

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/16/2024
NAME OF PROVIDER OR SUPPLIER  Mira Vista Court		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43791</p> <p>Based on interview and record review, the facility failed to ensure the resident had the right to exercise their rights and to be treated with respect and dignity for 3 of 8 residents (Residents #1, #2, and #3,) reviewed for resident rights.</p> <p>CNA A failed to treat Residents #1, #2, and #3 with respect and dignity during her interactions with them.</p> <p>This failure could result in residents receiving medication or treatment without consent and decreased feelings of self-worth.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated face sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included breast cancer, spinal cancer with cord compression, left sided paralysis, and high blood pressure.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 08/30/24, reflected a BIMS score of 15, indicating she was cognitively intact. Her Functional Status assessment indicated she required substantial assistance with most of her ADLs.</p> <p>Record review of Resident #1's care plan, dated 9/17/24, reflected she was paraplegic (paralysis below the waist), and she had a self-care deficit related to her paralysis.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/15/24 at 10:40 AM with Resident #1 revealed she had two interactions with CNA A in which she felt CNA A was rude and impatient with her. Resident #1 stated she called for incontinent care one night and CNA A responded. When CNA A entered she asked Resident #1 if she had her briefs and her wipes and had undone her brief and wiped her front. Resident #1 asked CNA A if she was supposed to have all that ready before she called for help., CNA A rolled her eyes and left to retrieve supplies. Resident #1 stated her second interaction was the next evening and went along the same lines as the previous interaction. Resident #1 stated she asked CNA A how she was supposed to do all of that when she was just recovering from back surgery, but CNA A did not answer and seemed to rush through the task. Resident #1 stated she was left to feel like she was a bother to CNA A and took up too much of her time. Resident #1 stated once she experienced care from other CNAs she realized how care was supposed to be done, that CNA A was being inappropriate, and notified the Administrator when he asked her about her care.</p> <p>Record review of Resident #2's undated face sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and discharged to another facility on 08/21/24. Resident #2 had diagnoses which included right sided paralysis following a stroke, muscle weakness, diabetes, and high blood pressure.</p> <p>Record review of Resident #2's admission MDS assessment, dated 07/17/24, reflected a BIMS score of 12, indicating moderate cognitive impairment. His Functional Status assessment indicated he required assistance with his ADLs.</p> <p>Record review of Resident #2's care plan, dated 07/26/24, reflected he had mobility impairment related to his stroke, and short-term memory issues.</p> <p>Record review of the facility's Provider Investigation Report, 07/31/24 reflected Resident #2 stated CNA A told him to use his brief to have a bowel movement because it was easier to clean him up than get him to the bathroom. After CNA A cleaned him up he felt she did not do a good job, when he put his hand on his left thigh, he had stool on his hand. When he told CNA A about this she gave him a wipe to clean his hand with.</p> <p>Telephone interview on 10/16/24 at 12:35 PM with Resident #2's family member revealed Resident #2 had told her about the incident with a CNA that told him to soil his brief instead of taking him to the bathroom, and then did not clean him very well afterwards. Resident #2 told her the CNA seemed to be bothered to have to care for him and he felt upset with the CNA. Resident #2 reported the incident to the Administrator.</p> <p>Record review of Resident #3's undated face sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 08/08/24, reflected a BIMS score of 3, indicating severe cognitive impairment. His Functional Status assessment indicated he was totally dependent on staff for his ADLs.</p> <p>Record review of Resident #3's care plan, dated 08/11/24, reflected he was considered a fall risk, resisted cares, and required assistance with his ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Provider Investigation Report, dated 07/31/24, reflected Resident #3 had asked CNA A what time it was, and she responded, It's dark outside. Another incident he had to use his call light several times one night and CNA A seemed annoyed to have to answer the call lights.</p> <p>Interview on 10/16/24 at 2:45 PM with the Administrator revealed CNA A was suspended pending the investigation into the complaints against her. When he interviewed CNA A at the conclusion of his investigation she denied all the allegations and refused to accept any responsibility of her actions and attitude. The Administrator stated the decision was made to terminate CNA A for acting indifferently or rudely toward a resident.</p> <p>Interview attempts on 10/16/24 at 1:12 PM and 3:00 PM with CNA A via telephone were unsuccessful.</p> <p>Review of the facility's policy Resident Rights, revised on 11/01/2017, reflected:</p> <p>The facility staff will provide the resident with the right to an environment that preserves dignity and contributes to a positive self-image,</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236</b></p> <p>Based on interview and record review, the facility failed to ensure the resident had the right to exercise their rights and to be treated with respect and dignity for 1 of 3 residents (Resident #5) reviewed for resident rights.</p> <p>The facility failed to honor the request by Resident #5's resident appointed representative to refuse medical treatment from a Physician's Assistant.</p> <p>This failure could result in residents receiving medication or treatment without consent and decreased feelings of self-worth.</p> <p>Findings included:</p> <p>Record review of Resident #5's MDS dated [DATE] assessment reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5's diagnoses included a pubis (pubic bone) fracture, diabetes mellitus, anemia, unspecified dementia, unsteadiness on feet, muscle weakness, cognitive communication deficit (difficulty understand abstract information, and fall on same level. The MDS also reflected a BIMS score of 3, which indicated a severe cognitive impairment.</p> <p>Record review of Resident #5's undated face sheet reflected Resident #5 designated Family Member A as her resident representative.</p> <p>Record review of Resident #5's EHR reflected RN F documented on 09/15/24 at 2:40 PM Apt with Orthopedic Surgeon .on 09/16/24 at 9:40 AM .</p> <p>Interview on 10/16/24 at 10:15 am with Family Member A revealed he called the facility on 09/13/24 (Friday) and 09/14/24 (Saturday). Family Member A was unsure of the exact times and the names of the Receptionist who he spoke with. Family Member A stated that he spoke with the Receptionist on both occasions and told the Receptionist that he wanted Resident #5's orthopedic appointment on 09/16/24 canceled and Resident #5 was not to be taken to the appointment. Family Member A said that he called both days to ensure that Resident #5 was not taken to the appointment the following Monday (09/16/24). Family Member A stated he did not want Resident #5 to be seen by the Physician's Assistant that the appointment was scheduled with. Family Member A stated that he only wanted Resident #5 to be seen by a medical doctor, not a Physician's Assistant. Family Member A continued by stating that he also did not want Resident #5 to be driven in the facility van due to her fracture and the distance of the trip. Family Member A said that he called and spoke with the PA at the office that the referral was made. Family Member A stated that he told her that he did not want Resident #5 to be seen by her. Family Member A said that the PA confirmed her understanding that she was not to see Resident #5. The PA stated that she understood.</p> <p>(continued on next page)</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/16/24 at 11:07 AM with the PA revealed Family Member A called and spoke with her. PA stated that Family Member A called and canceled the appointment before 09/16/24. PA confirmed that Family Member A did not want Resident #5 to be seen by a Physician's Assistant. He only wanted Resident #5 to be seen by an MD. The PA also stated that Resident #5 was dropped off by the facility the morning of 09/16/24 and was there with no escort. The PA stated that the resident was there for approximately 3 hours and was seen and examined by the PA.</p> <p>Interview on 10/16/24 at 11:12 AM with the Receptionist revealed she remembered receiving a call on 09/14/24 from Family Member A. The Receptionist stated Family Member A said that he needed to cancel Resident #5's appointment for Monday, 09/16/24. The Receptionist said that she walked the message back to the nurses' station and gave the message to the nurse on duty at the desk who said that they would take care of the message. Receptionist could not recall who was working that day.</p> <p>Interview on 10/16/24 at 1:19 PM with DON revealed the PRN nurse did not get the message of the appointment cancellation to the Monday through Friday nurse. DON stated that the driver took the resident to the appointment because the day shift nurse did not know about the appointment cancellation.</p> <p>Telephone interview was attempted on 10/16/24 at 12:29 PM with LVN-H, but the attempt was unsuccessful.</p> <p>Interview on 10/16/24 at 2:50 PM with the Administrator revealed the Weekend Receptionist took a message from Family Member A that said to cancel Resident #5's appointment on Monday (09/16/24). He stated the Receptionist then took the note to Resident #5's nurse, who then said they would take care of it. Administrator stated that he talked to the day and evening shift nurses, and they did not receive the note. Administrator revealed that after this incident, Resident #5 was sent out to the hospital to see the doctor per Family Member A's request.</p> <p>Record review of the facility's nurses report on 10/16/24 at 4:00 PM revealed there was no note given from 09/13/24 to 09/16/24 stating to cancel Resident #5's appointment. The nurses' report during that time period stated that Resident #5 had an appointment on 09/16/24. There was no indication that the appointment was canceled.</p> <p>Review of the facility's policy Resident Rights, revised on 11/01/2017, reflected:</p> <p>The facility staff will provide the resident with the right to an environment that preserves dignity and contributes to a positive self-image,</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791</b></p> <p>Based on interview, observation, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents (Resident #4) reviewed for quality of care.</p> <p>The facility failed to ensure Resident #4, who had a Stage 4 pressure ulcer on her left lateral ankle, was provided with wound care as ordered by the physician.</p> <p>This failure could place residents at risk of developing infections or worsening of their wounds.</p> <p>Findings included:</p> <p>Record review of Resident #4's undated face sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included tumor in skull and face, dementia, multiple soft tissue injuries (pressure ulcers and wounds), and contractures.</p> <p>Record review of Resident #4's annual MDS assessment, dated 08/13/24, reflected a BIMS score was not calculated related to the resident's medical condition. Her Functional Status indicated she was totally dependent on staff for all of her ADLs.</p> <p>Record review of Resident #4's care plan, dated 10/08/24, reflected she had multiple pressure ulcers and skin tears, required assistance with her ADLs, and received nutrition via a feeding tube.</p> <p>Record review of Resident #4's physician's orders, 08/12/24, reflected an order for: Daily Wound Treatment: Stage 4 pressure wound to left lateral ankle cleanse area with ns, pat dry and apply collagen powder and anasept gel. Cover with island border gauze.</p> <p>Telephone interview on 10/14/24 at 10:00 AM with Resident #4's family member revealed they had concerns about the resident's care. The family member stated they did not think the resident's brief was not being changed regularly, staff were not providing appropriate peri-care, and her wound care was not being done every day.</p> <p>Observation of a photograph supplied by Resident #4's family member, date stamped 09/08/24 at 8:23 AM, revealed a dressing on Resident #4's left ankle with a date of 9/6 with initials. The dressing appeared to be loose on two sides, there was reddish drainage soaked through the dressing, and a trail of dried red fluid from the bottom of the dressing down to the bottom of the resident's foot.</p> <p>Observation on 10/15/24 at 9:40 AM of Resident #4's left ankle dressing was dated 10/14 with initials. The dressing was clean, dry and intact. Resident #4's brief did not appear saturated, and no odor of urine was noted.</p> <p>Observation on 10/15/24 at 10:15 AM revealed the Wound Care Nurse assisted by CNA B providing Resident #4 with wound care using clean technique throughout the procedure. Both staff wore appropriate PPE of gown and gloves, and the resident did not complain of discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/15/24 at 10:35 AM with the Wound Care Nurse revealed she had been in her position for two weeks and had not interacted with the previous wound care nurse. The Wound Care Nurse reviewed the photograph submitted by Resident #4's family and stated the dressing should have been changed on 09/07/24, or whenever it was noted to be loose on the two sides or when the drainage soaked through the dressing. The Wound Care Nurse stated all nursing staff could provide wound care when she was not present by following the physician orders.</p> <p>Record review of Resident #4's September 2024 TAR reflected wound care to the resident's left ankle had been provided every day including on 9/7. The TAR did not reflect which nurse provided the care, only an x to indicate it was completed.</p> <p>Interview on 10/15/24 at 3:45 PM with LVN C revealed wound care was provided by the nursing staff whenever the Wound Care Nurse was not present at the facility. Wound care orders were present in the EHR to guide the staff. LVN C stated all dressings should be checked by the primary nurse every day and assessed for drainage, looseness, etcetera and notify the wound care nurse or change it themselves if needed.</p> <p>Interview on 10/16/24 at 2:21 PM with CNA D revealed she would report any issues with a dressing she noted while providing care to the resident's nurse. She stated if a dressing was coming off, or was dirty, she would notify the nurse immediately and help change the dressing if needed.</p> <p>Interview on 10/16/24 at 2:30 PM with CNA E revealed any time she discovered a resident's dressing needed to be changed she would notify the resident's nurse right away so it could be changed to prevent an infection.</p> <p>Interview on 10/16/24 at 3:00 PM with the DON revealed all nurses could provide wound care to residents and were expected to do so if the wound care nurse was unavailable, or if it needed to be changed emergently. Residents had wound care orders in the physician's orders that told the nurses how to provide the wound care needed.</p> <p>Review of the facility's Dressing Change Wound Evaluation policy, revised 06/01/15, reflected:</p> <p>An evaluation will be performed with each dressing change The evaluation is the ongoing process of noting wound characteristics each time a clinician sees that wound.</p>		