

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675977	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Village Creek Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3825 Village Creek Rd Fort Worth, TX 76119	

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>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (Residents #8) reviewed for abuse.</p> <p>The facility failed to ensure Hospice Aide did not abuse Resident #8.</p> <p>The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 05/08/24 and ended on 05/08/24. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could affect the residents at the facility and place them at risk for physical, verbal, and/or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #8's annual MDS assessment dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral palsy, non-Alzheimer's dementia, seizure disorder, anxiety disorder, contractures of muscles, and need for assistance with personal care. The MDS further reflected the resident was dependent of one staff member for all ADLs including bathing, dressing, and hygiene. Resident #8 had long and short-term memory impairment and speech was rarely understood and she rarely understood others.</p> <p>Review of Resident #8's care plan revealed she was on hospice services as of 08/22/23 for cerebral palsy. Interventions included to work cooperatively with hospice team to ensure resident's spiritual, emotional, intellectual, physical, and social needs are met.</p> <p>Review of the facility's Provider Investigation Report dated 05/08/24 reflected the following:</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
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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>Note: The nursing home is disputing this citation.</p>	<p>On 5/8/24 around 6:30 am [CNA A] was working 200 hall and heard Resident #8 screaming/crying louder than normal. [Resident #8] has a scream/cry when she needs changed or something, but this was heard from clear down the hall by the shower room and [Resident #8's] door was closed. When [CNA A] heard [Resident #8] screaming/yelling in a louder way than normal she went to check on her. [CNA A] opened the door to [Resident #8's] room and saw Hospice CNA performing a bed bath on [Resident #8]. She had [Resident #8] naked turned on her side facing the wall, the hospice aide had one hand on her thigh and the other hand by her waist. [Resident #8] was screaming and the hospice aide was standing facing the wall. The hospice CNA struck [Resident #8] on her side, between her ribs and buttock twice and said, Be Quiet! When [CNA A] saw this she audibly gasped. The hospice CNA turned around and saw [CNA A] and yelled HEY! [CNA A] left the door to the room open and immediately called for the nurse to come. Nurse was exiting a room across the hall and came immediately to intervene. Hospice aide claimed that she moved her hand quickly to keep resident from rolling back into BM.</p> <p>Observation on 07/09/24 at 10:00 AM revealed Resident #8 was in her bed connected to a feeding tube and her body appeared to be contracted. The resident was non-verbal and would only make a few auditory noises from time to time. The resident could not be interviewed due to her severely impaired cognition and would not even make eye contact when she was being spoken to.</p> <p>Interview on 07/10/24 at 9:48 AM with CNA A revealed she was working on 05/08/24 on the 200 Hall around 6:15 AM. CNA A said Resident #8 would normally make a crying out sound when she needed to be changed but that morning, Resident #8 was heard to be yelling louder than normal behind the resident's closed door. CNA A went to Resident #8's room and as she opened the door, she noticed the Hospice Aide was giving Resident #8 a bed bath and the resident was facing towards the window with her back to CNA A. At that time, when she opened the door CNA A saw the Hospice Aide pop Resident #8 on her side and told her to Be Quiet and CNA A yelled out HEY as the Hospice Aide gasped . CNA A said she went to the door and yelled for LVN B, who went to the room right away, and she told her what she had just witnessed. At that same time CNA A said she was on the phone with DON. CNA A said LVN B immediately asked the panicked Hospice Aide to leave. The Hospice Aide kept repeating she had not done anything and said she loved the resident. The Hospice Aide gathered her belongings and CNA A and LVN B finished caring for the resident. CNA A said the Hospice Aide was not her normal aide that worked with her, and when her normal aide was there, Resident #8 had never been heard yelling like she was that day of the incident. CNA A further stated there was some redness around where Resident #8 had been popped but that could have been from the abdominal binder she normally wore for her G-tube.</p> <p>Interview on 07/10/24 at 10:13 AM with Medical Records Coordinator revealed she was working the day of the incident (05/08/24) when she heard CNA A yelling for help in a panicked voice at the same time, she had heard Resident #8 yelling out at the top of her lungs, which was not normal for the resident. As the Medical Records went to the resident's room, CNA A and LVN B were already there and the Hospice Aide was gathering her stuff. CNA A told Medical Records what she had seen and the Hospice Aide was gathering her stuff and she was walked out of the building. Medical Records stated she had not seen that Hospice Aide and was later told she had been filling in for Resident #8's regular hospice aide.</p> <p>(continued on next page)</p>		

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