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Form Approved OMB
No. 0938-0391

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	10/30/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 6 residents (Resident #3) reviewed for enteral nutrition. 1. The facility failed to ensure Resident #3's head was elevated while his tube feeding was infusing. 2. The facility failed to date and time when Resident #3's bottle of liquid nutrition was hung. These failures could place residents at risk of aspiration (inhaling stomach contents into the lungs) and receiving nutrition fluid that is expired. Findings included: Record review of Resident #3's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included brain tumor, paralysis, esophageal disorders requiring a feeding tube, and muscle wasting. Record review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score not calculated due to the resident's medical conditions. His Functional Status assessment indicated he required full assistance of staff for all of his ADLs. The resident was unable to swallow, all nutrition was provided via a feeding tube. Record review of Resident #3's care plan, dated [DATE], indicated he had a self-care deficit, had impaired cognitive function, and required a feeding tube with interventions of keeping the head of the bed elevated to 45 degrees during the feeding. Observation on [DATE] at 2:20 PM revealed Resident #3 was lying on his back with the head of the bed flat. The resident's tube feeding was infusing at 55 ml per hour. The bottle of liquid nutrition was not dated or timed as to when it was hung. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:24 PM with LVN D revealed all residents with tube feedings infusing should have the head of their beds elevated at least 30 degrees while it was infusing. He also stated the bottle had to be dated and timed when it was hung so that staff knew when it was due to be changed. Interview on [DATE] at 5:05 PM with the DON revealed residents receiving tube feedings should have the head of the bed elevated at least 35 degrees to prevent aspiration. The bottle had to be labeled with time, date, rate, and name so that staff knew when to change out the bottle. The bottle was only good for 24 hours. Record review of the facility's Enteral Tube Medication Administration policy, dated [DATE], reflected: The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Record review of the Journal of Parenteral and Enteral Nutrition article ASPEN Safe Practices for Enteral Nutrition Therapy Volume 41 Number 1, [DATE], page ,d+[DATE] reflected the following: .What are the essential steps in EN administration to prevent aspiration? Practice Recommendations 1. Maintain elevation of the HOB to at least 30 [degrees] or upright in a chair, unless contraindicated . 2. Monitor the patient at least every 4 hours for appropriate positioning

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F 0694

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide for the safe, appropriate administration of IV fluids for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42859

Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 2 residents (Resident #1) reviewed for intravenous medications.

1. The facility failed to ensure the dressing on Resident #1's PICC line (used to deliver medications and other treatments directly to the large central veins near heart) was changed timely. Resident #1 went without a dressing change for 10 days.

2. The facility failed to have orders for PICC line dressing changes and flushes.

The failures could affect residents by placing them at risk for infections and cross-contamination.

Findings included:

Record review of Resident #1's entry MDS assessment, dated 10/22/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident had diagnoses which included: other acute osteomyelitis, right tibia, and fibula, (a bone infection of the two long bones located in the lower leg that develops quickly, usually within two weeks of the initial onset of symptoms) and methicillin resistant staphylococcus aureus (a staph bacteria that can cause serious infections and is resistant to many antibiotics). Resident #1 had intact cognition with a BIMS score of 15. He had intravenous access.

Record review of Resident #1's physician's orders dated 10/22/24 reflected: Daptomycin-sodium chloride intravenous solution 500-0.9mg/50ml-% (Daptomycin-Sodium Chloride) Use 1 dose intravenously one time a day related to methicillin resistant staphylococcus aureus infection as the cause of diseases). There were no orders for PICC line dressing changes and flushes.

Record review of Resident #1's Treatment Administration Records dated for October 2024 revealed there was no documentation of any PICC line dressing changes or in the progress notes.

Record review of Resident #1's current care plan initiated 10/25/24 revealed IV medication was addressed with a goal of not having any complications. Interventions included monitoring for signs and symptoms of infection at the insertion site. The care plan did not address PICC line dressing changes.

Observation and interview on 10/30/24 at 11:14 AM revealed Resident #1 was in his room, in his wheelchair. He was observed to have a PICC line dressing with no date on the right side of his chest. The dressing was intact but surface of the dressing was dirty. Resident #1 stated the PICC line dressing was put on at the hospital the facility, and it had not been changed. There were no signs or symptoms of infection noted at the PICC line site.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/30/24 at 4:04 PM with LVN B of Resident #1 revealed the resident had a PICC line in his right upper chest covered with a transparent dressing with no date. LVN B revealed he hung the intravenous medication in the morning. He stated he knew he was supposed to check the date on the dressing. He stated he did not check it, and he missed it. LVN B stated he was aware the dressing was supposed to be changed every 7 days and as needed when dirty. LVN B stated the dressing looked dirty on the surface and should have been changed, but he did not notify the DON or the RN on the floor to perform a dressing change. He checked Resident #1's EHR, and there were no orders for changing the PICC line dressing. He said he had not done training on PICC lines. The insertion site of the PICC line was clean with no signs of infection. Interview on 10/30/24 at 4:35 PM with the DON revealed she expected staff to change PICC dressings every seven days to prevent infection. She stated the admitting nurse was supposed to put the orders on the medication administration record, which was not done, and she was not aware. She stated it was the responsibility of the DON and the ADON to check after the nurses and ensure all orders were in place. She stated she had checked with the ADON in the morning meeting after the resident admitted and was assured the ADON had checked all the orders for new admissions, and they were up-to-date. She stated she had not done training with staff on dressing changes because she had not known there was a problem, but she would be training the ADON and the staff. Telephon interview on 10/30/24 at 6:17 PM with the ADON was attempted with no response. The facility's Administrator was asked to provide the facility's policy on PICC lines on 10/30/24; however, the policy was not provided as requested.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 8 residents (Resident #4) reviewed for infection control. CNA D failed to wear the appropriate PPE while providing care to Resident #4 who was on Enhanced Barrier Precautions. This failure could place residents at risk of being infected by staff in contact with other residents with infections. Findings included: Record review of Resident #4's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included cerebral palsy, seizures, cognitive communication deficit, and difficulty swallowing. Record review of Resident #4's admission MDS, dated [DATE], reflected a BIMS score not calculated due to the resident's medical conditions. His Functional Status assessment reflected he required the total assistance of staff for all of his ADLs. Record review of Resident #4's care plan, dated 09/11/24, reflected he had an ADL self-care deficit, a communication problem, and required a feeding tube. Observation on 10/28/24 at 2:10 PM revealed CNA D was providing incontinence care for Resident #4 wearing only gloves. A posting on the door of Resident #4's room indicated the resident was on Enhanced Barrier Precautions requiring staff to wear a gown and gloves when providing high contact care for the resident. Interview on 10/28/24 at 2:14 PM with CNA E revealed Resident #4 was not on Enhanced Barrier Precautions. CNA E verified Resident #4 had a urinary catheter, a wound to his hip, and a feeding tube. CNA E reviewed the posting and stated she just did not read the posting before providing care. CNA E stated this was not the first time she had provided care for Resident #4. She stated Enhanced Barrier Precautions were to prevent spreading infection from resident-to-resident, and she had been in-serviced on infection control recently. Interview on 10/28/24 at 2:35 PM with the ADON revealed residents on Enhanced Barrier Precautions required a gown and gloves with all care. PPE was stored in the central supply closet and staff knew where to get it. She stated the risk of not wearing PPE was infecting the resident through their wound, catheter, et cetera. Interview on 10/28/24 at 5:05 PM with the DON revealed staff were required to wear the appropriate PPE for the level of isolation the resident was on. Residents on Enhanced Barrier Precautions required staff to wear a gown and gloves before providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Enhanced Barrier Precautions policy, dated 04/05/24, reflected: An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds, indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO.