STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676067	A. Building B. Wing	06/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Court	7021 Bryant Irvin Rd Fort Worth, TX 76132

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on observation, interview, and record review, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of seven residents reviewed for accidents. The facility failed to ensure staff checked on Resident #1 from 05:15 am until 07:50 am during which time she laid on the floor next to the bed. This failure could place residents at risk for serious injury and distress that could result in a decreased psychosocial well-being. Findings included: Record review of Resident #1's face sheet revealed an [AGE] year-old female admitted on [DATE] with a diagnosis of muscle wasting and atrophy, muscle weakness, lack of coordination, and dementia (memory loss). Record review of Resident #1's MDS assessment revealed a BIMS score of five indicating severe cognitive impairment. Further review revealed Resident #1 needed extensive assistance with two staff members for transferring and bed mobility. Record review of Resident #1's Care Plan dated 5/22/24, with a revision date of 6/05/24, revealed Resident #1 was at risk for falls due to medication use, cognition (mental status), and weakness. Record review of facility Incident/Accident form dated 6/08/24 revealed Resident #1 was found on the floor six times since admission on 5/10/24, 5/11/24, 5/14/24, 5/19/24, 6/02/24, and 6/05/24. Observation of Resident #1s room on 06/08/24 at 11:00 am, revealed Resident #1 bed in the lowest position, fall mat folded up and against the wall. Observation of video, dated 5/19/24 at 04:56 am, showed Resident #1 in the bed. Her bed was in lowest position. Then Resident #1 sat up and swung her legs over the side of the bed, both of her feet touched the ground. The Resident #1 laid back down. Fall mat was diagonal next to bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of video, dated 5/19/24 at 05:15 am, showed Resident #1 laying on the floor partially on fall mat with blankets. Observation of video, dated 5/19/24 at 06:59 am, showed Resident #1 laying on the floor on mat on her left side. The observation of the video, dated 5/19/24 at 07:50 am, showed that Resident #1 was still laying on the floor partially on the fall mat with blankets. A staff member entered the room, did not check on the resident, left, and returned a few seconds later with an additional staff member, then the video stopped. In an interview on 06/08/24 at 09:00 am, LVN A reported that staff worked eight hour shifts and shift changes were at 6am, 2pm, and 10pm. LVN A stated that she tried to check on residents at least four to five times per shift and maybe an hour to an hour and a half was the longest a resident was not checked on. If a resident was found on the floor, they were assessed for any bruising, any abrasions to the skin, and range of motion during a head-to-toe assessment. If a resident needed to go to the hospital, emergency medical services were called, the physician was notified, and the family was contacted. In an interview on 06/08/24 at 1:25 pm, with the DON revealed Resident #1 is on the facilities falling star program, due to frequent falls. The DON stated when residents are on the falling star program the staff are expected to check on those residents more frequent than every two hours, but stated there is not a set timeframe. The DON stated the facility implemented the for Resident #1 her bed is to be in lowest position, fall mat laid next to bed when Resident #1 is in bed, and during the day she is at the nurse's station so that staff can keep a closer eye on resident to minimize the risk of falls. In an interview on 06/08/24 at 1:45 pm, with ADON A revealed when she worked the floor as a nurse, all residents that ADON A would be caring for were checked prior to receiving report at shift change. In an interview on 06/08/24 at 1:50 pm, LVN B revealed all residents were checked on before receiving report at shift change. In an interview on 06/08/24 at 1:52 pm, LVN A stated she always checked every resident at shift change. In an interview on 06/08/24 at 1:58 pm, the DON stated there was an incident where Resident #1 was left on the floor for an extended amount of time. The DON reported that the resident comes out of the bed often. The DON reported the resident was found on the fall mat next to bed, sleep covered with blanket off of bed. In an interview on 06/08/24 at 2:11 pm, with the Administrator revealed the expectation for nurses is to round at least every two hours and if someone needed to be monitored more frequently than that would be discussed during morning meeting with staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/08/24 at 2:31pm, with the DON revealed it was unknown how long Resident #1 was on the floor, but it was a while. The DON reported that staff are expected to round on residents every two hours but should be checking on Resident #1 more often. The DON reports that when Resident #1 was on the floor for an extended amount of time that the staff were doing a changing round which takes longer to complete. The DON stated she instructed the staff to start their rounds with Resident #1 due to her frequent falls and she does not holler out or use call light.