

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Fort Worth Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</b></p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections based on the resident's comprehensive assessment for 2 of 3 residents (Residents #1 and #2) reviewed for urine incontinence/catheters.</p> <p>The facility failed to ensure Resident #1 and Resident #2's catheter urine collection bags were kept off the floor and failed to ensure the collection bags had privacy covers.</p> <p>This failure could place residents with catheters at risk for a loss of dignity, decreased self-worth and decreased self-esteem.</p> <p>Findings included:</p> <p>1. Review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident #1's admission MDS assessment, dated 04/22/24, reflected the resident had moderate cognitive impairment with a BIMS score of 11. The resident had an indwelling catheter and required substantial/maximum assistance with toileting. Resident #1's diagnoses included renal insufficiency, end stage renal disease (kidney failure); obstructive uropathy, heart failure, hypertension (high blood pressure), depression, and diabetes (a disease that affects how the body uses glucose).</p> <p>Review of Resident #1's current, undated care plan reflected the resident had a Foley catheter due to obstructive uropathy. The care plan reflected: Goals .resident will be/remain free from catheter-related trauma .Interventions Catheter: The resident has 16 fr 30cc foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.</p> <p>Review of Resident #1's order summary report reflected the following orders:</p> <ul style="list-style-type: none"> <li>- Check Foley catheter every shift Use leg strap to secure Foley in place</li> <li>- Foley Catheter: Irrigate foley catheter with water as needed</li> <li>- Foley Catheter: Change 16 F[[NAME]] with 10 ml bulb as needed for PRN plugged or out</li> </ul> <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Fort Worth Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #2's undated Admission Record reflected the resident was a [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident #2's MDS assessment, dated 04/20/24, reflected the resident had severe cognitive impairment with a BIMS score was 7, and she required extensive assistance with toileting by one person. Resident #2's diagnoses included multiple sclerosis (an autoimmune condition that affects the central nervous system) and diabetes.</p> <p>Review of Resident #2's current, undate care plan reflected the resident had a suprapubic catheter related to neurogenic bladder. The care plan reflected: Goal .The resident will be/remain free from catheter-related trauma .Interventions .Catheter: The resident has 16 fr 10 ml supra pubic catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for signs and symptoms UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in RN behavior, change in eating patterns.</p> <p>Review of Resident #2's order summary report reflected the following cathether orders:</p> <p>12/21/21 - Irrigate Suprapubic Catheter as needed for leakage order;</p> <p>12/21/21 - Irrigate Suprapubic Catheter every shift for leakage order;</p> <p>11/17/22 - Location Suprapubic site, please monitor site for any urine drainage. Please consider GU referral if drainage continues or increases. Every shift for Suprapubic catheter order; and</p> <p>05/27/21 - Suprapubic catheter every shift for placement May use leg strap to secure Foley in place order.</p> <p>Observation and interview on 06/26/24 at 12:38 PM revealed Resident #1 was in his room, lying across his bed. The resident had a catheter in place, and the catheter bag was on the floor at the foot of the bed without a a privacy bag covering the urine collection bag. Resident #1 stated he went to dialysis the day before and could not recall if he had a bag to cover the catheter. Resident #1 stated he would like to ensure his bag was covered because he just had a urinary tract infection and did not like to drink water. Resident #1 stated he would not like to have his urine exposed.</p> <p>Observation on 06/26/24 at 12:40 PM revealed CNA A entered Resident #1's room to deliver the resident's lunch tray. She positioned the tray on the bedside table. CNA A positioned the table to ensure she did not touch the catheter bag, which was on the floor. CNA A did not handle Resident #1's catheter bag, and it remained on the floor.</p> <p>Observation and interview on 06/26/24 at 12:45PM with LVN B revealed Resident #1's catheter bag was on the floor, and it did not have a privacy bag. LVN B stated Resident #1 should have had a privacy bag present since he went to dialysis on 06/25/24. LVN B stated Resident #1 moved around his bed a lot, and the bag could have fallen the floor while he was repositioning.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Fort Worth Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/26/24 at 1:21 PM with CNA A revealed she was new to the floor and working with Resident #1. CNA A stated she was still in the process of learning each resident. CNA A stated she was aware Resident #1 had a catheter. She stated she did not pay attention to the catheter bag being on the floor or that it was uncovered. CNA A stated she was responsible for ensuring the catheter bag was covered and off the floor at all times. CNA A stated having the bag left uncovered would place this resident at risk of being embarrassed of the urine showing. CNA A stated catheter bags should not be on the floor because it placed this resident at risk of infection.</p> <p>Observation and interview on 06/26/24 at 1:35 PM revealed Resident #2's catheter bag was full, on the floor, and was not covered. Resident #2 stated she did not know the bag was on the floor. She would like staff to come and empty it more often because it sometimes got full. She stated she felt like it was backing up. Resident #2 stated there were no concerns or complications with her catheter use at this time.</p> <p>Interview on 06/26/24 at 1:45 PM with CNA C revealed he had worked with both Resident #1 and Resident #2. CNA C stated Resident #1 got restless and would move around his bed a lot causing the catheter to fall on the floor. CNA C stated he emptied Resident #2's catheter bag usually 2-3 times throughout the shift, but today he had only emptied it once. CNA C stated perhaps when the resident repositioned herself, the catheter bag fell to the floor, and the privacy bag came off. CNA C stated he was responsible for ensuring privacy bags were on all catheters and ensuring the catheters were properly hanging at the lower end of the bed. CNA C stated the privacy bags were used to provide privacy and dignity, if bags were on the floor, it placed residents at risk of infection control or leakage.</p> <p>Interview on 06/26/24 at 1:50 PM with LVN B revealed her expectation was for the aides working on the floor to ensure the catheters were hanging properly, covered with a privacy bag, and not facing the door. LVN B stated aides were able to place a privacy bag to provide privacy and a sense of dignity for the resident. LVN B stated it was the responsibility of the nursing staff to ensure privacy bags were placed over catheter bags. LVN B stated the aide should have alerted her that the catheter was on the floor and not doing so placed Resident #1 at risk of infection.</p> <p>Interview on 06/26/24 at 5:30 PM with DON revealed she was notified by the ADON that Resident #1's catheter was found without a privacy bag and was on the floor. The DON stated all catheter bags were to be covered with a privacy bag to protect resident privacy and dignity. The DON stated the ADON revealed she just rounded the room, and the bag was hanging at bedside. The DON stated Resident #1 had a history of constantly moving about the bed, and this could have caused the bag to fall on the floor. The DON stated she was unaware Resident #2's bag was on the floor and did not have a privacy bag. The DON stated her expectation was for all nursing staff to ensure catheter bags were covered and hanging properly to allow the fluid to drain properly and prevent possible infection and leaking.</p> <p>Record review of the s current, undated Admissions policy reflected:</p> <p>You have the right to be:</p> <p>.all care necessary for you to have the highest possible level of health.</p> <p>.safe, decent and clean conditions.</p> <p>.privacy</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/26/2024
NAME OF PROVIDER OR SUPPLIER  Fort Worth Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was asked to provide a policy regarding indwelling Foley catheter care, and the Administrator stated they did not have a policy.</p>