investigated. She said Resident #1 should have been sent out for a SANE exam rather than assuming nothing happened.</p> <p>In an interview on 07/03/2024 at 1:17 PM, ADON A stated she became aware of the incident between Residents #1 and #2 on 07/01/2024 when the DON asked her and the Social Worker to talk to Resident #1 about the Resident #2 being in her bed. She said they tried to assess Resident #1's ability to consent and her cognitive ability. ADON A stated Resident #1's competency level was very low, and she would not answer any of the BIMS questions. ADON A said she did not feel that Resident #1 had the capacity to invite Resident #2 into her bed. She said she told the DON Resident #1 did not seem like she was able to consent to anything. ADON A said she did not know where the incident investigation went from there but Resident #2 was not on any kind of supervision until 07/03/2024 when the State Surveyor started asking questions about the Incident. She said Resident #1 was sent to the hospital for a SANE exam and the police were called earlier today as well.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 1:31 PM, the Social Worker stated Resident #1 was not able to point to correct answers for any of the BIMS Assessment questions. She said Resident #1 was severely cognitively impaired and did not believe she had any capacity to concert to Resident #2's alleged actions. She said she shared this information with the DON and did not hear anything else about the incident. She stated Resident #1 should have been sent to the hospital for SANE exam and police notified. She said Resident #2 should have been placed on 1:1 to ensure all residents' safety.</p> <p>In an interview on 07/03/2024 at 1:49 PM, LVN C stated CNA F told her that LVN D told her that Resident #2 was found with his penis in Resident #1's mouth. She said she did not ask CNA F if the incident was reported to the Administrator and said she did not report it either. She stated she assumed the issue had been addressed and reported to the Abuse Coordinator. LVN C said she had worked in the facility about a year and was regularly in-serviced on abuse policy. She said she did not recall when the last in-service was.</p> <p>In a telephone interview on 07/03/2024 at 4:42 PM, CNA G stated on 06/30/2024 at about 9:15 AM, she opened Resident #1's door and saw her in the bed facing the wall. CNA G stated she saw Resident #2 in bed with Resident #1, behind her and also facing the wall. She stated she did not see if Resident #1 had clothes on but did see Resident #2's bare butt sticking out of the covers. She stated she did not know if Resident #2 had his pants all the way off or just around his ankles. CNA G said she left the room and called for LVN D. She stated LVN D came down the hall within a few seconds and Resident #2 opened Resident #1's room door and went across the hall to his room. She said LVN D called the DON and they talked to Resident #1 over the phone. She said she did not report the incident because LVN D had called the DON and she assumed they were addressing the issue. She said she had never seen Resident #2 display any type of sexual inappropriate behavior in the past. She stated LVN D did not send Resident #1 to the hospital and Resident #2 was not placed on 1:1 supervision. She said when she returned to work on 07/01/2024, staff told her that LVN D said Resident #2 was found with his penis in Resident #1's mouth. CNA G said she did not see Resident #2's penis in Resident #1's mouth when she entered the room on 06/30/2024.</p> <p>In an interview on 07/03/2024 at 4:50 PM, Law Enforcement Officer #4664 stated she was called today to respond to allegations of sexual assault. She said since the incident occurred on 06/30/2024, the facility should have called then and sent Resident #1 to the hospital for a SANE exam. She said the facility told her they sent Resident #1 to the hospital today.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Abuse prevention and prohibition program, revised 08/2020, reflected, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements . IV. Prevention: A. Staff, residents and families will be able to report concerns, incidents, and grievances without fear of retribution or retaliation. B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring . VI. Investigation: A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts . C. The Facility ensures protection of residents during abuse investigations . I. While the investigation is underway, accused individuals who are not Facility Staff may not have any unsupervised access to residents . IX. Reporting/Response: A. Facility Staff are Mandatory Reporters . C. Reporting Requirements: i. The Facility will report known or suspected instances of physical abuse, including sexual abuse, and criminal acts to the proper authorities by telephone or through a confidential Internet reporting tool as required by state and federal regulations. X. Special Considerations for Reporting Suspected Incidents of Rape: A. Anyone who suspects that a rape has been committed against a resident must immediately report this information Administrator and to the Director of Nursing Services. B. The Director of Nursing Services or designee will immediately report this information to the Attending Physician. C. The Administrator then acts to ensure the following steps are taken: i. The proper authorities and individuals are notified immediately or within 24 hours, including but not limited to law enforcement, the Attending Physician, the resident's representative, the state survey and certification agency, and any others necessary. ii. A Licensed Nurse assesses the resident (alleged victim) for possible injuries. iii. The resident is provided with the medical treatment and emotional support necessary to prevent further deterioration of his/her health and wellbeing. iv. The area where the alleged incident occurred is not disturbed or accessed by anyone before law enforcement arrives. v. The resident's clothing is not changed to avoid disturbing or destroying evidence. vi. The resident is not bathed or, if female, douched, to avoid compromising potential evidence. vii. The resident is transported to the hospital or other destination as instructed by law enforcement.</p> <p>The DON and Regional Director of Operations were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 07/03/2024 at 5:32 PM, due to the above failures and the IJ template was provided. The Administrator / Abuse Coordinator was on personal leave and not able to be interviewed, at the time of investigation.</p> <p>The facility's Plan of Removal was accepted on 07/04/2024 at 11:52 AM and included:</p> <p>Identify responsible staff/ what action taken:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Director of Nursing submitted a self-report to HHSC on July 3, 2024, regarding the incident 2. [Local Law Enforcement Agency] were notified on July 3, 2024, by Regional Nurse Consultant and an officer responded. 3. Attending Physician of Resident #1 was notified of the incident on July 3, 2024, by Assistant Director of Nursing. 4. Social Worker conducted a trauma assessment with Resident #1 on July 4, 2024. 5. Attempts to contact family of Resident #1 on July 3, 2024, were unsuccessful due to non-working phone number. They visit frequently and will be notified upon first opportunity and contact will be updated. Family of Resident # 2 were notified July 3, 2024, by facility social worker. 6. Resident #2 was placed on 1:1 monitoring on July 3, 2024, to consist of line-of-sight monitoring by facility staff. 7. Licensed Nurse conducted a head-to-toe assessment to assess for possible injuries on July 3, 2024. 8. Resident #1 was sent out for a SANE test at local hospital. Resident was unable to consent and per hospital no test was performed, and she will be returned to the facility with no new orders. 9. Director of Nursing began obtaining witness statements from staff. 10. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with all interviewable residents. Head to toe assessments were completed with all non-interviewable residents by facility Treatment Nurses. All were completed July 3, 2024. 11. Resident #1 and Resident #2 were referred to [mental health services] on July 3, 2024, for psychological assessment and to be picked up on services if needed.</p> <p>In-Service conducted:</p> <p>Regional Nurse Consultant and Director of Nursing (after [NAME]-servicing below) in-serviced all facility staff on: 1. On 7/3/24 Director of Nursing and Administrator were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Director of Operations. 2. An all-staff in-service was initiated on 7/3/24. All staff members were educated to report all allegations of abuse immediately upon notification or observation to the Administrator who is the abuse coordinator. All staff will complete an Abuse & Neglect competency posttest at time of in-servicing. 3. The expected completion date will be 7/4/2024. Staff who have not been trained on Abuse & Neglect will not be allowed to work until they have completed required in-services.</p> <p>Implementation of Changes:</p> <p>Staff will immediately inform the Administrator who is the abuse coordinator immediately when being made aware of the any abuse allegation or observation. The administrator or director of nursing will ensure competency through verbalization of understanding by staff through successful completion of Abuse/Neglect Post test. In the absence of Administrator abuse allegations will be reported to the Director of Nursing. The Administrator, abuse coordinator will be responsible for implementation of the process and will review process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents. 10 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week. 2. Administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements. Findings will be documented on Abuse & Neglect monitoring form. 3. RDO and RNC will conduct ten random staff interviews per month. 4. RDO or RNC will review grievances weekly which are located in the facility grievance binder for three months. 5. Any adverse outcomes will be reported to QAPI Committee</p> <p>Involvement of Medical Director:</p> <p>The Medical Director was notified about the Immediate Jeopardy on 7/3/2024.</p> <p>Involvement of QA:</p> <p>On July 3, 2024, an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review plan of removal.</p> <p>Who is responsible for implementation of process?</p> <p>Administrator and Director of Nursing will be responsible for implementation of new process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 7/3/2024.</p> <p>On 07/04/2024 at 12:05 PM the surveyor began monitoring the facility's Plan of Removal.</p> <p>An observation on 07/04/2024 at 11:45 AM revealed Resident #1 in her wheelchair in the television room. No concerns were noted. She was watching television with another resident in a chair beside her.</p> <p>In an interview on 07/04/2024 at 12:05 PM, the Regional Director of Operations stated he re-educated the Administrator and DON on the facility's abuse, neglect, and exploitation policy which included: Their initial response to this incident and the need to investigate immediately - rather than wait or make assumption. He said there was a step-by-step process for investigating all incidents and a process to ensure residents' safety during the investigation. He said he also in-served them on reportable incidents and, if in doubt then it needs to be reported. He stated the Administrator and DON did not validate the information they received from staff or follow up with an investigation when they received the information. He said they began in-servicing staff in the abuse policy on 07/03/2024.</p> <p>In an interview on 07/04/2024 at 12:10 PM, the Regional Nurse Consultant stated, she worked with the DON to follow up with reports to law enforcement and in-servicing the staff on the facility's abuse, neglect, and exploitation policy. She stated the staff in-services included a post test, and information on reporting all abuse or suspicion of abuse. She stated she will assist the POR to ensure compliance. She said Resident #2 was placed on 1:1 supervision</p> <p>starting about noon on 07/03/2024.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/04/2024 at 12:18 PM, the DON stated he failed to validate the information he received from the incident. He stated he and the Administrator assumed that Resident #1 invited the Resident #2's advances and therefore stopped the investigation. He stated he wanted to ensure he got all the information and in [TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152</p> <p>Based on observation, interview, and record review, the facility failed to implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents, establish policies and procedures to investigate any such allegations for one (Resident #1) of eight residents reviewed for abuse.</p> <p>The facility failed to implement their abuse, neglect, and exploitation policy to ensure Resident #1 was safe from sexual abuse when Resident #2 was found in her bed on 06/30/2024. Resident #2 had not been on any supervision from the time the incident occurred through 07/03/2024.</p> <p>The facility failed to follow their policy and investigate the alleged or suspected sexual abuse of Resident #1 and provide notification and information to the proper authorities according to state and federal regulations.</p> <p>An IJ was identified on 07/03/2024. The IJ template was provided to the facility on [DATE] at 5:32 PM. While the IJ was removed on 07/04/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.</p> <p>These failures could place all residents at risk for abuse and psychosocial harm.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet dated 07/03/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: unspecified sequelae cerebral infarction (stroke), cognitive communication deficit (trouble participating in conversation), aphasia (loss of ability to understand or express speech, caused by brain damage), dysarthria and anarthria (motor speech disorder), bipolar disorder (mental disorder causing unusual shift in mood, energy, and concentration), and major depressive disorder, recurrent, severe with psychotic symptoms (depression along with loss of touch with reality).</p> <p>Record review of Resident #1's quarterly MDS Assessment, dated 06/25/2024, reflected no BIMS score, indicating it was not able to be completed. She had short- and long-term memory problems, cognitive and daily decision-making skills reflected moderately impaired - decisions poor, cues/supervision required. Signs and symptoms of delirium reflected and altered level of consciousness. Resident #1 exhibited no behaviors and used a wheelchair to ambulate. She was totally dependent for toileting, showering, dressing, transfers, and personal hygiene.</p> <p>Record review of Resident #1's BIMS assessment dated [DATE] and signed by the Social Worker reflected, severely impaired cognition.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Care Plan dated 11/28/2023 - Present, reflected, Problem: [Resident #1] The resident has impaired cognitive function or impaired thought processes. Goal: will be able to communicate basic needs on a daily basis through the review date. Problem: The resident has a communication problem r/t aphasia. Intervention: Anticipate and meet needs. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Problem: [Resident #1] has an ADL Self Care Performance Deficit. Intervention: requires 1 staff participation to use toilet and all ADLs.</p> <p>Record review of Resident #2's Face Sheet dated 07/03/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses included: encephalopathy (group of conditions that cause brain disfunction), major depressive disorder (mental health condition that causes persistent depressive mood), intermittent explosive disorder (repeat sudden bouts of impulsive, aggressive outbursts), type 2 diabetes (problem in the way the body regulates and used sugar as fuel), hypertension (pressure in blood vessels is too high), and schizoaffective disorder (combination schizophrenia and mood disorder displayed by manic moods and hallucinations).</p> <p>Record review of Resident #2's quarterly MDS Assessment, dated 05/30/2024, reflected a BIMS score of 15, which indicated no cognitive impairment. No behaviors were exhibited. He was independent for all functional abilities and ADLs.</p> <p>Record review of Resident #2's Care Plan dated 06/14/2024 - Present, reflected, no prior sexually inappropriate behavior. The care plan was updated on 07/03/2024 and reflected, Problem: Behavior: Sexually inappropriate AEB: noted to have sexual urges at the facility. Date Initiated: 07/03/2024. Interventions: [Resident #2] to remain on one-on-one watch until further notice, Date Initiated: 07/04/2024. Report incidents of target behavior to charge nurse, Date Initiated: 07/03/2024. Staff to be in-serviced on behavioral approaches designed to effectively manage unacceptable sexual advances (avoid self-disclosing personal information), Date Initiated: 07/04/2024.</p> <p>Record review of the facility incident report, dated 07/03/2024 at 10:51 AM and signed by the DON, reflected, It was reported to this writer that [Resident #2] allegedly put his penis in [Resident #1's mouth. When asked if anyone touched [Resident #1] she indicated No. When asked if anyone placed their penis in her mouth she indicated No. Head to toe assessment completed with no visible injuries noted. Resident sent out to the ER for SANE evaluation. MD notified. Local law enforcement notified. Attempted no notify family but number is not working.</p> <p>Record review of the facility's transfer record dated 07/03/2024 at 2:30 PM and signed by ADON A, reflected Resident #1 was transferred to hospital.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Facility's Investigation Report, dated 07/03/2024, reflected, on 07/03/2024, a [State Surveyor] entered the facility on a complaint investigation and brought to [DON's] attention a situation of potential sexual abuse. The [State Surveyor] informed the [DON] that [Resident #2] told him that he had intention to get a blow job from [Resident #1]. [Resident #2] realized that it was wrong and decided not to act on that. [Resident #2] has been placed 1:1 and family and local law enforcement has been notified. Also included were 6 safe surveys, dated 07/01/2024 and signed by the Social Worker. The DON's interview on 6/30/24 with LVN D, reflected, [CNA G] reported to me that during her last rounds she found [Resident #2] in the bed of [Resident #1]. I quickly went to [Resident #1's] room and assessed her. No visible or emotional distress noted. I noted that she was fully clothed. I asked her if she wanted him in her room and she stated yes. [Resident #1] said that he was her friend and that she wanted him there. The DON's interview on 07/01/2024 with CNA G, reflected, During my last rounds on Sunday, [06/30/2024], I entered [Resident #1's room] and noticed [Resident #2] in [Resident #1's] bed with [Resident #1]. [Resident #1] was laying on her side facing the wall. [Resident #2] was laying behind her on his side as well. When asked if both residents were fully clothed, [CNA G] indicated that [Resident #1] had pants and shirt on and brief intact and that [Resident #2] had his pants and shirt on. [Resident #2] quickly got up and left the room.</p> <p>Record review of Resident #1's Hospital Record, dated 07/03/2024 at 3:39 PM, reflected, Chief Complaint: Sexual assault exam referral. Per EMS NH sent pt for SANE exam after finding another resident in her bed on Sunday, NH reported incident to state and state requested an exam. Pt is aphasic d/t CVA. Unable to contact family and patient was unable to consent due to her aphasia and dementia. Discussed case with sexual assault nurse examiner and she said that we would need a court order to pursue further investigation. For now, we are going to send the patient back to the nursing home with close monitoring. Patient was unable to consent for examination, so the patient was returned to the nursing home with instructions to contact the police department in family for further plan of action. 4:42 PM -initial contact made with patient. Patient is aphasic and unable to communicate and to consent to exam. Patient does responds uh huh or no when questioned but answers are inconsistent.</p> <p>Record review of Resident #1's nurse notes dated 07/03/2024 at 1:10 PM and signed by Corporate, reflected, Attempted to call family, number is not working. Resident seen by [Mental Health Services] today.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Psychological Services Progress Note, dated 07/03/2024, reflected, Intervention: Discussed a recent incident in which the pt was discovered in a female resident's room with his pants removed. Utilized open-ended questioning to investigate patient's version of events and potential precipitating factors. Identified inappropriate sexual behavior and processed patient's feelings of guilt and shame. Provided psychoeducation in the importance of maintaining boundaries to protect his own safety and the safety of others. Response to Intervention: Saw pt in a private area to discuss a recent incidence of sexual misconduct. Pt presented as anxious with a blunted affect. He was fully cooperative and expressed remorse regarding his behavior. Pt admitted to entering the female resident's room and removing his pants. He vehemently asserted that there was no sexual conduct during the encounter. Pt claimed that he was walking by the room when he heard a voice call his name. Pt indicated that he was aware that the female resident in question was nonverbal and hypothesized that the voice was a hallucination. In response to the voice, he entered the female resident's room. Pt alleged that the female resident made sexual advances after he entered the room (touched his leg, moved her head toward his groin area). He stated that he removed his pants because the female resident indicated her intention to provide oral sex. Pt then stated that he changed his mind prior to sexual contact and was attempting to pull up his pants when a staff member discovered him. Pt responded positively to therapeutic interventions and admitted that his behavior was inappropriate. He said that he felt guilty about the entire incident and said that he intended no harm. Pt was also receptive to psychoeducation on maintaining boundaries and stated that he would not enter a female's room again. Pt demonstrated understanding of the importance of boundaries in maintaining his safety and the safety of others.</p> <p>In an interview on 07/03/2024 at 9:17 AM, Resident #1, was not able to answer questions with words. She did not make any gestures of verbal comments that reflected her understanding of questions asked of her regarding the incident.</p> <p>In an interview on 07/03/2024 at 9:49 AM, the DON stated Resident #2 had no previous history of any sexual behaviors. He said when LVN D called him on 06/30/2024 at about 9:30 AM to inform him that Resident #2 had been found in bed with Resident #1, he wanted to find out whether Resident #1 invited Resident #2 into her bed. He stated Residents #1 and #2 were friends and often watched television together in the television room. The DON stated LVN D did not complete an incident report and he did not immediately start an investigation about regarding the incident. The DON stated Resident #1 had a BIMS of 0 but that was related to her inability to speak clearly. He said Resident #1 was able to understand and could give consent to a sexual act. He said when LVN D called him, he got on the phone with LVN D and Resident #1, and Resident #1 was able to say some words and responded yes / friend when asked if she wanted Resident #2 in her room. He said he did not ask if Resident #1 wanted Resident #1 in her bed with her but did not feel the need to immediately investigate the incident further. He stated on 07/01/2024, he asked the Social Worker and ADON A to speak to Resident #1. He said they completed a verbal BIMS Assessment on Resident #1, which resulted in no score, which indicated severely cognitively impaired. He said Resident #2 had a BIMS of 15 which indicated no cognitive impairment. He stated he and the Administrator talked to Resident #2 and he denied any type of sexual inappropriate behavior. The DON said he did not refer Resident #1 to the hospital for a SANE exam and did not contact the police.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 10:50 AM, Resident #2 stated, on 06/30/2024 at about 9:30 AM, he was walking past Resident #1's room and she was in bed and waved him into her room. He said she waved at everyone in that way, but he felt she wanted him to come in. He said he knew Resident #1 because they occasionally watched television together in the day room. He said he did go into Resident #1's room because he was looking for a blow job, [oral sex]. He said he took his pants off and got into bed with Resident #1. He said when he was in bed with her, he started to feel bad and was about to get out of the bed when CNA G entered the room and saw him in bed with Resident #1. He said CNA G did not say anything and left the room and closed the door. He said he got up and put his pants on and heard CNA G call for LVN D. Resident #2 said he left the room and returned to his room. He denied he had done this with any other residents in the facility. Resident #2 said he did not place his penis in Resident #1's mouth and denied any penetration of any kind. He stated the Administrator talked to him about the incident on 07/01/2024 and told him if this type of behavior happened again he would call the police.</p> <p>In an interview on 07/03/2024 at 11:16 AM, CNA F said she heard from LVN D the Resident #2 was found in Resident #1's room, with his penis in Resident #1's mouth on 06/30/2024. She stated that in a similar incident involving different residents, a few years ago, the facility managers immediately sent the offending resident out of the facility and called police. CNA F stated she felt that should have occurred this time but had not. She said the Administrator and DON should have placed Resident #2 on some kind of supervision while they investigated the incident to ensure the safety of all residents in the facility. She said if what she heard was true, Resident #2 had access to Resident #1 and all other residents until today when he was placed on 1:1 supervision. She said she has worked at the facility for [AGE] years and was familiar with the facility's abuse policy because she received training on the policy almost weekly. She stated she did not report the incident to the Abuse Coordinator and was not sure if LVN D reported it. She stated she assumed it was reported.</p> <p>In an interview on 07/03/2024 at 12:00 PM, the DON stated the alleged incident between Resident #1 and Resident #2 was not discussed in the manager's stand-up meeting. He said not every manager needed to know about every incident that occurred. He said after the stand-up meeting on 07/01/2024, the Social Worker and ADON A interviewed Resident #1 and reported to him that Resident #1 answered no when they asked if Resident #2 did anything to her. The DON stated, [Resident #2] did not tell him any intentions to get oral sex from Resident #1. He stated at the time, he did not feel there was any sexual abuse so there was no need to report to police or the state. He stated he did not investigate further because he felt there was no evidence the incident was of a sexual nature and therefore did not move Resident #2. He said, Looking back, we did not get the full truth from [Resident #2] and [Resident #1's] BIMS does limit her ability to consent. He said, We should have called police to follow up with a SANE exam and placed Resident #2 on 1:1 supervision to ensure all residents' safety. He stated Resident #1 was sent to hospital, police have been called, Resident #2 was placed on 1:1 supervision, and the incident was reported to state today.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 12:10 PM, the Regional Director of Operations (RDO) stated the incident between Residents #1 and #2 should have been thoroughly investigated. He said Resident #2 should have been put on 1:1 supervision to ensure the safety of all residents, Resident #1 should have been sent to the hospital for examination, law enforcement should have been called, the incident should have been reported to the state agency, and a facility investigation started. He said based on Resident #1's BIMS, it was not clear she could have consented to anything, and the facility's policy was in place to ensure the safety of all residents during an investigation of any allegation of abuse. He stated, We should have confirmed what we observed was what happened through investigation in order to ensure the safety of [Resident #1].</p> <p>An observation and interview on 07/03/2024 at 12:40 PM revealed Resident #2 in his room sleeping on his bed. CNA I was observed outside the room. CNA I stated she was directed to supervise Resident #2 and document wherever he when in the facility.</p> <p>In a telephone interview on 07/03/2024 at 12:54 PM, LVN D stated she was at the nurses' station on 06/30/2024 at about 9:30 AM, when CNA G called her to Resident #1's room. She stated when she went down the hall she saw Resident #2 leaving Resident #1's room. CNA G told her she opened Resident #1's room door and saw Resident #2 in bed with Resident #1. She stated Resident #1 was facing the wall and Resident #2 was in the bed behind her also facing the wall. LVN D stated CNA G did not say she witnessed Resident #2's penis in Resident #1's mouth. She said CNA G told her Resident #2 told her he was talking to his friend. She said she observed Resident #2 with clothes on when he left Resident #1's room but did not observe Resident #2 in the bed. LVN D said she observed Resident #1 in bed with her clothes on. LVN D said she asked Resident #1 what happened, and Resident #1 only nodded no. She stated Resident #1 was not crying and did not appear in distress. She said Resident #1's brief was on and did not appear to be tampered with. LVN D said she felt like Resident #1 could give consent but could not verbalize the consent. LVN D said she could not be sure if she consented to any sexual act of to have Resident #2 in her bed. LVN D said she called the DON when the incident occurred and was instructed to do an emotional assessment. She stated she talked to Resident #1 and she seemed to have her normal demeanor. She did not appear to be afraid and did not behave differently from how she normally did. She said she did not document any assessment of Resident #1 and did not complete an incident report, she said she did not know why she did not document the incident. She said Resident #2 was not on 1:1 watch at the time of the incident on 06/30/2024 but looking back believed he should have been to ensure the safety of all residents while the incident was investigated. She said Resident #1 should have been sent out for a SANE exam rather than assuming nothing happened.</p> <p>In an interview on 07/03/2024 at 1:17 PM, ADON A stated she became aware of the incident between Residents #1 and #2 on 07/01/2024 when the DON asked her and the Social Worker to talk to Resident #1 about the Resident #2 being in her bed. She said they tried to assess Resident #1's ability to consent and her cognitive ability. ADON A stated Resident #1's competency level was very low, and she would not answer any of the BIMS questions. ADON A said she did not feel that Resident #1 had the capacity to invite Resident #2 into her bed. She said she told the DON Resident #1 did not seem like she was able to consent to anything. ADON A said she did not know where the incident investigation went from there but Resident #2 was not on any kind of supervision until 07/03/2024 when the State Surveyor started asking questions about the Incident. She said Resident #1 was sent to the hospital for a SANE exam and the police were called earlier today as well.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 1:31 PM, the Social Worker stated Resident #1 was not able to point to correct answers for any of the BIMS Assessment questions. She said Resident #1 was severely cognitively impaired and did not believe she had any capacity to concert to Resident #2's alleged actions. She said she shared this information with the DON and did not hear anything else about the incident. She stated Resident #1 should have been sent to the hospital for SANE exam and police notified. She said Resident #2 should have been placed on 1:1 to ensure all residents' safety.</p> <p>In an interview on 07/03/2024 at 1:49 PM, LVN C stated CNA F told her that LVN D told her that Resident #2 was found with his penis in Resident #1's mouth. She said she did not ask CNA F if the incident was reported to the Administrator and said she did not report it either. She stated she assumed the issue had been addressed and reported to the Abuse Coordinator. LVN C said she had worked in the facility about a year and was regularly in-serviced on abuse policy. She said she did not recall when the last in-service was.</p> <p>In a telephone interview on 07/03/2024 at 4:42 PM, CNA G stated on 06/30/2024 at about 9:15 AM, she opened Resident #1's door and saw her in the bed facing the wall. CNA G stated she saw Resident #2 in bed with Resident #1, behind her and also facing the wall. She stated she did not see if Resident #1 had clothes on but did see Resident #2's bare butt sticking out of the covers. She stated she did not know if Resident #2 had his pants all the way off or just around his ankles. CNA G said she left the room and called for LVN D. She stated LVN D came down the hall within a few seconds and Resident #2 opened Resident #1's room door and went across the hall to his room. She said LVN D called the DON and they talked to Resident #1 over the phone. She said she did not report the incident because LVN D had called the DON and she assumed they were addressing the issue. She said she had never seen Resident #2 display any type of sexual inappropriate behavior in the past. She stated LVN D did not send Resident #1 to the hospital and Resident #2 was not placed on 1:1 supervision. She said when she returned to work on 07/01/2024, staff told her that LVN D said Resident #2 was found with his penis in Resident #1's mouth. CNA G said she did not see Resident #2's penis in Resident #1's mouth when she entered the room on 06/30/2024.</p> <p>In an interview on 07/03/2024 at 4:50 PM, Law Enforcement Officer #4664 stated she was called today to respond to allegations of sexual assault. She said since the incident occurred on 06/30/2024, the facility should have called then and sent Resident #1 to the hospital for a SANE exam. She said the facility told her they sent Resident #1 to the hospital today.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Abuse prevention and prohibition program, revised 08/2020, reflected, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements . IV. Prevention: A. Staff, residents and families will be able to report concerns, incidents, and grievances without fear of retribution or retaliation. B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring . VI. Investigation: A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts . C. The Facility ensures protection of residents during abuse investigations . I. While the investigation is underway, accused individuals who are not Facility Staff may not have any unsupervised access to residents . IX. Reporting/Response: A. Facility Staff are Mandatory Reporters . C. Reporting Requirements: i. The Facility will report known or suspected instances of physical abuse, including sexual abuse, and criminal acts to the proper authorities by telephone or through a confidential Internet reporting tool as required by state and federal regulations. X. Special Considerations for Reporting Suspected Incidents of Rape: A. Anyone who suspects that a rape has been committed against a resident must immediately report this information Administrator and to the Director of Nursing Services. B. The Director of Nursing Services or designee will immediately report this information to the Attending Physician. C. The Administrator then acts to ensure the following steps are taken: i. The proper authorities and individuals are notified immediately or within 24 hours, including but not limited to law enforcement, the Attending Physician, the resident's representative, the state survey and certification agency, and any others necessary. ii. A Licensed Nurse assesses the resident (alleged victim) for possible injuries. iii. The resident is provided with the medical treatment and emotional support necessary to prevent further deterioration of his/her health and wellbeing. iv. The area where the alleged incident occurred is not disturbed or accessed by anyone before law enforcement arrives. v. The resident's clothing is not changed to avoid disturbing or destroying evidence. vi. The resident is not bathed or, if female, douched, to avoid compromising potential evidence. vii. The resident is transported to the hospital or other destination as instructed by law enforcement.</p> <p>The DON and Regional Director of Operations were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 07/03/2024 at 5:32 PM, due to the above failures and the IJ template was provided. The Administrator / Abuse Coordinator was on personal leave and not able to be interviewed, at the time of investigation.</p> <p>The facility's Plan of Removal was accepted on 07/04/2024 at 11:52 AM and included:</p> <p>Identify responsible staff/ what action taken:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Director of Nursing submitted a self-report to HHSC on July 3, 2024, regarding the incident 2. [Local Law Enforcement Agency] were notified on July 3, 2024, by Regional Nurse Consultant and an officer responded. 3. Attending Physician of Resident #1 was notified of the incident on July 3, 2024, by Assistant Director of Nursing. 4. Social Worker conducted a trauma assessment with Resident #1 on July 4, 2024. 5. Attempts to contact family of Resident #1 on July 3, 2024, were unsuccessful due to non-working phone number. They visit frequently and will be notified upon first opportunity and contact will be updated. Family of Resident # 2 were notified July 3, 2024, by facility social worker. 6. Resident #2 was placed on 1:1 monitoring on July 3, 2024, to consist of line-of-sight monitoring by facility staff. 7. Licensed Nurse conducted a head-to-toe assessment to assess for possible injuries on July 3, 2024. 8. Resident #1 was sent out for a SANE test at local hospital. Resident was unable to consent and per hospital no test was performed, and she will be returned to the facility with no new orders. 9. Director of Nursing began obtaining witness statements from staff. 10. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with all interviewable residents. Head to toe assessments were completed with all non-interviewable residents by facility Treatment Nurses. All were completed July 3, 2024. 11. Resident #1 and Resident #2 were referred to [mental health services] on July 3, 2024, for psychological assessment and to be picked up on services if needed.</p> <p>In-Service conducted:</p> <p>Regional Nurse Consultant and Director of Nursing (after [NAME]-servicing below) in-serviced all facility staff on: 1. On 7/3/24 Director of Nursing and Administrator were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Director of Operations. 2. An all-staff in-service was initiated on 7/3/24. All staff members were educated to report all allegations of abuse immediately upon notification or observation to the Administrator who is the abuse coordinator. All staff will complete an Abuse & Neglect competency posttest at time of in-servicing. 3. The expected completion date will be 7/4/2024. Staff who have not been trained on Abuse & Neglect will not be allowed to work until they have completed required in-services.</p> <p>Implementation of Changes:</p> <p>Staff will immediately inform the Administrator who is the abuse coordinator immediately when being made aware of the any abuse allegation or observation. The administrator or director of nursing will ensure competency through verbalization of understanding by staff through successful completion of Abuse/Neglect Post test. In the absence of Administrator abuse allegations will be reported to the Director of Nursing. The Administrator, abuse coordinator will be responsible for implementation of the process and will review process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents. 10 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week. 2. Administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements. Findings will be documented on Abuse & Neglect monitoring form. 3. RDO and RNC will conduct ten random staff interviews per month. 4. RDO or RNC will review grievances weekly which are located in the facility grievance binder for three months. 5. Any adverse outcomes will be reported to QAPI Committee</p> <p>Involvement of Medical Director:</p> <p>The Medical Director was notified about the Immediate Jeopardy on 7/3/2024.</p> <p>Involvement of QA:</p> <p>On July 3, 2024, an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review plan of removal.</p> <p>Who is responsible for implementation of process?</p> <p>Administrator and Director of Nursing will be responsible for implementation of new process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 7/3/2024.</p> <p>On 07/04/2024 at 12:05 PM the surveyor began monitoring the facility's Plan of Removal.</p> <p>An observation on 07/04/2024 at 11:45 AM revealed Resident #1 in her wheelchair in the television room. No concerns were noted. She was watching television with another resident in a chair beside her.</p> <p>In an interview on 07/04/2024 at 12:05 PM, the Regional Director of Operations stated he re-educated the Administrator and DON on the facility's abuse, neglect, and exploitation policy which included: Their initial response to this incident and the need to investigate immediately - rather than wait or make assumption. He said there was a step-by-step process for investigating all incidents and a process to ensure residents' safety during the investigation. He said he also in-served them on reportable incidents and, if in doubt then it needs to be reported. He stated the Administrator and DON did not validate the information they received from staff or follow up with an investigation when they received the information. He said they began in-servicing staff in the abuse policy on 07/03/2024.</p> <p>In an interview on 07/04/2024 at 12:10 PM, the Regional Nurse Consultant stated, she worked with the DON to follow up with reports to law enforcement and in-servicing the staff on the facility's abuse, neglect, and exploitation policy. She stated the staff in-services included a post test, and information on reporting all abuse or suspicion of abuse. She stated she will assist the POR to ensure compliance. She said Resident #2 was placed on 1:1 supervision</p> <p>starting about noon on 07/03/2024.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/04/2024 at 12:18 PM, the DON stated he failed to validate the information he received from the incident. He st [TRUNCATED]</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152</p> <p>Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress for one (Resident #1) of eight residents reviewed for abuse.</p> <p>The facility failed to implement their abuse, neglect, and exploitation policy and investigate an alleged or suspected sexual assault when Resident #2 was found in Resident #1's bed on 06/30/2024. The facility did not provide notification and information to the proper authorities according to state and federal regulations.</p> <p>An IJ was identified on 07/03/2024. The IJ template was provided to the facility on [DATE] at 5:32 PM. While the IJ was removed on 07/04/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.</p> <p>These failures could place all residents at risk for abuse and psychosocial harm.</p> <p>Findings include:</p> <p>Record review of Resident #1's Face Sheet dated 07/03/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: unspecified sequelae cerebral infarction (stroke), cognitive communication deficit (trouble participating in conversation), aphasia (loss of ability to understand or express speech, caused by brain damage), dysarthria and anarthria (motor speech disorder), bipolar disorder (mental disorder causing unusual shift in mood, energy, and concentration), and major depressive disorder, recurrent, severe with psychotic symptoms (depression along with loss of touch with reality).</p> <p>Record review of Resident #1's quarterly MDS Assessment, dated 06/25/2024, reflected no BIMS score, indicating it was not able to be completed. She had short- and long-term memory problems, cognitive and daily decision-making skills reflected moderately impaired - decisions poor, cues/supervision required. Signs and symptoms of delirium reflected and altered level of consciousness. Resident #1 exhibited no behaviors and used a wheelchair to ambulate. She was totally dependent for toileting, showering, dressing, transfers, and personal hygiene.</p> <p>Record review of Resident #1's BIMS assessment dated [DATE] and signed by the Social Worker reflected, severely impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Care Plan dated 11/28/2023 - Present, reflected, Problem: [Resident #1] The resident has impaired cognitive function or impaired thought processes. Goal: will be able to communicate basic needs on a daily basis through the review date. Problem: The resident has a communication problem r/t aphasia. Intervention: Anticipate and meet needs. Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Problem: [Resident #1] has an ADL Self Care Performance Deficit. Intervention: requires 1 staff participation to use toilet and all ADLs.</p> <p>Record review of Resident #2's Face Sheet dated 07/03/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses included: encephalopathy (group of conditions that cause brain disfunction), major depressive disorder (mental health condition that causes persistent depressive mood), intermittent explosive disorder (repeat sudden bouts of impulsive, aggressive outbursts), type 2 diabetes (problem in the way the body regulates and used sugar as fuel), hypertension (pressure in blood vessels is too high), and schizoaffactive disorder (combination schizophrenia and mood disorder displayed by manic moods and hallucinations).</p> <p>Record review of Resident #2's quarterly MDS Assessment, dated 05/30/2024, reflected a BIMS score of 15, which indicated no cognitive impairment. No behaviors were exhibited. He was independent for all functional abilities and ADLs.</p> <p>Record review of Resident #2's Care Plan dated 06/14/2024 - Present, reflected, no prior sexually inappropriate behavior. The care plan was updated on 07/03/2024 and reflected, Problem: Behavior: Sexually inappropriate AEB: noted to have sexual urges at the facility. Date Initiated: 07/03/2024. Interventions: [Resident #2] to remain on one-on-one watch until further notice, Date Initiated: 07/04/2024. Report incidents of target behavior to charge nurse, Date Initiated: 07/03/2024. Staff to be in-serviced on behavioral approaches designed to effectively manage unacceptable sexual advances (avoid self-disclosing personal information), Date Initiated: 07/04/2024.</p> <p>Record review of the facility incident report, dated 07/03/2024 at 10:51 AM and signed by the DON, reflected, It was reported to this writer that [Resident #2] allegedly put his penis in [Resident #1's mouth. When asked if anyone touched [Resident #1] she indicated No. When asked if anyone placed their penis in her mouth she indicated No. Head to toe assessment completed with no visible injuries noted. Resident sent out to the ER for SANE evaluation. MD notified. Local law enforcement notified. Attempted no notify family but number is not working.</p> <p>Record review of the facility's transfer record dated 07/03/2024 at 2:30 PM and signed by ADON A, reflected Resident #1 was transferred to hospital.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Facility's Investigation Report, dated 07/03/2024, reflected, on 07/03/2024, a [State Surveyor] entered the facility on a complaint investigation and brought to [DON's] attention a situation of potential sexual abuse. The [State Surveyor] informed the [DON] that [Resident #2] told him that he had intention to get a blow job from [Resident #1]. [Resident #2] realized that it was wrong and decided not to act on that. [Resident #2] has been placed 1:1 and family and local law enforcement has been notified. Also included were 6 safe surveys, dated 07/01/2024 and signed by the Social Worker. The DON's interview on 6/30/24 with LVN D, reflected, [CNA G] reported to me that during her last rounds she found [Resident #2] in the bed of [Resident #1]. I quickly went to [Resident #1's] room and assessed her. No visible or emotional distress noted. I noted that she was fully clothed. I asked her if she wanted him in her room and she stated yes. [Resident #1] said that he was her friend and that she wanted him there. The DON's interview on 07/01/2024 with CNA G, reflected, During my last rounds on Sunday, [06/30/2024], I entered [Resident #1's room] and noticed [Resident #2] in [Resident #1's] bed with [Resident #1]. [Resident #1] was laying on her side facing the wall. [Resident #2] was laying behind her on his side as well. When asked if both residents were fully clothed, [CNA G] indicated that [Resident #1] had pants and shirt on and brief intact and that [Resident #2] had his pants and shirt on. [Resident #2] quickly got up and left the room.</p> <p>Record review of Resident #1's Hospital Record, dated 07/03/2024 at 3:39 PM, reflected, Chief Complaint: Sexual assault exam referral. Per EMS NH sent pt for SANE exam after finding another resident in her bed on Sunday, NH reported incident to state and state requested an exam. Pt is aphasic d/t CVA. Unable to contact family and patient was unable to consent due to her aphasia and dementia. Discussed case with sexual assault nurse examiner and she said that we would need a court order to pursue further investigation. For now, we are going to send the patient back to the nursing home with close monitoring. Patient was unable to consent for examination, so the patient was returned to the nursing home with instructions to contact the police department in family for further plan of action. 4:42 PM -initial contact made with patient. Patient is aphasic and unable to communicate and to consent to exam. Patient does responds uh huh or no when questioned but answers are inconsistent.</p> <p>Record review of Resident #1's nurse notes dated 07/03/2024 at 1:10 PM and signed by Corporate, reflected, Attempted to call family, number is not working. Resident seen by [Mental Health Services] today.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Psychological Services Progress Note, dated 07/03/2024, reflected, Intervention: Discussed a recent incident in which the pt was discovered in a female resident's room with his pants removed. Utilized open-ended questioning to investigate patient's version of events and potential precipitating factors. Identified inappropriate sexual behavior and processed patient's feelings of guilt and shame. Provided psychoeducation in the importance of maintaining boundaries to protect his own safety and the safety of others. Response to Intervention: Saw pt in a private area to discuss a recent incidence of sexual misconduct. Pt presented as anxious with a blunted affect. He was fully cooperative and expressed remorse regarding his behavior. Pt admitted to entering the female resident's room and removing his pants. He vehemently asserted that there was no sexual conduct during the encounter. Pt claimed that he was walking by the room when he heard a voice call his name. Pt indicated that he was aware that the female resident in question was nonverbal and hypothesized that the voice was a hallucination. In response to the voice, he entered the female resident's room. Pt alleged that the female resident made sexual advances after he entered the room (touched his leg, moved her head toward his groin area). He stated that he removed his pants because the female resident indicated her intention to provide oral sex. Pt then stated that he changed his mind prior to sexual contact and was attempting to pull up his pants when a staff member discovered him. Pt responded positively to therapeutic interventions and admitted that his behavior was inappropriate. He said that he felt guilty about the entire incident and said that he intended no harm. Pt was also receptive to psychoeducation on maintaining boundaries and stated that he would not enter a female's room again. Pt demonstrated understanding of the importance of boundaries in maintaining his safety and the safety of others.</p> <p>In an interview on 07/03/2024 at 9:17 AM, Resident #1, was not able to answer questions with words. She did not make any gestures of verbal comments that reflected her understanding of questions asked of her regarding the incident.</p> <p>In an interview on 07/03/2024 at 9:49 AM, the DON stated Resident #2 had no previous history of any sexual behaviors. He said when LVN D called him on 06/30/2024 at about 9:30 AM to inform him that Resident #2 had been found in bed with Resident #1, he wanted to find out whether Resident #1 invited Resident #2 into her bed. He stated Residents #1 and #2 were friends and often watched television together in the television room. The DON stated LVN D did not complete an incident report and he did not immediately start an investigation about regarding the incident. The DON stated Resident #1 had a BIMS of 0 but that was related to her inability to speak clearly. He said Resident #1 was able to understand and could give consent to a sexual act. He said when LVN D called him, he got on the phone with LVN D and Resident #1, and Resident #1 was able to say some words and responded yes / friend when asked if she wanted Resident #2 in her room. He said he did not ask if Resident #1 wanted Resident #1 in her bed with her but did not feel the need to immediately investigate the incident further. He stated on 07/01/2024, he asked the Social Worker and ADON A to speak to Resident #1. He said they completed a verbal BIMS Assessment on Resident #1, which resulted in no score, which indicated severely cognitively impaired. He said Resident #2 had a BIMS of 15 which indicated no cognitive impairment. He stated he and the Administrator talked to Resident #2 and he denied any type of sexual inappropriate behavior. The DON said he did not refer Resident #1 to the hospital for a SANE exam and did not contact the police.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER FT Worth Southwest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Alta Mesa Blvd Fort Worth, TX 76133	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 10:50 AM, Resident #2 stated, on 06/30/2024 at about 9:30 AM, he was walking past Resident #1's room and she was in bed and waved him into her room. He said she waved at everyone in that way, but he felt she wanted him to come in. He said he knew Resident #1 because they occasionally watched television together in the day room. He said he did go into Resident #1's room because he was looking for a blow job, [oral sex]. He said he took his pants off and got into bed with Resident #1. He said when he was in bed with her, he started to feel bad and was about to get out of the bed when CNA G entered the room and saw him in bed with Resident #1. He said CNA G did not say anything and left the room and closed the door. He said he got up and put his pants on and heard CNA G call for LVN D. Resident #2 said he left the room and returned to his room. He denied he had done this with any other residents in the facility. Resident #2 said he did not place his penis in Resident #1's mouth and denied any penetration of any kind. He stated the Administrator talked to him about the incident on 07/01/2024 and told him if this type of behavior happened again he would call the police.</p> <p>In an interview on 07/03/2024 at 11:16 AM, CNA F said she heard from LVN D the Resident #2 was found in Resident #1's room, with his penis in Resident #1's mouth on 06/30/2024. She stated that in a similar incident involving different residents, a few years ago, the facility managers immediately sent the offending resident out of the facility and called police. CNA F stated she felt that should have occurred this time but had not. She said the Administrator and DON should have placed Resident #2 on some kind of supervision while they investigated the incident to ensure the safety of all residents in the facility. She said if what she heard was true, Resident #2 had access to Resident #1 and all other residents until today when he was placed on 1:1 supervision. She said she has worked at the facility for [AGE] years and was familiar with the facility's abuse policy because she received training on the policy almost weekly. She stated she did not report the incident to the Abuse Coordinator and was not sure if LVN D reported it. She stated she assumed it was reported.</p> <p>In an interview on 07/03/2024 at 12:00 PM, the DON stated the alleged incident between Resident #1 and Resident #2 was not discussed in the manager's stand-up meeting. He said not every manager needed to know about every incident that occurred. He said after the stand-up meeting on 07/01/2024, the Social Worker and ADON A interviewed Resident #1 and reported to him that Resident #1 answered no when they asked if Resident #2 did anything to her. The DON stated, [Resident #2] did not tell him any intentions to get oral sex from Resident #1. He stated at the time, he did not feel there was any sexual abuse so there was no need to report to police or the state. He stated he did not investigate further because he felt there was no evidence the incident was of a sexual nature and therefore did not move Resident #2. He said, Looking back, we did not get the full truth from [Resident #2] and [Resident #1's] BIMS does limit her ability to consent. He said, We should have called police to follow up with a SANE exam and placed Resident #2 on 1:1 supervision to ensure all residents' safety. He stated Resident #1 was sent to hospital, police have been called, Resident #2 was placed on 1:1 supervision, and the incident was reported to state today.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 12:10 PM, the Regional Director of Operations (RDO) stated the incident between Residents #1 and #2 should have been thoroughly investigated. He said Resident #2 should have been put on 1:1 supervision to ensure the safety of all residents, Resident #1 should have been sent to the hospital for examination, law enforcement should have been called, the incident should have been reported to the state agency, and a facility investigation started. He said based on Resident #1's BIMS, it was not clear she could have consented to anything, and the facility's policy was in place to ensure the safety of all residents during an investigation of any allegation of abuse. He stated, We should have confirmed what we observed was what happened through investigation in order to ensure the safety of [Resident #1].</p> <p>An observation and interview on 07/03/2024 at 12:40 PM revealed Resident #2 in his room sleeping on his bed. CNA I was observed outside the room. CNA I stated she was directed to supervise Resident #2 and document wherever he when in the facility.</p> <p>In a telephone interview on 07/03/2024 at 12:54 PM, LVN D stated she was at the nurses' station on 06/30/2024 at about 9:30 AM, when CNA G called her to Resident #1's room. She stated when she went down the hall she saw Resident #2 leaving Resident #1's room. CNA G told her she opened Resident #1's room door and saw Resident #2 in bed with Resident #1. She stated Resident #1 was facing the wall and Resident #2 was in the bed behind her also facing the wall. LVN D stated CNA G did not say she witnessed Resident #2's penis in Resident #1's mouth. She said CNA G told her Resident #2 told her he was talking to his friend. She said she observed Resident #2 with clothes on when he left Resident #1's room but did not observe Resident #2 in the bed. LVN D said she observed Resident #1 in bed with her clothes on. LVN D said she asked Resident #1 what happened, and Resident #1 only nodded no. She stated Resident #1 was not crying and did not appear in distress. She said Resident #1's brief was on and did not appear to be tampered with. LVN D said she felt like Resident #1 could give consent but could not verbalize the consent. LVN D said she could not be sure if she consented to any sexual act of to have Resident #2 in her bed. LVN D said she called the DON when the incident occurred and was instructed to do an emotional assessment. She stated she talked to Resident #1 and she seemed to have her normal demeanor. She did not appear to be afraid and did not behave differently from how she normally did. She said she did not document any assessment of Resident #1 and did not complete an incident report, she said she did not know why she did not document the incident. She said Resident #2 was not on 1:1 watch at the time of the incident on 06/30/2024 but looking back believed he should have been to ensure the safety of all residents while the incident was investigated. She said Resident #1 should have been sent out for a SANE exam rather than assuming nothing happened.</p> <p>In an interview on 07/03/2024 at 1:17 PM, ADON A stated she became aware of the incident between Residents #1 and #2 on 07/01/2024 when the DON asked her and the Social Worker to talk to Resident #1 about the Resident #2 being in her bed. She said they tried to assess Resident #1's ability to consent and her cognitive ability. ADON A stated Resident #1's competency level was very low, and she would not answer any of the BIMS questions. ADON A said she did not feel that Resident #1 had the capacity to invite Resident #2 into her bed. She said she told the DON Resident #1 did not seem like she was able to consent to anything. ADON A said she did not know where the incident investigation went from there but Resident #2 was not on any kind of supervision until 07/03/2024 when the State Surveyor started asking questions about the Incident. She said Resident #1 was sent to the hospital for a SANE exam and the police were called earlier today as well.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/03/2024 at 1:31 PM, the Social Worker stated Resident #1 was not able to point to correct answers for any of the BIMS Assessment questions. She said Resident #1 was severely cognitively impaired and did not believe she had any capacity to concert to Resident #2's alleged actions. She said she shared this information with the DON and did not hear anything else about the incident. She stated Resident #1 should have been sent to the hospital for SANE exam and police notified. She said Resident #2 should have been placed on 1:1 to ensure all residents' safety.</p> <p>In an interview on 07/03/2024 at 1:49 PM, LVN C stated CNA F told her that LVN D told her that Resident #2 was found with his penis in Resident #1's mouth. She said she did not ask CNA F if the incident was reported to the Administrator and said she did not report it either. She stated she assumed the issue had been addressed and reported to the Abuse Coordinator. LVN C said she had worked in the facility about a year and was regularly in-serviced on abuse policy. She said she did not recall when the last in-service was.</p> <p>In a telephone interview on 07/03/2024 at 4:42 PM, CNA G stated on 06/30/2024 at about 9:15 AM, she opened Resident #1's door and saw her in the bed facing the wall. CNA G stated she saw Resident #2 in bed with Resident #1, behind her and also facing the wall. She stated she did not see if Resident #1 had clothes on but did see Resident #2's bare butt sticking out of the covers. She stated she did not know if Resident #2 had his pants all the way off or just around his ankles. CNA G said she left the room and called for LVN D. She stated LVN D came down the hall within a few seconds and Resident #2 opened Resident #1's room door and went across the hall to his room. She said LVN D called the DON and they talked to Resident #1 over the phone. She said she did not report the incident because LVN D had called the DON and she assumed they were addressing the issue. She said she had never seen Resident #2 display any type of sexual inappropriate behavior in the past. She stated LVN D did not send Resident #1 to the hospital and Resident #2 was not placed on 1:1 supervision. She said when she returned to work on 07/01/2024, staff told her that LVN D said Resident #2 was found with his penis in Resident #1's mouth. CNA G said she did not see Resident #2's penis in Resident #1's mouth when she entered the room on 06/30/2024.</p> <p>In an interview on 07/03/2024 at 4:50 PM, Law Enforcement Officer #4664 stated she was called today to respond to allegations of sexual assault. She said since the incident occurred on 06/30/2024, the facility should have called then and sent Resident #1 to the hospital for a SANE exam. She said the facility told her they sent Resident #1 to the hospital today.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Abuse prevention and prohibition program, revised 08/2020, reflected, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements . IV. Prevention: A. Staff, residents and families will be able to report concerns, incidents, and grievances without fear of retribution or retaliation. B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring . VI. Investigation: A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts . C. The Facility ensures protection of residents during abuse investigations . I. While the investigation is underway, accused individuals who are not Facility Staff may not have any unsupervised access to residents . IX. Reporting/Response: A. Facility Staff are Mandatory Reporters . C. Reporting Requirements: i. The Facility will report known or suspected instances of physical abuse, including sexual abuse, and criminal acts to the proper authorities by telephone or through a confidential Internet reporting tool as required by state and federal regulations. X. Special Considerations for Reporting Suspected Incidents of Rape: A. Anyone who suspects that a rape has been committed against a resident must immediately report this information Administrator and to the Director of Nursing Services. B. The Director of Nursing Services or designee will immediately report this information to the Attending Physician. C. The Administrator then acts to ensure the following steps are taken: i. The proper authorities and individuals are notified immediately or within 24 hours, including but not limited to law enforcement, the Attending Physician, the resident's representative, the state survey and certification agency, and any others necessary. ii. A Licensed Nurse assesses the resident (alleged victim) for possible injuries. iii. The resident is provided with the medical treatment and emotional support necessary to prevent further deterioration of his/her health and wellbeing. iv. The area where the alleged incident occurred is not disturbed or accessed by anyone before law enforcement arrives. v. The resident's clothing is not changed to avoid disturbing or destroying evidence. vi. The resident is not bathed or, if female, douched, to avoid compromising potential evidence. vii. The resident is transported to the hospital or other destination as instructed by law enforcement.</p> <p>The DON and Regional Director of Operations were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 07/03/2024 at 5:32 PM, due to the above failures and the IJ template was provided. The Administrator / Abuse Coordinator was on personal leave and not able to be interviewed, at the time of investigation.</p> <p>The facility's Plan of Removal was accepted on 07/04/2024 at 11:52 AM and included:</p> <p>Identify responsible staff/ what action taken:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Director of Nursing submitted a self-report to HHSC on July 3, 2024, regarding the incident 2. [Local Law Enforcement Agency] were notified on July 3, 2024, by Regional Nurse Consultant and an officer responded. 3. Attending Physician of Resident #1 was notified of the incident on July 3, 2024, by Assistant Director of Nursing. 4. Social Worker conducted a trauma assessment with Resident #1 on July 4, 2024. 5. Attempts to contact family of Resident #1 on July 3, 2024, were unsuccessful due to non-working phone number. They visit frequently and will be notified upon first opportunity and contact will be updated. Family of Resident # 2 were notified July 3, 2024, by facility social worker. 6. Resident #2 was placed on 1:1 monitoring on July 3, 2024, to consist of line-of-sight monitoring by facility staff. 7. Licensed Nurse conducted a head-to-toe assessment to assess for possible injuries on July 3, 2024. 8. Resident #1 was sent out for a SANE test at local hospital. Resident was unable to consent and per hospital no test was performed, and she will be returned to the facility with no new orders. 9. Director of Nursing began obtaining witness statements from staff. 10. Safe surveys (series of questions for residents to identify possible Abuse/Neglect) were completed by Social Worker and other Facility management staff with all interviewable residents. Head to toe assessments were completed with all non-interviewable residents by facility Treatment Nurses. All were completed July 3, 2024. 11. Resident #1 and Resident #2 were referred to [mental health services] on July 3, 2024, for psychological assessment and to be picked up on services if needed.</p> <p>In-Service conducted:</p> <p>Regional Nurse Consultant and Director of Nursing (after [NAME]-servicing below) in-serviced all facility staff on: 1. On 7/3/24 Director of Nursing and Administrator were in-serviced on Abuse & Neglect Policy and Texas HHSC LTCR Provider Letter PL19-17 by Regional Director of Operations. 2. An all-staff in-service was initiated on 7/3/24. All staff members were educated to report all allegations of abuse immediately upon notification or observation to the Administrator who is the abuse coordinator. All staff will complete an Abuse & Neglect competency posttest at time of in-servicing. 3. The expected completion date will be 7/4/2024. Staff who have not been trained on Abuse & Neglect will not be allowed to work until they have completed required in-services.</p> <p>Implementation of Changes:</p> <p>Staff will immediately inform the Administrator who is the abuse coordinator immediately when being made aware of the any abuse allegation or observation. The administrator or director of nursing will ensure competency through verbalization of understanding by staff through successful completion of Abuse/Neglect Post test. In the absence of Administrator abuse allegations will be reported to the Director of Nursing. The Administrator, abuse coordinator will be responsible for implementation of the process and will review process weekly X3 months by reviewing safe surveys, grievance forms and staff interviews. Weekly review will be documented on Abuse Coordinator Review Log.</p> <p>Monitoring:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Social worker/RN Supervisor will complete five safe surveys per day for two weeks then one per day for one month on interviewable residents. 10 Non interviewable residents will receive a head-to-toe physical assessment daily for two weeks then one per week. 2. Administrator and Director of Nursing will interview five staff members per day for two weeks then one staff member per day for one month for return demonstration for types of abuse and reporting requirements. Findings will be documented on Abuse & Neglect monitoring form. 3. RDO and RNC will conduct ten random staff interviews per month. 4. RDO or RNC will review grievances weekly which are located in the facility grievance binder for three months. 5. Any adverse outcomes will be reported to QAPI Committee</p> <p>Involvement of Medical Director:</p> <p>The Medical Director was notified about the Immediate Jeopardy on 7/3/2024.</p> <p>Involvement of QA:</p> <p>On July 3, 2024, an Ad Hoc QAPI meeting was held with the facility administrator, medical director, director of nursing, and social services director to review plan of removal.</p> <p>Who is responsible for implementation of process?</p> <p>Administrator and Director of Nursing will be responsible for implementation of new process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 7/3/2024.</p> <p>On 07/04/2024 at 12:05 PM the surveyor began monitoring the facility's Plan of Removal.</p> <p>An observation on 07/04/2024 at 11:45 AM revealed Resident #1 in her wheelchair in the television room. No concerns were noted. She was watching television with another resident in a chair beside her.</p> <p>In an interview on 07/04/2024 at 12:05 PM, the Regional Director of Operations stated he re-educated the Administrator and DON on the facility's abuse, neglect, and exploitation policy which included: Their initial response to this incident and the need to investigate immediately - rather than wait or make assumption. He said there was a step-by-step process for investigating all incidents and a process to ensure residents' safety during the investigation. He said he also in-served them on reportable incidents and, if in doubt then it needs to be reported. He stated the Administrator and DON did not validate the information they received from staff or follow up with an investigation when they received the information. He said they began in-servicing staff in the abuse policy on 07/03/2024.</p> <p>In an interview on 07/04/2024 at 12:10 PM, the Regional Nurse Consultant stated, she worked with the DON to follow up with reports to law enforcement and in-servicing the staff on the facility's abuse, neglect, and exploitation policy. She stated the staff in-services included a post test, and information on reporting all abuse or suspicion of abuse. She stated she will assist the POR to ensure compliance. She said Resident #2 was placed on 1:1 supervision</p> <p>starting about noon on 07/03/2024.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/04/2024 at 12:18 PM, the DON stated he failed to validate the information he received from the incident. He stated he and the Administrator assumed that Resident #1 invited the Resident #2's advances and therefore stopped the investigation. He stated he wanted to ensure he got all the information and</p>