STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to provide residents with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #5) of five residents reviewed for call lights. The facility failed to ensure Resident #5's call light was accessible. This failure could place the residents at risk of falling, further injury, and unnecessary pain from not being able to call for help. Findings included: Review of Resident #5's Admission Record, dated 04/25/24, revealed the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included unspecified intellectual disabilities (a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits), cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit), and muscle wasting and atrophy (loss of muscle leading to its shrinking and weakening). Review of Resident #5's quarterly MDS assessment, dated 03/04/24, reflected he had a BIMS score of 03 indicating severe cognitive impairment. Further review revealed Resident #5 was dependent on staff for eating and putting on/taking off footwear, and required maximal assistance for oral hygiene, toilet hygiene, shower/bathing, dressing, and personal hygiene. Resident #5 was also always incontinent. Review of Resident #5's care plan, revised on 12/14/23, reflected the following: Problem: [Resident #5] has an ADL self-care performance deficit r/t unspecified intellectual disability, functional quadriplegia, hx of brain cancer .Interventions: Encourage the resident to use bell to call for assistance. And Problem: [Resident #5] is moderate risk for falls r/t impaired mobility, functional quadriplegia, unspecified intellectual disability .Goal: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance [sic] . (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and attempted interview on 04/25/24 at 9:34 AM with Resident #5 revealed he was lying in bed with a fall mat to one side of his bed. Resident #5's call light was observed to be on the other side of the room, underneath his roommate's bed on the floor, out of his reach. Resident #5 was able to answer yes/no questions only but answered ya to any question asked and did not seem to be able to understand what was being asked. Observation on 04/25/24 at 12:08 PM of Resident #5 revealed he was still lying in bed with a fall mat to one side of the his bed. Resident #5's call light was observed to be on the other side of the room underneath his roommate's bed on the floor, out of his reach. Observation and interview on 04/25/24 at 12:45 PM with CNA V revealed she was not caring for Resident #5 but went to his room and saw that his call light was on the other side of the room, underneath his roommate's bed on the floor, out of his reach. CNA V said it should be within Resident #5's reach. CNA V walked over to the roommate's bed to retrieve Resident #5's call light and placed it within his reach before leaving the room. Interview on 04/24/24 at 4:54 PM with the Interim DON revealed call lights should be within a resident's reach at all times. The Interim DON said it was the responsibility of the CNAs and nurses to ensure that a resident's call light was within reach at all times. The Interim DON said the purpose of having the call light within reach was to be able to alert staff that the resident needed some type of help. The Interim DON said without the call light within reach anything could happen to the resident as in they could fall or need something like water, a remote, or help to the bathroom. Review of the facility's Call Lights: Accessibility and Timely Response policy, dated 10/13/22, reflected: .5. Staff will ensure the call light is within reach of resident and secured, as needed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately to the Administrator for two (Residents #3 and #4) of four residents reviewed for abuse. The facility failed to ensure CNA Z immediately reported an allegation of abuse, on 02/03/24, when she observed Residents #3 and #4 were seen touching each other inappropriately, to the Administrator. This failure could place residents at risk of emotional, physical, and mental abuse. Findings included: Review of Resident #3's admission record, dated 04/25/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included dementia (a term for a range of conditions that affect the brain's ability to think, remember, and function normally). Review of Resident #3's quarterly MDS assessment, dated 02/20/24, reflected she had a BIMS score of 05 indicating severe cognitive impairment. Further review revealed Resident #3 had physical behaviors towards others that occurred for 1 to 3 days. Review of Resident #3's care plan, revised on 02/05/24, reflected the following: Problem: Resident seeks out male resident with intention of inappropriate/ sexual touch . [sic]. Observation and attempted interview on 04/25/24 at 9:30 AM with Resident #3 revealed she was in the living room area of the facility with multiple other residents. Resident #3 was sitting in her wheelchair at a table and was dressed and groomed. Review of Resident #4's admission record, dated 04/25/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included quadriplegia (a paralysis of all four limbs and the torso, usually caused by a spinal cord injury in the neck) and fusion of spine (surgical fusing of two or more unstable vertebrae into one to relieve pain.). Review of Resident #4's annual MDS assessment, dated 03/28/24, reflected he had a BIMS score of 12 indicating mild cognitive impairment. Further review revealed he had no behaviors towards others. Review of Resident #4's care plan, revised on 02/05/24, reflected the following: Problem: The resident has a behavior problem- Resident allegedly seeks out female resident with intention of inappropriate/sexual touch. Review of Resident #4's progress notes reflected the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 02/05/24 written by LVN X reflected: This nurse was notified by CNA, about an incident that occurred over the weekend. Per CNA account, [Resident #4] came into contact with another resident on the floor of facility. Female resident is not alert and oriented x4. Female resident was touching [Resident #4] shoulders; [Resident #4] then placed residents' hand over his private area. This nurse notified social services and Administrator. This nurse let administrator and SS know that it occurred over the weekend, and this nurse did not witness it firsthand. Administrator was made aware; details of the incident were given by CNA to administrator .[sic]. Observation and interview on 04/25/24 at 3:50 PM with Resident #4 revealed he was in his room sitting in his wheelchair. Resident #4 said he felt safe in the facility and had no intention of being sexual with anyone. Resident #4 said a resident had tried touching him at one point but that had not happened again. Review of the facility's Provider Investigation Report reflected the date of the incident occurred was 02/03/24 at 9:30 AM and the date the incident was reported was 02/05/24 at 1:00 PM. The description of the allegation revealed [CNA Z] reported that she had seen an interaction between [Resident #3 and Resident #4] which she stated she saw [Resident #3] touching/feeling the upper body area of [Resident #4] down the hallway while she was near the nurse's station. Resident [the rest of the description was cut off from the box] Interview via phone on 04/25/24 at 11:34 AM with CNA Z revealed she observed Residents #3 and #4 in the hallway both in their wheelchairs. CNA Z said she saw Resident #4 grab Resident #3's breast and then wheeled away. CNA Z said she never saw either resident have sexual behaviors towards each other or others before this occurred. CNA Z said she told LVN Y because she was close by and thought she would tell the Administrator about the incident. CNA Z said this incident occurred on a Saturday and when she returned to work on Monday, she saw Resident #3 touching Resident #4's chest. CNA Z said she wondered why no one had taken any action and reported what she saw to LVN X. CNA Z said she now knew to immediately report any abuse allegation to the Administrator. Interview via phone on 04/24/24 at 12:17 PM with LVN Y revealed she no longer worked at the facility. LVN Y said it had been a while and she could not recall any details about what happened between Residents #3 and #4. Interview on 04/25/24 at 1:42 PM with LVN X revealed she was not working on Saturday, 02/03/24, when the alleged sexual abuse occurred between Residents #3 and #4. LVN X said she was told by CNA Z that she had seen inappropriate touching between Residents #3 and #4 over the weekend and told the nurse on duty who did not report that to anyone. LVN X said she immediately reported the allegation to the Administrator that same day which was a weekday. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/24 at 5:28 PM with the Administrator revealed it was reported to him that staff had seen Resident #4 coming from the dining room in the hallway and Resident #3 had stopped in front of Resident #4 and began to rub his chest, then Resident #4 grabbed Resident #3's arm and put it on his crotch area. The Administrator said this occurred on 02/03/24 and was not reported to him until 02/05/24. The Administrator said CNA Z was responsible for reporting the alleged sexual abuse to him on 02/03/24 if that was what she felt it was. The Administrator said he assumed in CNA Z's mind that since she told the charge nurse, they would report it to him. The Administrator said all staff, including CNA Z, know to immediately report any allegation of abuse to him. The Administrator said the purpose of reporting allegations of abuse to him immediately was so that the allegations could be reported on time, and he could begin his investigation. The Administrator said if abuse allegations were not immediately reported to him then he doesn't have a way of making sure everything was okay. Review of an in-service, dated 02/05/24, and titled Abuse and Neglect, Reporting, Sexual Activity revealed staff had been in-serviced on the facility's abuse/neglect policy. Review of an undated sheet of paper provided by the facility in their incident report, titled Reporting Abuse, reflected the following: If you witness or suspect abuse, neglect, exploitation, or mistreatment you MUST stop the abuse and report it IMMEDIATELY to your Abuse Prevention Coordinator/ Administrator and/ Supervisor. [sic]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44937 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent elopement for one (Resident #1) of five residents reviewed for elopements. The facility failed to ensure Resident #1, who had dementia and a history of wandering, had on a WanderGuard device as care planned to prevent elopement. This failure could place residents at risk of elopement or injury. Findings included: Record review of Resident #1's face sheet, dated 04/25/23, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (the loss of cognitive functioning that interferes with daily life and activities), muscle weakness, lack of coordination, and unsteadiness on her feet. Record review of Resident #1's admission MDS assessment, dated 02/25/24, revealed Resident #1's BIMS score was 8 indicating moderate cognitive impairment. The assessment reflected Resident #1 had no wandering behavior that had occurred one to three days during the assessment period. Resident #1 had use of a wheelchair, however presented with requiring partial/moderate assistance to walk 10 feet. Active diagnoses included Alzheimer's Disease (a degenerative brain disorder), dementia, need for assistance, muscle weakness, osteoarthritis (joint disease), and thrombocytopenia (increased risk of bleeding). Record review of Resident #1's care plan, revised 04/07/24, reflected: Focus: The Resident is an elopement risk/wanderer related to history of attempts to leave facility unattended, impaired safety awareness. Goal: The resident's safety will be maintained through the review date. Resident #1 will not leave facility unattended. Intentions/Tasks: Complete wandering evaluation tool, distract resident from wandering by offering pleasant diversion, structured activities, food conversation, television, book. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Wander Alert: Wander guard Placed 05/16/2023. Record review of Resident #1's wandering evaluation dated 04/07/24 reflected: Resident was disoriented, does not understand what is being said (due to language or cognition), loss of self-control, diagnosis of early dementia, taking narcotics, known wanderer/ history of wandering, resident is a wandering risk, interventions and care plan updated. (Wander Guard BIMS 8 DX Dementia Meds: Tylenol #4) Record review of Resident #1's orders revealed the following orders: Wander guard use for exit seeking risk. Monitors replace prior to (expiration of 1 year) every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wander guard use, check function every day using tester every shift for wander guard monitoring. Wander guard use, check placement each shift (location of wander guard lower body) every shift for wander guard monitoring. Record review of Resident #1's April 2024 MAR revealed the following: Document the number of times resident was exit seeking on current shift. Every shift for wander guard monitoring. MAR revealed Resident #1's Monitoring Administration Record for April 2024 reflected the following dates had no entries: 04/02/24, 04/03/24, 04/04/24, 04/05/24, 04/08/24, 04/10/24, 04/11/24, 04/16/24, 04/17/24, 04/18/24, 04/22/24, and 04/24/24 for the day shift. Observation and interview on 04/25/24 at 12:07 PM with Resident #1 revealed the resident was in the hallway speaking with LVN W. Resident #1 stated she had finished taking her medication, and she was waiting on lunch. Resident #1 was observed ambulating independently to her room. Observation of both the resident's legs revealed she did not have on a WanderGuard device. Resident #1 was asked if she had a WanderGuard or a bracelet on her ankle. Resident #1 lifted her pant legs and revealed no WanderGuard. Resident #1 stated she did not know of such a device, and she had not had anything on her legs in a long time. The WanderGuard band was observed on the bedside table on the phone, among personal items. The WanderGuard square box was removed from the WanderGuard band on the bedside table in a box covered with other trinkets. Observation of the WanderGuard revealed jagged edges where the strap had been tampered with in the removal process. The strap appeared discolored and as if the removal had taken place some time ago, the box appeared smashed, it was undetermined if the device was in working condition. Observation and interview on 04/25/24 at 12:53 PM with LVN W revealed she was the nurse on duty, and she worked from 6:00 AM to 2:00 PM. LVN W named Resident #1 as one of her residents with a WanderGuard. LVN W stated she checked placement this morning, and Resident #1 was in possession of the WanderGuard on her right ankle. Observation with LVN W revealed Resident #1 was not wearing the WanderGuard. LVN W asked Resident #1 where the WanderGuard was, and Resident #1 stated she did not know. LVN W picked up the strap and identified the box among personal items on the bedside table. LVN W educated Resident #1 that she would be required to have a new WanderGuard placed on her ankle. LVN W stated she would begin one-on-one monitoring with Resident #1 to prevent exit-seeking behaviors. Interview on 04/25/24 at 1:15 PM with the DON revealed an in-service and audit was done with residents to determine residents with BIMS scores below 13. The DON stated anyone with a score below 13 indicated they required a WanderGuard. The DON stated Resident #1 required a WanderGuard due to her cognitive impairment. The DON stated monitoring residents with WanderGuards was done daily and on each shift. The DON stated her expectation for nurses on the floor were to physically check to ensure the WanderGuard bracelets were on the residents' left ankle, document the check, and check off the MAR that the monitoring was done. The DON stated the nursing staff were responsible for ensuring the band was intact, the resident was safe, and making sure the band was working. The DON stated not completing the monitoring placed residents at risk of exiting the building, placing residents at risk of not being able to return to the building, and possible harm or injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/25/24 at 4:26 PM with the Administrator revealed WanderGuards were in place with all residents in the facility with BIMS score less than 13. The Administrator stated there were procedures in place to add more security measures against residents being able to exit the building unattended. The Administrator stated elevators were secured by the WanderGuards if residents came within so many feet of the elevator doors the elevator would shut down and a code was required to activate the elevators. The Administrator stated he was not aware Resident #1 did not have a WanderGuard on. He stated some residents would cut them off. He stated if she was to somehow enter the elevator without it, she would be able to exit the floor, if not being monitored by staff. The Administrator stated he expected all residents, who required WanderGuards, to have them on at all times. and the nursing staff were supposed to monitor this daily on each shift. The Administrator stated he would reevaluate the risk at a later time; however, getting out of the building unattended and without staff acknowledgment, could place resident at risk of harm, danger, and not being able to return to the facility if lost. Record review of the facility's Elopements and Wandering Residents policy, dated 11/21/22, reflected: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Facility may be equipped with door locks/alarms to help avoid elopements. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness sand modifying interventions when necessary. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 (Resident #3) of 5 residents reviewed for clinical records. The facility failed to ensure staff accurately documented on Resident #3's April 2024 Skilled Administration Record that she was being monitored for her behaviors. This failure could affect residents and place them at risk of inaccurate or incomplete clinical records. Findings included: Review of Resident #3's admission record, dated 04/25/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included dementia (the loss of cognitive functioning that interferes with daily life and activities). Review of Resident #3's quarterly MDS assessment, dated 02/20/24, revealed she had a BIMS score of 05 indicating severe cognitive impairment. Further review revealed Resident #3 had physical behaviors towards others that occurred for 1 to 3 days. Review of Resident #3's care plan, revised on 02/05/24, reflected the following: Problem: Resident seeks out male resident with intention of inappropriate/ sexual touch .Interventions: Monitor behavior episodes . Document behavior and potential causes. [sic] Review of Resident #3's physician's orders, dated 04/25/24, reflected the following: Monitor resident q shift for inappropriate behavior towards staff and other residents. Indicate how many times this behavior occurs. Every shift for Behavior monitoring with a start date of 02/05/24. Review of Resident #3's Skilled Administration Record for April 2024 reflected the following dates had no entries: 04/02/24, 04/03/24, 04/04/24, 04/05/24, 04/10/24, 04/17/24, 04/18/24, 04/19/24, and 04/24/24 for the day shift. Observation and attempted interview on 04/25/24 at 9:30 AM with Resident #3 revealed she was in the living room area of the facility with multiple other residents. Resident #3 was sitting in her wheelchair at a table and was dressed and groomed. Interview on 04/25/24 at 12:43 PM with LVN W revealed she was caring for Resident #3 and monitored her for behaviors in the (electronic health record system) and through progress notes. LVN W said she was responsible for documenting any behaviors that occurred during her shift on the resident's MAR/TAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/25/24 at 4:54 PM with the Interim DON revealed she had been completing chart audits and found a lot of holes in the residents' MARs/TARs. The Interim DON said it was the responsibility of the nurse on duty to chart during their shift on a residents' MAR/TAR for behavior monitoring. The Interim DON said the purpose of this was because it was a legal document and to ensure that staff were monitoring for what they were supposed to be. The Interim DON said the risk for not documenting was that something could be happening, and it was not being documented . Review of the facility's Documentation in the Medical Record policy, dated 10/24/22, reflected: .1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred