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	06/24/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** Based on observations, interviews and record reviews the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accidents. RN A and CNA B failed to monitor/supervise Resident #1 on 05/27/25 who suffered a fall and laid on the floor for 3 hours before being found. The resident sustained a broken leg as a result of the fall. The noncompliance was identified as past noncompliance that began on 05/27/25 and ended on 05/28/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of injury. Findings included: Record review of Resident #1's undated admission Record reflected Resident #1 was admitted to the facility on [DATE] with diagnoses which included liver failure, dementia, and repeated falls. Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 9 indicating she had moderate cognitive impairment. Her Functional Ability assessment indicated she required staff assistance with her ADLs. The resident uses a walker to transfer from her bed to her chair. Record review of Resident #1's care plan, dated 06/10/25, indicated she had an ADL self-care deficit requiring assistance from staff, she had impaired cognitive function related to liver failure, and she was at risk for falls related to her disease processes. Interventions included bed in lowest position, and call light within reach. The resident's care plan was updated on 04/13/25 to include fall risk interventions. After the fall on 05/27/25 the plan was again updated to add frequent rounding. Record review of the facility's Accident and Injury report from April to June of 2025 revealed Resident #1 had suffered unwitnessed falls on 04/13/25 and 05/27/25. The resident suffered no injury with the fall on 04/13/25. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's investigation report revealed in the early morning hours of 05/27/25 around 6:00 AM RN C entered Resident #1's room while making her morning rounds and found Resident #1 lying on the floor of her room. Resident #1 stated she had been trying to get to her chair when she fell, and she complained of right shoulder pain. The resident was assisted back to bed, the physician was contacted and an order for a shoulder x-ray was ordered. The family was also contacted. Resident#1's family member reviewed video footage from the camera in her room and discovered the resident fell at 3:20 AM and RN C discovered the resident at 6:20 AM. The resident could be heard calling for help, but her door was closed. The x-ray of her shoulder was negative for any injury. Later that afternoon the resident complained of right knee pain. The x-ray of her knee indicated she had broken her lower leg bone just below he knee. The resident refused to go to the Emergency Room, instead followed up with an orthopedist the next week. The resident was ordered to not bear weight on her right leg for 4 weeks. Record review of RN C's nursing progress note from 05/27/25 reflected: This nurse was doing rounds and checking on residents when I hear a this resident call for help, this nurse went into the room and found resident laying on the floor with a pillow under her head, resident stated that she needed help getting up and that she slipped out of her chair and onto the floor, resident stated that she believes she slipped out of her chair as she was sleeping, resident states she did not hit her head and could not reach her call light to ask for help so she was calling out for someone, this nurse assessed vitals and began neuro checks, this nurse had aid help resident up into wheelchair, resident then wanted to lay in bed, this nurse assisted resident into bed, residents neck range of motion within normal limits, this nurse contacted NP, and DON, this nurse called family member and left voicemail. Observation and interview on 06/24/25 at 10:00 AM revealed Resident #1 was in her bed. The bed was in the lowest position, and a fall mat was on the floor. The resident could not answer questions about her fall, other than to say she fell. The resident's conversation was very scattered. The resident's room was located directly across from the nurses sta'tion. In an interview on 06/24/25 at 10:40 AM, the Administrator stated Resident #1's family had called back after reviewing the video footage from her room and reported the resident fell at 3:20 AM and was not discovered until the day nurse came in at 6:20 AM. The family member reported the resident was using her walker to transfer to her recliner, where she preferred to sleep, when she fell. The Administrator stated the resident's room was the last room at the end of the hallway, and her door was closed at her request, so it would have been difficult for staff to hear her call for help from the nurse's station. CNA B stated she had last checked on the resident around 2:30 AM. RN A and CNA B were both suspended and CNA B was eventually terminated and RN A resigned. The resident was moved to a room closer to the nurse station for closer monitoring and so she could be heard if she called out instead of using her call light. In an interview on 06/24/25 at 1:20 PM, CNA B stated she had checked on Resident #1 throughout the evening of 05/26/25. She last saw the resident around 2:30 AM when the resident requested some water. CNA B stated she did not check on Resident #1 the rest of the shift because her door was closed, and she did not want to wake her up. CNA B stated she knew she was supposed to check on the residents every two hours. She stated she should have checked on the resident, but she just did not want to wake her up. She stated the risk to the residents was just what happened to Resident #1, they could fall and no one would know. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Phone interview attempts on 06/24/25 at 2:00 PM and 2:32 PM with RN A were unsuccessful. Phone interview attempts on 06/24/25 at 2:05 PM and 3:38 PM with RN C were unsuccessful. In an interview on 06/24/25 at 1:30 PM, RN D stated she had been recently in-serviced by the ADON on abuse and neglect. She stated the in-service covered reducing fall risks by ensuring call lights were within reach, frequent rounding on the residents, and what to do if a resident did fall. They also discussed frequent rounding on at risk residents. In an interview on 06/24/25 at 1:25 PM, CNA E stated she had been recently in-serviced by the ADON on abuse and neglect. The in-serviced covered reducing fall risks by ensuring the residents needs were met, and the call light was within reach. It also covered what to do if a resident was found on the floor. They also discussed frequent rounding on at risk residents. In an interview on 06/24/25 at 1:35 PM, LVN F stated she had been in-serviced by the ADON recently on abuse and neglect. The in-service addressed fall prevention and what to do when a resident falls. Staff needed to check on the residents frequently, make sure their call lights were within reach, and offer toileting at least every two hours. They also discussed frequent rounding on at risk residents. In an interview on 06/24/25 at 1:40 PM, CNA G stated she had been in-serviced recently on abuse and neglect. She stated the focus was on fall prevention and what to do if a resident fell. Staff had to check on the residents frequently, offer toileting and keep their call light within reach. They also discussed frequent rounding on at risk residents. In an interview on 06/24/25 at 1:45 PM, CNA H stated she had been in-serviced on abuse and neglect. She stated staff had to try to prevent falls by keeping the call light within reach and checking on the residents frequently. They also discussed frequent rounding on at risk residents. In a phone interview on 06/24/25 at 1:50 PM, CNA I stated she had been in-serviced on abuse and neglect. She stated they covered fall prevention actions and what to do if a resident falls. They also discussed frequent rounding on at risk residents. In a phone interview on 06/24/25 at 2:00 PM, LVN J stated she had been in-serviced on abuse and neglect recently. She stated they discussed fall prevention and frequent rounding on the residents. and what to do when a resident falls. They also discussed frequent rounding on at risk residents. In a phone interview on 06/24/25 at 2:10 PM, RN K stated he had been in-serviced on abuse and neglect. They discussed what to do if a resident fell, and fall prevention methods. They also discussed frequent rounding on at risk residents. In a phone interview on 06/24/25 at 2:15 PM, CNA L stated she had been in-serviced on abuse and neglect. The in-service covered fall prevention, frequent rounding, and what to do if a resident falls. They also discussed frequent rounding on at risk residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a phone interview on 06/24/25 at 2:18 PM, Resident #1's Responsible Party stated he had been contacted by the Administrator the morning of the resident's fall, and again later that day when they had x-rayed her knee and found the fracture. They discussed the resident's refusal to go to the hospital and he was ok with waiting until she could she the orthopedist in the office. He stated the resident had been getting more confused but she refused to take the medication to lower her ammonia levels. He stated the other family member, who monitored the camera, was very ill and would not be able to be interviewed. He was satisfied with the resident's overall care and the communication with the Administrator. In an interview on 06/24/25 at 2:55 PM, the ADON stated she had in-serviced staff immediately after the event on 05/27/25. She emphasized that the facility's expectation was for staff to round on the residents at least every two hours, and that rounding could be done by the nurse or the CNA. She covered the need to coordinate rounding times, fall prevention actions such as low beds, call lights within reach, post-fall assessment, and frequent toileting. In-servicing of all staff had been completed by 05/28/25. Resident #1 had also been moved to a room next to the nurse's station because she sometimes would not use the call light, but yell for help instead. She stated shechecks with the residents to confirm frequent rounding is being done. She stated the resident's confusion has been improving since she agreed to start taking her lactulose again, her amonia levels are lowering. In an interview on 06/24/25 at 5:30 PM, the Administrator stated he did not have a policy addressing rounding on the residents. He stated it was his expectation that staff round at least every two hours, and more frequently on residents at higher risk of falling.

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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** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received treatment to prevent complications of enteral feedings for 1 of 1 resident (Resident #2) reviewed for enteral feedings. CNA H paused the resident's feeding pump for perineal care and failed to re-start the pump after the care was completed, or ask a nurse to re-start it. This failure could place the resident at risk of not receiving the prescribed nutritional calories she required. Findings included: Record review of Resident #2's undated admission Record reflected Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting her left side, inability to swallow requiring the placement of a gastric tube, and difficulty maintaining her airway requiring the placement of a tracheostomy. Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score not calculated based on her medical conditions. Her Functional Ability assessment reflected she required total assistance of staff for her ADLs. Record review of Resident #2's care plan, dated 06/16/25, reflected she had an ADL self-care deficit, and she received all nutrition via her gastric tube. Record review of Resident #2's physician orders reflected an order dated 06/01/25 every shift for nutrition Glucerna 1.5 @ 70mL/hr x 20hrs/day (1680 kcal, 84 g pro) via stationary pump. Observation on 06/24/25 at 3:32 PM revealed CNA H and CNA E providing incontinence care to Resident #2. CNA H paused the resident's feeding pump prior to initiating incontinence care. The incontinence care was provided appropriately, and the CNAs exited the room leaving the feeding pump paused. Both CNAs then continued to round on other residents. In an interview on 06/24/25 at 3:45 PM with CNA H and ADON M, CNA H admitted she had paused the feeding pump for Resident #2 and did not re-start it or alert a nurse to re-start it. ADON M stated CNAs were not allowed to start, stop, or pause feeding pumps because the formula was considered a medication. ADON M stated the fact the pump was not restarted proved why CNAs should not pause the pump. CNA H did not answer when asked if this was a normal action for her to pause feeding pumps. ADON M was observed to immediately pull CNA H to her office to in-service her. In an interview on 06/24/25 at 5:30 PM, the Administrator stated he could not locate a policy addressing gastric tube feedings or gastric tube management.