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	04/11/2025

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of its residents and failed to be responsible for the quality and timeliness of the services for one (Resident #1) of five residents reviewed for laboratory services. The facility failed to complete Resident #1's lab order for a urinalysis with C&S (a diagnostic test that involves analyzing a urine sample to detect and identify potential infections and determine their susceptibility to antibiotics) as ordered by the physician. The failure could place residents at risk for delays in the provision of treatment for laboratory abnormalities and acute exacerbation of clinical conditions. Findings included: Record review of Resident #1's Face Sheet dated 03/27/25 revealed the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] from an acute stay at the hospital. Resident #1's diagnosis included a fracture of the left femur (upper leg bone), orthopedic aftercare following surgical amputation, dysphagia (difficulty swallowing foods or liquids), cirrhosis of liver (late-stage liver disease where healthy liver tissue is replaced by scar tissue, hindering the liver's ability to function properly), gangrene (a condition where tissue dies due to a lack of blood supply), peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain), repeated falls, hypertension (a condition where the force of blood pushing against the artery walls is consistently too high), sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage), atrial fibrillation (irregular heart rhythm) and urinary tract infection (an infection of the urinary system, which includes the kidneys, ureters, bladder, and urethra). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 09, which indicated moderately impaired cognition and a mood score of 13 with negative mood issues of fatigue, depression, difficulty concentrating and issues with sleep. Resident #1 had no signs of psychosis, delirium or behaviors that affected his care. Resident #1 had range of motion impairment on one side of his lower extremities and used a walker and wheelchair for mobility. Resident #1 was always incontinent of bowel and bladder and required staff assistance for all his ADLs. Resident #1 had six unstageable pressure ulcers and one deep tissue injury. All skin issues were present upon admission to the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan initiated on 02/10/25 reflected, Problem: Resident has dehydration or potential fluid deficit r/t diuretic use; Goal: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor; Interventions: Administer medications as ordered, Monitor/document for side effects and effectiveness, Monitor/document/report PRN any s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record review of a progress note written by the NP dated 03/16/25 reflected that on 03/14/25, Resident #1 had complained of a sore throat, no fever or shortness of breath and he tested negative for COVID. He was started on throat lozenges as needed and Claritin 10 mg po. On 03/16/25, the NP documented the facility nurse reported that per family, Resident #1 was confused the nurse was not able to collect UA. During the visit, the NP stated Resident #1 was observed to be in bed not in distress and answered questions appropriately, denied pain, and had no complaints of health issues. The NP documented there were no new concerns voiced by nursing staff. His vitals were reviewed and a physical exam completed with no new concerns. Record review of Resident #1's nursing progress notes reflected the following: - 03/16/25 6:09 PM [written by RN A]: Resident family request to check his UA C&S. They feel he seems confusion [sic]. NP made aware. - 03/25/25 7:58 PM [written by RN A]: Family member called EMS to transport pt to the hospital because they thought he seemed more confused. Nurse attempted to give EMS face sheet and order summary, but they declined stating that they already had the information. Record review of Resident #1's physician orders reflected: -03/16/25 reflected an order for, Urinalysis reflex***Sent to lab 3/16/25 6:08 PM Verbal CT***one time only related to urinary tract infection [status reflected completed]. -03/25/25 reflected an order for, Urinalysis to C/S if indicated***Sent to lab 3/25/25 7:14 PM CT***one time only related to urinary tract infection [status reflected completed]. Review of Resident #1's clinical chart from 03/16/25 through 03/25/25 revealed no evidence of a lab collection for urine or a lab result for the urinalysis ordered on 03/16/25 or 03/25/25. Record review of Resident #1's hospital records reflected he admitted to the hospital on 03/25/25 for antibiotic therapy, trending of creatine values, IV fluids and monitoring of his neurological statis as well as wound care for a chronic decubitus ulcer on his sacrum. Resident #1 was placed on empiric Cefepime; however, the urinalysis did not show any definite infection. His chest x-ray did not reveal any infiltrates and his urine culture showed no growth. Resident #1's white blood cell count at the time of the hospital admission was 7.3 [reference range value is 4-11]. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with ADON D on 03/27/25 at 1:36 PM revealed it was important to act on a concern that a resident had a UTI to prevent it from worsening. He stated Resident #1 had no changes in his behavior but was transferred to the hospital on 03/25/25 when his family called 911 to have him sent out. ADON D stated he looked at Resident #1's orders on the e-chart and saw there was an order on 03/16/25 for a UA and another on 03/25/25 for a UA, but Resident #1 got sent out before the latter one could be collected. ADON D said the 03/16/25 UA reflected it was not collected on the facility's lab report, but it did not indicate why. ADON D stated he knew when it was first ordered because one of the charge nurses let him know it was difficult to collect Resident #1's urine due to his fluctuating continence. ADON D stated if a resident was retaining urine, a nurse could do a straight cath as long as the resident agreed or use a foley catheter if the resident already had one and do a clean catch. ADON D said the nurse could also use a specimen cup or a urine collection hat if the resident used a urinal or the toilet. ADON D stated, I know the charge nurse would check on him but I guess bad timing. ADON D stated he was not sure which options were used to try and collect urine for Resident #1. He stated RN A was Resident #1's usual daytime nurse and RN B was his usual night nurse. An interview with RN B on 03/27/25 at 2:40 PM revealed from what she could remember, the order for Resident #1's UA came on the night shift when RN A was working and it was passed to the next shift and they were not able to collect it, so then it was passed to her morning/afternoon shift the next day. RN B stated she got Resident #1 a new urinal that morning and told him she needed a urine sample and if he could please press the call light. When Resident #1 pressed the call light, RN B said she went in but he had already urinated in his brief so she could not collect the sample. RN B stated Resident #1 did not use the urinal during her shift and she left around 6:00 PM. When the night nurse arrived, RN B said she told him she could not collect the urine specimen. RN B stated when the nurse cannot collect a urine specimen, they should write a progress note to chart it, and she should have done one but did not. RN B stated if Resident #1 was not allowing the nurses to help him get the urine into his urinal, then she could have told the doctor after so many attempts and then done a straight cath. RN B said Resident #1 would have been a candidate for that, but we didn't' go that route. RN B stated she was not working when Resident #1 was sent out 911 by his family but read the progress note that reflected he was sent out due to family noticing increased confusion. RN B said she last saw Resident #1 on Sunday 03/23/25 and he was acting normal, at his baseline and did not present as confused. She stated Resident #1 usually slept a lot, ate a lot of snacks and normally complains of pain but that day he didn't. RN B said Resident #1 did not present as confused. RN B stated it was important to follow physician orders because if the doctor was asking for it, then they were trying to see if the resident had an infection and it was important to catch it so the resident could heal and the infection did not worsen. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 03/27/25 at 3:05 PM revealed Resident #1's cognition waxed and waned, for example, when he admitted to the facility his BIMS was zero and six days later it was a 13 when he was re-assessed. The DON stated the only thing mentioned by Resident #1's family member was that he was having increased confusion. The DON said she did not see any change other than the normal ups and downs with his mood. The DON stated RN B was a newer nurse to the facility and what she should have done was reach out to the doctor and straight cath Resident #1. The DON stated, That is going to be something she [RN B] has to learn, to reach out and get an order to obtain it. The DON additionally stated, Yes, we should have called the doctor and done a straight cath, I just wound have done it, but these nurses are new and maybe they didn't realize that should be done versus waiting on him to urinate. She stated the facility did complete a CBC and CMP three days before the UA was ordered and all values were towards the bottom of norm, with his white blood cell count being 6.5. The DON said she would have been more concerned if his white blood cell count had been elevated but it was not. The DON stated, I am saying within three days he would not have gotten an infection of a UTI to the extent of showing any change in his vitals and mentation. The DON stated if the specimen had been collected and the UA with C&S completed and showed Resident #1 had a UTI, she would have contacted the physician with the results and placed him on antibiotics based on the culture and sensitivity. The DON stated any labs ordered for residents in the facility were reviewed on a daily basis by the charge nurses who are on the front line and supposed to check on labs throughout their shift. She said there were clinical meetings every day with herself, ADON D, the MDS nurse, social worker, director of rehab and the administrator. During those meetings, the charge nurses came in and presented on their assigned residents where they went over new orders, nursing notes, changes in condition, discharges, admissions and labs. The DON stated with labs, she wanted to know during those meetings which ones were abnormal. When a lab could not be completed, the DON said the charge nurse should document it and bring it up during the daily clinical meetings. She said the nurses could only document on a specimen attempt three times and that was why the nurses placed an order for another UA on 03/25/25 which she did believe they got before Resident #1 was sent out to the hospital. The DON stated Resident #1 was expected to return back to the facility in a few days and the hospital updated the facility that he admitted with a diagnosis of encephalophagy (a medical condition that affects the brain's function, leading to changes in mental state and cognitive abilities) and a preliminary UTI, but they did not have a C&S on it for growth yet. An interview with Resident #1's family member on 04/11/25 at 10:05 AM revealed the concern the family had was during a visit on 03/14/25, he appeared to be talking about random things that did not make sense to his situation and environment. When they came back to visit him a week later, he seemed to be in the same state of mind. Since Resident #1 had a UTI in his past, the family member stated they figured he had one again or was developing one. The family member stated Resident #1 did have intermittent confusion as a baseline, however, they felt his confusion was more pronounced than before. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MD on 04/11/25 at 11:11 AM revealed Resident #1's family had requested a UA because they thought he had some increased confusion. The MD stated according to his NP, the UA request was not pursued because there was no clinical indication it was needed and Resident #1 did not have any signs or symptoms of a UTI and appeared fine. However, because the family was concerned, the MD said an order was written for a UA, but the nurses were not able to obtain a specimen. The MD stated to use a straight cath was not a routine technique and an aggressive procedure that could introduce an infection into his system just trying to get a sample. The MD stated he had reviewed Resident #1's hospital records after the family had him sent out but did not see any indicated he had an infection. The MD stated he did not give an order to get a urine sample via a straight cath as that was not their routine way to handle a urine collection. The MD stated We wanted to wait until we could get one [urine sample] and if we believed from a clinical assessment he was showing signs and symptoms of an infection, especially a UTI, we will get a sample whatever it takes. If the nurses could not get it [urine sample], maybe they should have called us and let us know there was no clean catch and we could have said wait 12 hours and try the next day or to a straight cath. The MD stated, My nurses are my eyes and ears, family is important, but I rely on the NP and the nurses int he facility to give clinical judgement of signs and symptoms, which he did not present with any. They are capable. And with the vital signs prior, there was nothing going on with the patient. An interview with the NP on 04/11/25 at 11:30 AM revealed she remembered a facility nurse reported that Resident #1's family members were concerned he was more confused and requested a UA because he had fallen twice in three days. The NP told the facility they could get a UA, but she did not know they could not get a urine specimen. The NP stated, however, that Resident #1 did not have a change in his mental status from what she could tell during her last visit on 03/16/25. She stated the concern at the time of her visit was that the nurses were reporting he would not call for staff help for transfers and had fallen. The NP stated not completing an ordered lab could cause an abnormal lab value to go missed. The NP said if a nurse could not get a urine specimen through a clean catch, they could do a straight cath, but they would have to call and get an order for that procedure because there was not a standing order for it. Record review of the facility's policy titled, Laboratory Services and Reporting dated 04/08/2023 reflected, Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law .2. The facility is responsible for the timeliness of the services .