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	08/16/2024

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility for one resident (Resident #1) of six residents reviewed for discharge planning. SW A and MDS Nurse B failed to ensure Resident #1 filed her NOMNC appeal by 08/10/24 to continue to stay at the facility. SW A and MDS Nurse B failed to ensure Resident #1 was given the second option to appeal to her Medicare Health plan, before she discharged [DATE]. SW A failed to follow-up with the DME Provider on 08/14/24 to give them additional documents needed to process the delivery of Resident #1's wheelchair. SW A failed to ensure Resident #1's correct address was given to the Home Health Care provider to ensure they could provide services to the town she lived in. These failures could place residents at risk of being discharged home too soon and not having the appropriate healthcare services to meet their needs which could result in falls, skin breakdown, dehydration and hunger and cause a decline in their health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female who admitted [DATE] with a BIMS score of 13, indicating she was cognitively intact. The MDS reflected Resident #1 had lower extremity weakness and used a wheelchair and Dependent: Helper does all of the effort and resident does none - for Toileting, lower body dressing, and putting and taking off footwear. She was always incontinent of bladder and bowel with active diagnoses: Fractures with multiple other trauma. She had hypertension, diabetes, thyroid disorder, other fracture and anxiety disorder, unspecified lower left femur (leg) fracture, morbid obesity, lack of coordination, muscle wasting and atrophy, unsteadiness on feet. She received routine pain management with occasional pain frequency. She had surgical procedures: Other orthopedic surgery-repair fractures of leg. She was 5'3 and 226 pounds. (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

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 08/16/2024
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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's SW Progress Note dated 08/06/24 10:05 AM written by SW A reflected: LATE ENTRY: Social services followed up with patient to confirm if patient requesting early d/c. Patient stated, I know I will have to go home eventually. Patient reported not wishing to d/c early. Interdisciplinary team informed. Record review of Resident #1's undated NOMNC reflected: Effective date coverage of your current skilled nursing services will end: 08/11/24 .How to ask for an immediate appeal: your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above .If you miss the deadline to request immediate appeal, you may have other appeal rights .If you belong to a Medicare health plan call the # below. Signed by Resident #1 and MDS B On 08/08/24. Record review of Resident #1's SW Progress note dated 08/12/24 at 10:15 AM written by SW A reflected: SW reviewed d/c with patient. Patient verbalized wishing to remain pvt pay at facility through Monday, 8/19. SW referred patient to BOM & ABOM to discuss payment plan and price. Patient verbalized understanding. Interdisciplinary team informed. Record review of Resident #1's SW Progress note dated 08/13/24 at 3:20 PM written by SW D reflected: The patient has informed us that she is scheduled to be discharged and sent home on August 14, 2024. Transportation for her departure has been arranged for between 10 and 11 am. She has stated that she plans to notify her family about her discharge by sending a group text. Additionally, durable medical equipment (DME) has been ordered, and all necessary discharge orders have been signed. Record review of an email addressed to MDS B dated 08/13/24 at 5:01 PM sent by the Skilled Inpatient Care Coordinator reflected: I got the determination for Resident #1. The Appeals office advised to have her appeal with the health plan directly. Do you know if she's done that? Her last covered date was 08/11/24, so she is currently in a private pay status unless her health plan appeal wins. Thanks Record review of Resident #1's Nurse Progress dated 08/14/24 at 9:49 AM written by RN C reflected: Resident is discharge from the facility via wheelchair with transportation person. Resident Skin assessment was done by the time of discharge skin looks intact. All paperworks [sic] were signed by Resident and medication and medication list were given to Resident. Review of Resident #1's SW Progress note dated 08/14/24 at 2:28 PM reflected: SW, MDS, Administrator followed up with APS for follow up on previous call from APS caseworker. APS reviewed notes from report made. Social Services and Administrator reviewed resources provided by facility and conversations had with patient and family. APS inquired as to process when insurance provided d/c date. MDS brought in to provide information on insurance process. APS inquired as to BIMS score. APS inquired as to Home Heath and DME companies. Information provided. APS stated she will follow up with the Home Health to provide CNA Staff. Record review of Resident #1's SW Progress note dated 08/14/2024 at 3:59 PM written by SW A reflected: PCP Follow up: follow up not available until November 26 with NP. PCP office will contact patient to explain protocol. Social services will collaborate with HHA to send out NP. (continued on next page)

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

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Occupational Discharge on 08/14/24 written by OT E reflected: Discharge Recommendations: 24-hour care at this time, Home exercise program, Home health services. DME recommendations include w/c with removable armrests, drop-arm 3-in-1 commode, sliding board, hospital bed, reacher, sock aid. Record review of Resident #1's Physical Therapy Discharge on 08/14/24 written by PT F reflected: Prognosis: to Maintain CLOF (Current Level of Functioning) = NIA (Patient lives at home and should not be without assistance in the home) Discharge Recommendations: Patient should be with family or friends in home setting with follow up Home health. Record review of Resident #1's Care Plan, printed on 08/16/24, reflected there were care plans addressing the following: bladder incontinence, moderate risk for falls related to deconditioning, on anticoagulant therapy related to post surgical, bowel incontinence, limited physical mobility related to being non-weight bearing to left lower extremity, ADL self-care performance deficit related to recent hospitalization for motor vehicle collision fracture of lower left extremity. Record review of Resident #1's August 2024 MAR printed on 08/16/24 reflected the resident had orders for Lisinopril 20 mg (used to treat high blood pressure and heart failure), Metoprolol ER 25 mg (used to treat high blood pressure, chest pain, heart failure), Quetiapine Fumarate 25 mg (used to treat schizophrenia, acute manic episodes), sertraline 25 mg (used to treat depression and PTSD), gabapentin 600 mg (used to treat nerve pain), Acetaminophen extra strength 500 mg (used to treat pain), lower left extremity - non weight bearing until 08/18/24, then weight bear as tolerated until 09/01/24, Hydrocodone 5-325 mg (PRN) (used to treat pain) and tramadol 50 (PRN) (used to treat pain). (continued on next page)

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F 0624

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 08/16/24 at 12:34 PM, the APS Worker stated the nursing facility told her Resident #1 returned home a few days ago because her health insurance no longer covered her stay at the nursing facility. She stated Resident #1 did an appeal to stay at the facility that was approved, but the second appeal was not filed in time, so it was denied. She stated they did not arrange Resident #1's home health appropriately. There was no DME at the resident's house, and the resident was just sitting in her house, not able to move or go to the bathroom. She stated the Medical Transporter did not leave the wheelchair, and the resident was by herself. She stated SW A said he set up her home health with therapy services but not for a CNA for ADL care. The APS Worker stated she spoke to FM B, and he said the home health had not come out yet, so Resident #1's Orthopedic Surgeon made arrangements for her to admit to the Hospital because she needed to go back to a healthcare center until her leg healed. She stated FM G said he could not toilet or provide incontinence care for Resident #1. She stated FM G said he went to the store on 08/14/24 while getting incontinence briefs for Resident #1 and asked a lady if she could go to change Resident #1's incontinence brief. She stated FM G said they waited for home health and for someone to drop off her DME on 08/14/24 but no one called or showed up, so FM said he had Resident #1 taken to the hospital. The APS Worker stated she had a conference call with the facility's Administrator and SW A, and she told them she could not understand what documentation was sent to the resident's health insurance provider because the resident could not bear weight. She stated telling the Administrator and SW they did not do enough to ensure Resident #1 did not miss the deadline to appeal her NOMNC. She stated Resident #1's discharge planning was not done right. She stated Resident #1 was at the facility for four weeks, and SW A said he was not sure if she was Medicaid Pending. The APS Worker stated the resident had family members she had not spoken to in about two years, and there was a lot of family dynamics. She stated they were trying to get Resident #1 a wheelchair from her PCP and trying to assist the FM with next steps to ensure Resident #1 was safe. She stated it was this nursing facility's job to set up her discharge planning and to make sure everything was followed through on.

Interview on 08/16/24 at 2:03 PM, the Hospital SW stated Resident #1 was admitted to the hospital yesterday 08/15/24 because she was discharged home and had leg pain, but no severe pain. She stated the resident had two family members who needed assistance with the care of Resident #1. She stated the Hospital Doctor was recommending the resident go back to a skilled nursing facility, and the resident was currently pending placement. She stated Resident #1 was out of rehab skilled nursing home days with her insurance and would have to admit as a Medicaid Pending or Private Pay resident. She stated the nursing facility who discharged her home had made it very difficult for Resident #1 because she was not able to do much for herself.

Interview on 08/16/24 at 2:40 PM, MDS B stated Resident #1's Orthopedic Doctor said she was non-weight bearing and was getting skilled nursing services. She stated once Resident #1 was told she would have to private pay she was understandably upset after giving her the NOMNC on 08/08/24. She stated she tried to give her options and tried to get her family involved, but it did not seem they were willing or able to assist. She stated the second NOMNC was given to Resident #1 on 08/08/24. The resident was told she had to appeal by 08/10/24, which was a Saturday. She stated she spoke to Resident #1 Monday 08/11/24, and the resident said she had not appealed by that time. She stated she assisted with appealing the second NOMNC to her Medicare plan and sent 72 hours of her medical and therapy records on 08/14/24, but the resident had discharged by then. She stated Resident #1's biggest hurdle was she was non-weight bearing on one leg, and they typically liked the residents to be weight bearing before discharging home. She stated Resident #1 wore a leg stabilizer similar to an immobilizer from her heel to knee because she had a femur fracture.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/24 at 3:22 PM, SW A stated Resident #1 was a 20-day stay resident with a very challenging situation. He stated the resident lived alone and had no family support. He stated the resident signed the NOMNC that she appealed and won. She then received another NOMNC on 08/08/24 by the MDS Coordinator. He stated the MDS Coordinator told the resident she had the right to appeal and had until 12:00 PM on 08/09/24 to appeal. He stated he reminded Resident #1 she needed to call the appeal number, and she said okay. He stated FM G told the Administrator he was unable to transport Resident #1 home and Resident #1 said she would talk to FM G about returning home and about her discharge date . He stated since Resident #1's family was not willing to drive her home he gave Resident #1 the contact information to call an outside Transport Provider on 08/12/24. He stated she asked if she could private pay until 08/19/24, and then the BOM spoke to her about private pay options. He stated she was stable, non-weight bearing, and her cognition was good when she discharge. He stated the resident had a BIMS score of 15 before she discharged , and her understanding was good whenever he spoke to her. He stated he was able to get home health set up with the Home Health Provider and DME. He stated he called in an APS referral for her safety and order for a wheelchair from the first DME Provider with removable arm rests and order for a sliding board from a second DME Provider. He stated he informed Resident #1 before she left the DME and Home Health providers were trying to reach her, and her response was okay. He stated he requested speedy delivery of the home health and DME and at this time he was not sure if she received the DME and home healthcare. He stated he had no discussion with her family about Resident #1's discharge information because Resident #1 called the transport company herself, and she discharged on [DATE]. Interview on 08/16/24 at 3:58 PM, the DOR stated Resident #1 was in a motor vehicle accident two months ago. He stated she discharged home on 08/14/24 and stated her bed mobility was contact with guard assistance, and she was not able to walk. He stated she was not able to bear weight on her leg, needed toileting assistance, and needed maximum assistance with showers. He stated she was able to move around in her wheelchair independently. He stated FM G was not involved in her care or discharge planning. He stated for home Resident #1 needed a wheelchair and other items in order to be safe. He stated she was getting physical therapy and occupational therapy at this facility, and her cognition was okay with them. He stated she was a nice lady and wished she could have stayed longer because they did not feel she had a safe discharge, but her health insurance denied her for an extended stay. Interview on 08/16/24 at 4:16 PM, the DME provider stated she needed more of Resident #1's documentation to get her wheelchair and tried to reach out to Resident #1 on 08/12/24 and 08/14/24. She stated she left a message for SW A on 08/14/24 to send more documentation, but he had not returned her call. Attempted interview on 08/16/24 at 4:30 PM revealed the phone number for the Home Health Provider was a disconnected phone number. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/24 at 4:59 PM, FM G stated Resident #1 got a room at the hospital because they were trying to figure out what rehabilitation center she would go to. He stated they had to take her to the hospital yesterday 08/15/24 to get her back to a rehabilitation facility. He stated this nursing facility put Resident #1 in a bad situation, and no one told him she would discharge on 08/14/24. He stated he spoke to the Administrator and was told her health insurance stopped paying for her stay. He stated he found out about her second appeal to stay too late and was told she would have to private pay. He stated he told the facility they could not afford to pay the co-insurance, then was told she had to go home. He stated he went to her home to help get her situated. When he got there, he saw she was already at her home, sitting on the sofa. He stated she could not do much for herself. He stated the transportation driver wheeled her in and took the wheelchair away. FM G stated what if fire happened, she would have burned because she was sitting in the corner on her love seat. He stated they got to Resident #1's house approximately an hour and half after she got home and went to get her some food and luckily, they had a key to unlock her door. He stated Resident #1 was soaking wet, and he went to get her some incontinence briefs. He stated he got a stranger from the store go to change Resident #1. The next day on 08/15/24 there still was no home health or DME, and her bed was soaking wet. He stated he then was able to get her transferred to the hospital yesterday on 08/15/24. He stated he was pissed off about this, because Resident #1 had no home health or wheelchair. He stated this nursing facility had his phone number, and SW A said he was working on getting Resident #1 DME. He stated this nursing facility said she was a private pay resident then found out last Monday 08/11/24 it was too late to appeal. He stated she had a compound fracture of her leg and ankle and had surgery to put 6/8 inches of steel into her bone. He stated the amount of problems with not having Resident #1's discharge planning done properly was not good. Interview on 08/16/24 at 5:49 PM, the DON stated Resident #1 was in a MVA and she admitted to this nursing facility for skilled therapy, and her motivation was not extremely good. She stated the resident propelled in a wheelchair with staff assistance, and the resident made comments about returning home, but she and her family were not on the same page with that. She stated Resident #1's first NOMNC was appealed, and she won. The resident then she received another NOMNC last Friday 08/09/24, and she chose not to appeal it. The DON stated she did not think the resident shared that information with her family. She stated on Monday 08/12/24, Resident #1 changed her mind and wanted to appeal, but it was denied because it was too late. She stated they knew she was not safe to return home and that was why they called APS and spoke to Resident #1's caseworker about assisting with her needs. She stated Resident #1 discharged on [DATE], and the next day she was sent to the hospital. She spoke to APS who said they were expediting her home health, and she was not sure if the resident received her wheelchair and sliding board yet. She stated Resident #1 was sent to the hospital ER, and she wanted to re-admit back to this nursing facility. The DON stated they told the hospital if her insurance approved her to come back, she could re-admit. She stated the Hospital Doctor stated there was no medical reason to keep Resident #1 there. She stated the problem was that Resident #1 had family members not willing to provide support and her insurance ran out. The DON stated the resident did not meet LTC medical necessity to apply for Nursing Home Medicaid. She stated Resident #1 was not Medicaid Pending, and they had not tried to send her to another facility. She stated Resident #1 needed one person assistance for transfers and showers and ate independently. She stated the resident had Steri strips (skin closure strips) on her leg and ankle. She stated she could not speculate on what could happen to a resident if they discharged home without home health and DME. She stated they could not go against the resident's rights and hold her captive. She stated the resident was stable and called to arrange her own transport home. She stated Resident #1's cognition was fully intact with a BIMS of 14. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/24 at 6:10 PM, SW A stated he did not know the phone number for Resident #1's Home Health Agency and would provide it shortly. SW A then gave the HHSC Surveyor the correct contact number. Interview on 08/16/24 at 6:15 PM, the Home Health Representative stated they accepted Resident #1's insurance and were scheduled to visit her on Monday 08/19/24. He stated they were set to provide her occupational and physical therapy. He stated there was an error with her address because they did not provide services for Resident #1's out of town address. He stated he thought she lived locally and would not be able to visit her Monday 08/19/24. He stated he would check around to see who covered that area. Interview on 08/16/24 at 6:20 PM, SW A stated he had not received any messages from the DME Provider about any additional items needed to get Resident #1's wheelchair. He stated he did not know the phone number for the Home Health Agency was wrong and that Resident #1's home health was set up through his referral representative. He stated he was going to advocate to get Resident #1 the discharge resources, DME, and home health services she needed. He stated he was aware she was in the house without a wheelchair and was not sure why she could not use their wheelchair until she was able to get her own. He stated he confirmed Resident #1 had an out-of-town address with the Home Health Representative, but the Home Health Representative covered multiple home health agencies. He stated he was not sure why it showed she had a local address. He stated not having resident's home health and DME confirmed before they discharged from the nursing facility could cause them to be a fall risk, a safety risk especially for someone non-weight bearing. He stated discharge planning was a team effort, but he was responsible for ensuring the resident's discharge was coordinated properly. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/16/24 at 6:47 PM, the Administrator stated FM G was told on 08/12/24 that Resident #1's insurance ended her coverage of stay, and she had the options to private pay but her NOMNC appeal was denied. He stated FM G asked what if they could keep her at facility to see if they could reverse the decision. He stated FM G said he was not aware of the second NOMNC, and the resident could not go home because he could not take care of her. The Administrator stated Resident #1 must have told FM G about the first NOMNC but not the second one. The Administrator stated he told FM G they could not force the resident to stay at the facility, then FM G said he would not pick up Resident #1. The Administrator stated Resident #1 called her insurance company to arrange her pick-up to return home and did not think FM G knew she discharged home 08/14/24 at 10:00 AM. The Administrator stated FM G was told that APS was called to get the resident some extra help with extra resources and help with expediting home health. The Administrator stated the hospital called about Resident #1 being at the hospitalER on [DATE] because she was discharged unsafely and wanted to see if she could be readmitted back to facility. The Administrator stated the hospital was told they would have to get authorization from her insurance company to re-admit or Resident #1 would have to pay $249.00 per day. The Administrator stated he did not think she would qualify for Medicaid and stated he did not know what else they could have done to assist her. The Administrator stated he was not aware SW A received a message from the DME Provider about more documents being needed to deliver Resident #1's wheelchair. The Administrator stated SW A confirmed the Home Health was coming out, but it usually took 24 to 48 hours for them to come out, and that was why they got APS involved. The Administrator stated he was not aware the Home Health had the wrong address for Resident #1 and could not provide her services. The Administrator stated he was not aware she was at home without assistance and had a soaking wet brief that FM G would not change. The Administrator stated they provided as much assistance as they could. He stated at what point did Resident #1's her family members have accountability because they chose not to do anything to help Resident #1. He stated SW A was responsible for arranging discharge planning of the residents, and his expectation was for the SW to provide whatever resources given to the resident were received, such as DME and Home Health services. Record review of the Facility's Discharge Planning policy, dated 10/24/22, reflected the following: Policy: It is the policy of this facility to ensure that a discharge planning process is in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies. Definitions: Discharge planning is a process that generally begins on admission and involves identifying each resident's goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure successful discharge. Local Contact Agency refers to each State's designated community contact agencies that can provide individuals with information about community living options and available supports and (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services. For discharge. .2. The Discharge Plan should include: .b. During the initial Social History and Assessment, the social service designee should determine the resident and family's goals for discharge and the support systems available to the resident. .d. To ensure the needs of the resident will be met after discharge from the facility, the social service designee should identify and arrange for post-discharge needs such as nursing and therapy services, medical equipment for discharge home or to an alternate care setting. e. Referrals to local contact agencies, the local ombudsman or other appropriate entities; f. Documentation of the referrals and response to the referrals; g. Re-evaluation regularly and be updated when the resident's needs or goals change.