| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676132 | A. Building<br>B. Wing | 03/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Trail Lake Nursing & Rehabilitation | 7100 Trail Lake Dr<br>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) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #3) of 10 residents reviewed for accommodation of needs.<br><br>The facility failed to ensure Resident #3's call light was accommodating to meet his needs, with the resident being diagnosed with quadriplegia.<br><br>This failure could place all residents at risk of the inability to contact the nursing staff and obtain assistance when needed.<br><br>Findings included:<br><br>Record review of Resident #3's face sheet, dated 03/28/24, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: muscle wasting and atrophy (loss of muscle mass), muscle spasms, spinal stenosis (narrowing of spine), quadriplegia (paralysis of legs and arms), and major depressive disorder (mood disorder)<br><br>Review of Resident #3's quarterly MDS assessment, dated 01/24/24, revealed a BIMS score of 14 indicating he was cognitively intact. His functional status indicated he was totally dependent on staff to complete all ADLs. Further review reflected Resident #3 liked to have his call light on his right shoulder for ease of use with an intervention to place the call light at the resident's right shoulder.<br><br>Review of Resident #3's care plan, revised 01/31/2024, reflected the resident required total staff assistance with ADLs with an intervention that included keeping call light within reach and encouraging him to use it for assistance.<br><br>(continued on next page) |

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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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and observation on 03/28/24 at 10:23 AM, revealed Resident #3 was on isolation for COVID-19 and his room door was observed to be closed. Resident #3 was bedbound and watching television. His call light was observed at the head of his bed, near his right shoulder. The call light was flat and soft touch for easy use; however, Resident #3 stated due to his paralysis he was unable to move enough to reach the call light. Resident #3 stated staff tried placing the call light under his head, elbow or back and when he would have muscle spasms it would set the call light off, so he requested for it to be placed near his right shoulder and at the top of the bed to keep it out of the way. Resident #3 stated if it was placed just right or when he could scoot, he could sometimes hit the call light when needed, but most times he could not. Resident #3 stated he would yell for help and if staff were in the hall they could hear him, but he would normally have to wait several hours before someone would come check on him. Resident #3 stated he was prone to infections and was afraid that he would fall ill again and not be able to call for help. Resident #3 stated there had not been any recent incidents or need for immediate help. The Investigator requested Resident #3 to activate his call light and he demonstrated that he was unable to move his shoulder enough to do so.<br><br>In an interview on 03/28/24 at 10:38 AM, CNA D stated she worked at the facility since 11/2023. She stated she normally worked with Resident #3 because he would request her; however, she had not worked with him since he was placed on isolation for COVID-19. CNA D stated she was aware that Resident #3 was unable to use his call light so she would check on him more frequently, about every 20 minutes when possible. She stated it was protocol to check on all residents at least every 2 hours. CNA D stated Resident #3 would also yell when he needed help, but she did not know how he was getting help with his door being closed due to him being on isolation.<br><br>In an interview on 03/28/24 at 10:42 AM, CNA E stated she worked at the facility for about a week. She stated she worked with Resident #3 and was aware that he could not use his call light because he was paralyzed. CNA E stated she was told to keep his call light near his shoulder anyway, and to check on him often. CNA E stated the hall was busy and she was not always able to check on his more often. She stated it was sometimes hard to even check on him every 2 hours, but she did her best.<br><br>In an interview on 03/28/24 at 10:45 AM, the RQC (RN) stated she had only been at the facility for about 4 days to help due to the ADON and DON being out sick, and she knew very little about the residents. The RQC (RN) stated it was her understanding that Resident #3 had a soft touch call light that he was able to use, and it was care planned for it to remain near his shoulder by Resident #3's request. The RQC (RN) stated she was not aware that Resident #3 could not use his call light even with it near his shoulder. RQC (RN) stated not ensuring all residents had access to a call light could place them at risk of not getting help as needed which could cause harm .<br><br>In an interview on 03/28/24 at 3:33 PM, the RDO stated the expectation was for all residents to have access to a call light they could use. The RDO stated Resident #3 demonstrated to staff that he could use his call light if it was near his shoulder, and it was care planned for the call light to be always placed there. The RDO stated staff worked with Resident #3 to see where he could best reach his call light and tried it under his elbow, but resident wanted it near his shoulder. The RDO stated she was unaware that Resident #3 could not access his call light. She stated the facility was in the process of looking for a different type of call light to accommodate Resident #3's needs.<br><br>Review of the facility's Answering the Call Light policy, revised October 2010, reflected in part the following:<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Purpose: The purpose of this procedure is to respond to the resident's requests and needs.<br><br>.3. Ask the resident to return demonstration so that you will be sure that the resident can operate the system.<br><br>.5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.<br><br>6. Some residents may not be able to use their call light. Be sure you check these residents frequently . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054<br><br>Based on interview and record review, the facility failed to develop a person-centered, comprehensive care plan for each resident that included measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs for two (Resident #1 and Resident #2) of ten residents reviewed for care plans.<br><br>1. The facility failed to ensure Resident #1's comprehensive care plan addressed the resident's interventions for her pacemaker.<br><br>2. The facility failed to ensure Resident #2's comprehensive care plan addressed the resident's interventions for GI diagnoses and chronic symptoms.<br><br>These failures could affect residents at the facility who require a care plan and place them at risk for not receiving the appropriate care and services needed to maintain optimal health.<br><br>Findings included:<br><br>1. Record review of Resident #1's face sheet revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: heart failure, cardiac arrythmia with a pacemaker, malignant neoplasm of unspecified female breast (breast cancer), edema unspecified (swelling caused by trapped fluid), cognitive communication deficit, hypotension (low blood pressure), and morbid obesity.<br><br>Review of Resident #1's quarterly MDS assessment, dated 06/01/23, reflected the resident had clear speech, was understood, and usually understood others. The MDS assessment reflected Resident #1 had a BIMs score of 8, which indicated moderate cognitive impairment. Further review reflected Resident #1 needed substantial assistance with most tasks regarding self-care.<br><br>Review of Resident #1's care plan, revised 12/27/23, reflected the resident had potential for complications related to diagnosis of cancer with interventions to administer medication as ordered and monitor for side effects, encourage resident to verbalize feelings, hospice referral as indicated, monitor nutritional status, observe/document/report s/sx, obtain and monitor lab/diagnostic work as ordered, and psychiatric consult as needed. Further review revealed Resident #1 was not care planned with interventions for monitoring of her pacemaker.<br><br>Record review of Resident #1's progress note by the PA, dated 06/13/23, reflected .Resident admitted to the facility after breast surgery, with surgical site dressing, clean, dry, and intact Resident has left chest pacemaker and right Mediport (medical appliance placed under skin to access veins)<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation and interview on 03/26/24 at 11:04 AM, Resident #1 was observed lying in bed. She was dressed in a gown and well groomed, with no odors or visible marks/bruises. Resident #1 stated she had been at the facility for almost a year. She stated the staff took good care of her for the most part, but she was concerned that she had not seen an oncologist or cardiologist. Resident #1 stated she admitted to the facility a month after having a lumpectomy (surgical removal of cancer in breasts) and she did not know whether they got all of it because she had not seen the doctor. Resident #1 also stated she had a pacemaker that needed to be reset. Resident #1 could not recall the last time she had her pacemaker reset but stated it had not been done since she was admitted to the facility. Resident #1 denied feeling any specific pain or symptoms related to breast cancer or heart issues. Resident #1 stated she experiences general pain and discomfort due to diagnoses.<br><br>In an interview on 03/27/24 at 10:42 AM, the ADON stated she started working at the facility in 9/2023, after Resident #1 admitted . The ADON stated she was not made aware that Resident #1 needed to follow up with an oncologist or cardiologist until about a week ago when Resident #1 mentioned it. The ADON stated she did not receive a report about Resident #1 when she started working at the facility and Resident #1 did not say anything about the appointments until recently. The ADON stated when Resident #1 was told that she would have to be transported out on a stretcher for the appointments, Resident #1 stated she was ashamed to be seen that way. The ADON stated shortly after she caught COVID-19 and had not been back at work to follow up on scheduling the appointments. The ADON stated the MD gives orders for all appointments that need to be made and she is only responsible for scheduling them. When asked how often a resident should be monitored after a lumpectomy and for a pacemaker, the ADON stated she was not a doctor and could not answer that.<br><br>In an interview on 03/27/24 at 11:00 AM, the PA stated he worked with Resident #1 since she admitted to the facility. The PA stated he was not aware that Resident #1 needed to follow-up with an oncologist or cardiologist. The PA stated he was aware that she had a pacemaker and admitted with a diagnosis of malignant neoplasm of breast; however, he could not state why Resident #1 had not followed up with an oncologist or cardiologist. The PA stated pacemakers should be monitored/reset at least annually but it also depended on the resident. The PA could not state when Resident #1 last had her pacemaker monitored/reset. The PA stated he worked with the ADON and DON to follow-up on medical appointments, but it was his responsibility to ensure that it happened.<br><br>2. Record review of Resident #2's face sheet revealed the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: vascular dementia (memory loss caused by decreased blood flow to the brain), atrial fibrillation (irregular heart rate), cognitive communication deficit, chronic obstruction pulmonary disease, nausea and vomiting, constipation, gastro-esophageal reflux disease with esophagitis (acid reflux with inflammation of esophagus), peripheral vascular disease (circulation disorder), and type II diabetes.<br><br>Review of Resident #2's quarterly MDS assessment, dated 01/02/24, reflected the resident had clear speech, was understood, and usually understood others. The MDS assessment reflected Resident #1 had a BIMS score of 13, which indicated cognition was intact. Further review reflected Resident #2 was dependent and needed assistance with most tasks regarding self-care.<br><br>Review of Resident 2's care plan, revised 01/02/24, reflected the resident was not care planned for vomiting/nausea or gastrointestinal issues.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation on 03/26/24 at 2:45 PM of Resident #2 revealed the resident was lying in bed and unresponsive. Resident #2 could not be interviewed due to condition.<br><br>In an interview on 03/27/24 at 03:26 PM, the RDO stated she was helping at the facility due to the Administrator being out on leave and had only been at the facility for a few days. She stated she had helped periodically and was familiar with some of the residents. The RDO stated she was not aware of Resident #1's follow-up appointments and could not state why they were not scheduled. The RDO stated she recalled Resident #2 having an appointment with an ENT to address his nausea and vomiting. She stated Resident #2 refused to go to one, but she thought they were able to convince him to go to a second appointment. The RDO was not able to provide records of the second appointment. She stated the facility had a hard time getting him in with a GI specialist due to his insurance. The RDO stated Resident #2 refused care often and it was care planned. The RDO stated the expectation was for the nurse managers to review clinical documents and obtain orders from the MD for any follow appointments needed.<br><br>In an interview on 03/28/24 at 12:27 PM, the RQC (RN) stated the expectation for new residents or residents returning to the facility from the hospital was for the ADON/DON to check all clinical documents/hospital records for any follow-up treatment or appointments. The RQC (RN) stated it was also good to obtain information from the family regarding the residents because they know a lot about them. The RQC (RN) could not provide information on how often clinical records of residents were reviewed to catch any missed follow-up treatments or appointments. The RQC (RN) stated the risk of not following up on appts. could be missed new diagnoses or existing diagnoses could get worse, which could cause harm to the resident.<br><br>The facility's policy on Comprehensive Person-Centered/Care Plans was not obtained at exit. |