

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 01/08/2025
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<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** 43791</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 4 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 was free from inappropriate touching by Resident #2 in which Resident #2 was observed to have his hand under the gown of Resident #1.</p> <p>The noncompliance was identified as past noncompliance that began on 12/17/24 and ended on 12/17/24. The facility had corrected the noncompliance before the investigation had begun.</p> <p>This failure could place residents at risk of unwanted touching by other residents and psychosocial harm.</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 Alzheimer's disease, unsteadiness on feet, and muscle wasting.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 12/31/24, reflected her BIMS score was 5 indicating she had severe cognitive impairment. Her Functional Status assessment indicated she required maximum assistance with all of her ADLs.</p> <p>Record review of Resident #1's care plan, dated 12/17/24, reflected she was at risk of psychosocial well being related to allegations of abuse, with interventions of monitoring the resident for any changes in behaviors.</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] with diagnoses which included end stage kidney disease requiring dialysis, dementia, diabetes, and communication deficit.</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 12/31/24, reflected his BIMS score was 6 indicating severe cognitive impairment. His Functional Assessment indicated he was independent in his ADLs.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's care plan, dated 12/17/24, reflected he was at risk for behavioral symptoms related to allegations of inappropriate behavior with residents and staff with intervention of 1:1 monitoring at all times and obtaining psychosocial therapy.</p> <p>Record review of the facility's investigation report reflected Resident #2 was observed to have his hand under the gown of Resident #1. Staff intervened immediately and separated the residents. Resident #2 was placed on 1:1 monitor by a CNA, and Resident #1 was assessed for any injury or psychosocial harm. Resident #1 had not exhibited inappropriate behaviors with other residents, only staff. Resident #1 appeared not to be aware of what had happened. Resident #2 was sent to the hospital for psych evaluation, and was returned with addition of Zoloft to his medication regime. The facility initiated search for alternative placement for Resident #2 when he returned from the hospital.</p> <p>Record review of the hospital records reflected Resident #2 was started on Zoloft again.</p> <p>Record review of psychologist note on 12/18/24 for Resident #2 reflected: His behavior is mostly likely due to dementia. The filter of what is appropriate and what is not, is not functional. So he just does things and doesn't know they are inappropriate (nor does he remember doing them). Unfortunately, no medication can fix this, so transfer to another facility may be best.</p> <p>Interview on 01/08/25 at 9:18 AM with Resident #2 revealed he did not know why he had a sitter (Restorative Aide currently) with him all the time. Resident #2 denied being inappropriate with staff or other residents. He later stated, they say I touched someone. Resident #2 blamed his medications for making him forgetful.</p> <p>Observation and interview on 01/08/25 at 9:50 AM revealed Resident #1 was pleasantly confused. The resident's family member was present and requested the resident not be interviewed about the event of her being touched inappropriately. The family member stated she had been notified immediately of what had happened by the facility and was at the facility within about 15 minutes of being notified. When the family member and the DON questioned Resident #1 about the incident, the resident denied anything had happened. The family member stated she was happy with how the facility had handled the situation and had no concerns about the resident's safety.</p> <p>Interview on 01/08/25 at 10:26 AM with the Housekeeper revealed she had entered the restorative dining area on 12/17/24 just after breakfast was over and witnessed Resident #2 with his hand under the gown, but above the underlying clothes of Resident #1. Resident #2's hand was at Resident #1's abdominal region. She told Resident #2 to remove his hand and reported it to the nurse. Resident #2 was immediately removed from the dining area. She stated Resident #1 did not appear to aware of what Resident #2 was doing and did not appear to be upset. The Housekeeper stated she had never had a negative interaction with Resident #2 in the past.</p> <p>Interview on 01/08/25 at 11:44 AM with the Restorative Aide revealed she was monitoring Resident #2 for any inappropriate comments and to prevent him from contacting any female residents. Any behaviors were reported to the nurse for them to document. The Restorative Aide stated Resident #2 was known to make inappropriate remarks to staff members and attempt to touch them inappropriately. She stated since 12/17/24 Resident #2 was monitored at all times by staff while he was in his room or whenever he left his room. Resident #2 would still make inappropriate comments to the staff, but he had no interactions with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/08/25 at 11:54 AM with CNA A revealed staff were aware Resident #2 had started to make inappropriate remarks and try to touch them since around November 2024, but he had never tried to touch any other residents. She stated after his touching of Resident #1 in December he had been kept on 1:1 monitoring, and the resident rarely left his room. When he did leave the room, they stayed with him. She stated she had been in-serviced on abuse and neglect right after the incident and was able to identify several forms of abuse.</p> <p>Interview on 01/08/25 at 1:10 PM with the DON revealed Resident #2 was immediately placed on 1:1 monitoring after the event on 12/17/24. She stated she and Resident #1's family member interviewed the resident after she was back in her room and the resident denied anything happening. The DON stated the resident did not appear to be in any distress or upset. The resident wore a brief, shirt and pants, sometimes a blanket, and then a hospital gown on top. When she and the family member assessed the resident immediately following the incident, the resident's clothing and brief did not appear to be disturbed. The DON discussed having psych services meet with Resident #1, but the family member did not want the event to be continued to be discussed with the resident. The DON stated the facility immediately sent Resident #2 to the hospital for a psych evaluation, and they began to reach out to facilities with secured units for males. One facility was located and had accepted Resident #2, but his family objected to the transfer based on the facility's reviews. The DON stated Resident #2 would continue to stay on 1:1 monitoring until he was transferred. The DON stated Resident #2 had not demonstrated any behaviors towards other residents prior, only staff. The DON stated staff noted an increase in the resident's behaviors around November 2024 when the resident's BIMS score had decreased from 10 to 6, mild cognitive impairment to severe cognitive impairment.</p> <p>Interview on 01/08/25 at 2:10 PM with CNA B revealed staff were aware of Resident #2's behaviors and attempts to touch staff, but she had never seen or heard about him touching another resident until he did so in December. She knew he had been sent to the hospital afterwards and that he was on 1:1 monitoring ever since. She stated the restorative aides were used for monitoring, and a CNA was assigned for overnight monitoring. Staff were to report any behaviors to the nurse for her to document. CNA-B stated she had been in-serviced on abuse and neglect by the DON and ADON, and she was able to identify several types of abuse.</p> <p>Interview on 01/08/25 at 3:45 PM with the Administrator revealed he was the Abuse and Neglect Coordinator. He stated Resident #2 was sent to the hospital on 12/17/24 for a psychiatric evaluation, and he was returned the same day with a new medication added. The Social Worker began the process of locating another facility for the resident, sending out 10-12 inquiries. One facility did accept the resident, but his family objected to the transfer based on reviews of the facility. The decision was made to keep Resident #2 on 1:1 monitoring 24/7 until placement could be secured. An additional staff member was added to the schedule for the 1:1 monitoring to prevent a decrease in staffing.</p> <p>Record review of the facility's daily staffing schedules for January 2025 reflected one staff member identified for 1:1 monitoring on each shift.</p> <p>Record review of the facility's Abuse, Neglect, Exploitation, or Mistreatment policy, dated 10/01/20, reflected: .The facility's leadership prohibits neglect, mental and/or verbal abuse, use of a physical and/or chemical restraint .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>.5. Mistreatment means inappropriate treatment or exploitation of a resident.</p> <p>.7. Sexual abuse is non-consensual sexual contact of any type with a resident.</p> <p>Facility leadership will report immediately, but no later than 2 hours after the allegation is made, if the event causes serious bodily injury, and no later than 24 hours if the allegation does not result in serious bodily injury.</p> <p>.5. Ongoing assessment, care planning, and monitoring of those residents with special need that may lead to neglect is conducted, for example:</p> <p>A. History of aggressive behavior</p> <p>B. History of entering other resident rooms</p> <p>Record review of the facility's interventions reflected:</p> <ol style="list-style-type: none"> 1. Resident #2 was placed on 1:1 monitoring, which continues. 2. Resident #1 was assessed for any injury or psychosocial harm. 3. Staff were in-serviced on abuse and neglect. 4. Resident #2 was assessed by psych services and his medications were adjusted. 5. The facility is seeking alternative placement for Resident #2. 		