

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 02/13/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781</p> <p>43791</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 5 of 16 residents (Residents #26, #32, #37, #54, and #194) reviewed for care plan accuracy.</p> <p>1. The facility failed to develop and implement care plans for Residents #26, #32, #37, and #54, which addressed the residents' physician orders to be weighed weekly.</p> <p>2. The facility failed to develop and implement a care plan for Resident #194, which addressed his need for a mechanical lift to be used for transfers.</p> <p>The failure placed residents at risk for potential weight loss and nutritional decline.</p> <p>Findings included:</p> <p>1. Record review of Resident #26's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included prostate cancer, bone cancer, and diabetes.</p> <p>Record review of Resident #26's admission MDS, dated [DATE], reflected a BIMS score of 3, indicating severely impaired cognitive impairment. The MDS reflected Resident #26 required partial assistance with bed mobility and transfers.</p> <p>Record review of Resident #26's care plan, dated 01/16/25, reflected he required assistance with his ADLs, he was known to wander, and had a cognitive impairment. The care plan did not address weekly weights.</p> <p>Record review of Resident #26's physician orders, dated 01/06/25, reflected the following order: Weekly weights x 4 weeks, then monthly and prn.</p> <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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review on 01/30/25 of Resident #26's weights reflected the following weights:</p> <p>01/06/25 171.2 pounds, 01/07/25 171.2 pounds, and 01/14/25 167.3 pounds.</p> <p>Record review of Resident #32's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, kidney disease, difficulty swallowing requiring the placement of a feeding tube.</p> <p>Record review of Resident #32's annual MDS dated [DATE] reflected her BIMS score was not calculated. The MDS reflected Resident #32 required total assistance with all her ADLs.</p> <p>Record review of Resident #32's care plan, dated 12/02/24, reflected she had a self-care deficit, impaired cognition, and required a feeding tube, and unplanned/unexpected weight loss with an intervention to monitor and evaluate any weight loss. She was not care planned for weekly weights.</p> <p>Record review of Resident #32's physician orders, dated 10/21/24, reflected the following order: Weekly weights related to gastric tube status.</p> <p>Record review on 01/30/25 of Resident #32's weights reflected the following weights:</p> <p>11/08/24 130.4 pounds, 11/13/24 124.3 pounds, and 12/08/24 123.9 pounds.</p> <p>The 12/08/24 weight was a 4.98% weight loss for Resident #32.</p> <p>Record review of Resident #37's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting her left side, difficulty swallowing requiring a feeding tube, and tracheostomy placement.</p> <p>Record review of Resident #37's quarterly MDS assessment, dated 01/10/25, reflected her BIMS score was not calculated. The MDS reflected Resident #37 required total assistance with all her ADLs.</p> <p>Record review of Resident #37's care plan, dated 01/15/25, reflected she had a self-care deficit, required a feeding tube for all nutrition, and requires a tracheostomy for breathing. She is not care planned for weekly weights.</p> <p>Record review of Resident #37's physician orders, dated 12/31/24, reflected the following order: Weigh weekly x 4 weeks, then monthly and as needed.</p> <p>Record review of Resident #37's weights reflected the following weights:</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/31/24 158.0 pounds, and</p> <p>01/10/25 162.1 pounds.</p> <p>Record review of Resident #54's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes, chronic respiratory failure requiring a tracheostomy, and Parkinson's disease.</p> <p>Record review of Resident #54's quarterly MDS reflected his BIMS score was not calculated. The MDS reflected Resident #54 required total assistance with all his ADLs.</p> <p>Record review of Resident #54's care plan, dated 01/24/25, reflected he had a self-care deficit, limited physical mobility, potential for fluid deficit related to dehydration, and a nutritional problem related to NPO status. He was not care planned for weekly weights.</p> <p>Record review of Resident #54's physician orders, dated 10/21/24, reflected the following order: Weigh weekly related to feeding tube status.</p> <p>Record review of Resident #54's weights reflected the following weights:</p> <p>11/13/24 175.1 pounds,</p> <p>12/16/24 170.9 pounds, and</p> <p>01/10/25 176.4 pounds.</p> <p>Interview on 01/30/25 at 2:45 PM with the DON revealed residents with feeding tubes should be weighed weekly to monitor for weight loss and nutritional status. She stated she did not know why the residents had not been weighed as ordered by the physician. She stated she would have to educate the staff on weighing residents as ordered.</p> <p>2. Record review of Resident #194's Face Sheet dated 01/31/25 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE].</p> <p>Record review of Resident #194's quarterly MDS dated [DATE] reflected Resident #194 was cognitively intact with a BIMS score of 15. Functional limitation in range in motion indicated there was no impairment for upper and lower extremities and a mobility device of a wheelchair. Resident #194 was dependent on 2 or more staff for chair/bed-to-chair transfers, sit to lying, lying to sitting on side of the bed, toilet transfer, and tub/shower transfer. His active diagnosis included abnormalities of gait and mobility, muscle wasting and atrophy (wasting or loss of muscle tissue), lack of coordination, Type 1 Diabetes (chronic condition where the pancreas produces little or no insulin), Stroke (blood flow to an area in the brain is cut off), Renal Insufficiency/Failure or End Stage Renal Disease (poor function of the kidneys).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #194's Care Plan reflected Resident #194 was moderate risk for falls related to deconditioning and gait/balance problems. The care plan goals reflected Resident #194 would be free of minor injury. The care plan interventions included: Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Provide resident with mobility device: Wheelchair, walker, or cane. Physical therapy evaluate and treat as ordered or as needed. The Care Plan did not address how much assistance was required for transferring the resident.</p> <p>Observation and interview on 01/28/25 at 1:07 PM with Resident #194 revealed he returned from therapy and was in his room sitting in his wheelchair. The resident had a mechanical lift sling under him in his wheelchair. According to Resident #194 he had a fall, he further stated there was a male aide that was helping him transfer to bed and he fell between the nightstand and the bed. Resident #194 stated he did not hit his head or go to the hospital but did have a skin injury to his elbow which was observed to be losing scab. Resident #194 stated he did not have any further injuries and staff assessed him for pain and injury. Resident #194 stated since the failed transfer he was now transferred by mechanical lift with two people.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</p> <p>Based on observation, interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #194) reviewed for supervision.</p> <p>CNA A failed to safely transfer Resident #194 on 01/15/25, which resulted in the resident having to be lowered to the floor.</p> <p>The failure placed residents at risk of injury.</p> <p>Findings included:</p> <p>Record review of Resident #194's Face Sheet dated 01/31/25 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE].</p> <p>Record review of Resident #194's quarterly MDS dated [DATE] reflected Resident #194 was cognitively intact with a BIMS score of 15. Functional limitation in range in motion indicated there was no impairment for upper and lower extremities and a mobility device of a wheelchair. Resident #194 was dependent on 2 or more staff for chair/bed-to-chair transfers, sit to lying, lying to sitting on side of the bed, toilet transfer, and tub/shower transfer. His active diagnosis included abnormalities of gait and mobility, muscle wasting and atrophy (wasting or loss of muscle tissue), lack of coordination, Type 1 Diabetes (chronic condition where the pancreas produces little or no insulin), Stroke (blood flow to an area in the brain is cut off), Renal Insufficiency/Failure or End Stage Renal Disease (poor function of the kidneys).</p> <p>Record review of Resident #194's Care Plan reflected Resident #194 was moderate risk for falls related to deconditioning and gait/balance problems. The care plan goals reflected Resident #194 would be free of minor injury. The care plan interventions included: Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Provide resident with mobility device: Wheelchair, walker, or cane. Physical therapy evaluate and treat as ordered or as needed. The Care Plan did not address how much assistance was required for transferring the resident.</p> <p>Record review of Resident #194's progress Nurses Notes documented the following:</p> <p>01/15/25 12:30 AM written by LVN C</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Note Text: Nurse was call by another nurse to answer a phone call, at this time this writer was on the floor making rounds. Patient's [family member] was on the phone requesting to speak with the nurse. Nurse answers the phone, introduced myself. Patient's family member asked why she was not call and when patient return from dialysis. I inform the [family member] that I was the night shift nurse and by the time I came in, the patient was already in bed. Then she requests to speak to the patient. This writer took her number return back to patient's room and call her to facilitate the conversation between the two. Approximately 5 minute later, nurse went returned to room to see if patient needed any further help and found my aide speaking to the patient's [family member] on the phone. The aide informed me that the [family member] inquired about a fall the patient had mentioned. At this time, I took over the phone from my aide and informed the [family member] that I was the night nurse and was not aware of any fall incident but would investigate and follow up. The [family member] consented to receive and update in the morning unless it was urgent.</p> <p>Upon review of the patient's chart, I found no documentation of a fall. I spoke with the aide who had worked a double shift, and he confirm that the patient was lowered on to the floor while he was transferring him to the bed. I inform my DON about the situation and proceeded to perform a physical assessment of the patient for any sign of injury related to the reported fall. No new finding from the assessment was found. Vital Signs 97/78, 97.6, 15, 104, saturate 96%. Patient stated that he feels like he has a cut to his anterior lower leg but denies any pain in that area. assessment reveal no cut in that area.</p> <p>Observation and interview on 01/28/25 at 1:07 PM with Resident #194 revealed he returned from therapy and was in his room sitting in his wheelchair. The resident had a mechanical lift sling under him in his wheelchair. According to Resident #194 he had a fall, he further stated there was a male aide that was helping him transfer to bed and he fell between the nightstand and the bed. Resident #194 stated he did not hit his head or go to the hospital but did have a skin injury to his elbow which was observed to be losing scab. Resident #194 stated he did not have any further injuries and staff assessed him for pain and injury. Resident #194 stated since the failed transfer he was now transferred by mechanical lift with two people.</p> <p>Attempted interview on 01/29/25 at 1:20 PM with family member was unsuccessful.</p> <p>Interview on 01/31/25 at 11:19 AM with LVN C revealed she was working with Resident #194 on 01/15/25 10:00 PM shift. LVN C stated she received a call from Resident #194's family member asking why no one had contacted her regarding his return to the facility from dialysis and that he had a fall. LVN C stated no one had reported to her Resident #194 had a fall. LVN C stated she began asking questions and he did tell me he was on the floor, I tried to find out what happened. I think I reported to the DON, ADON and the Administrator. LVN C stated she did an assessment which resulted with no findings.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/31/25 at 12:51 PM with LVN B revealed she worked with Resident #194 on 01/15/25 on 2:00 - 10:00 PM shift and it was reported to her by aides that they had lowered Resident #194 to the floor while trying to get him ready for bed. LVN B stated it was reported to her that they saw Resident #194 about to fall out of the wheelchair, so they caught him and placed him softly on the floor. LVN B stated, I did not make a big deal about it because I did not think lowering him to the ground was a fall. LVN B stated she did not document or report to the DON, physician, Administrator, family, or next shift that Resident #194 had a fall or was lowered to the ground. LVN B stated she did do an assessment and she had no findings. LVN B stated it was her responsibility to report such findings to ADON, DON, physician, and family, not doing so placed Resident #194 at risk of injury.</p> <p>Interview on 01/31/25 at 3:02 PM with the DON revealed she got report from LVN C that Resident #194 had a fall and responded for LVN C to complete assessment. According to the DON this was LVN B's last shift to work and because of that LVN B did not follow facility protocol to document, complete accident and incident report, and complete proper notification to the family, physician, and leadership. The DON stated charge nurses were responsible for reporting and notifying family when residents had a change in their status, not doing so placed Resident #194 at risk of his family not being updated on his health.</p> <p>Record review of the facility's Fall Prevention Program policy, dated 08/15/22, reflected:</p> <p>Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.</p> <p>A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force.</p> <p>A near miss which is also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so.</p> <p>When any resident experiences a fall, the facility will</p> <ul style="list-style-type: none"> Assess the resident. Complete a post-fall assessment. Complete an incident report. Notify physician and family. 		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</p> <p>Based on observation, interview and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (Resident #28) of ten residents reviewed for nutrition.</p> <p>The facility failed to ensure Resident #28 maintained an acceptable weight causing her to trigger a -7.75 percent weight loss.</p> <p>The facility failed to provide weekly weight checks for Resident #28 beginning 12/19/24 with missing dates of 12/19/24, 12/26/24, 01/02/25, 01/09/25, 01/17/25, 01/23/25.</p> <p>These failures placed residents at-risk for weight loss and inadequate nutrition.</p> <p>Findings included:</p> <p>Review of Resident #28's quarterly MDS assessment, dated 12/11/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #28 had a BIMS score of 6 which indicated severe cognition impairment. The resident's diagnoses included Anemia (not having enough red blood cells to carry oxygen), High Blood Pressure (pressure inside arteries are higher than it should be) , End Stage Renal Disease (kidney failure), Dysphagia Oropharyngeal Phase (difficulty swallowing which involves the movement of food or liquid from the mouth to the esophagus) and non-Alzheimer's dementia. Resident #28 required supervision or touching assistance with eating. Resident #28's MDS indicated no signs or symptoms of a swallowing disorder. Resident #28's weight indicated 111 with a weight loss/gain of 5% or more in the last month or loss/gain of 10% or more in the last 6 months.</p> <p>Review of Resident #28's care plan, initiated on 1/19/24, reflected Resident #28 had a swallowing problem related to complaints of difficulty or pain with swallowing. Holding food in mouth/cheeks (pocketing), Dysphagia. Goal: Resident #28 will have no choking episodes when eating. Interventions included All staff to be informed of resident's special dietary and safety needs. Check mouth after a meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris. Monitor for shortness of breath, choking, labored respirations, lung congestion.</p> <p>Record review of Resident #28's care plan, initiated on 03/18/24, revised 12/12/24 also reflected the resident had unplanned or unexpected weight loss. 12/12/24 30-day weight loss. Goal: Resident's weight will return to baseline range by review date. Interventions included: Alert dietician if consumption is poor for more than 48 hours. Give Resident supplements as ordered. Alert nurse/dietician if not consuming on a routine basis. If weight decline persists, contact physician and dietician immediately. Labs as ordered. Report results to physician and ensure dietician is aware. Monitor and evaluate any weight loss. Determine percentage loss and follow facility protocol for weight loss. Monitor and record food intake at each meal.</p> <p>Record review of Resident #28's orders included:</p> <p>orders:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/30/25 at 9:56 AM with LVN A revealed she was working with Resident #28, when asked about orders, LVN A stated she was to be weighed every Thursday. LVN A stated Resident #28 had missed weight checks dates of 12/19/24, 12/26/24, 01/02/25, 01/09/25, 01/17/25, 01/23/25. LVN A stated she could not be sure why Resident #28's physician orders had not been followed. LVN A stated aides were responsible for weighing residents, LVN A stated she was also able to weigh residents. LVN A stated Resident #28 had Dementia which led to a diagnosis of Anxiety. LVN A stated Resident #28 would forget that she had not eaten. LVN A stated Resident #28 was on a puree diet and at times would not eat because she did not like the texture, currently on mechanical soft diet. LVN A stated Resident #28 went through a spell of having to be encouraged to eat in the dining room where she could be monitored and encouraged to eat. LVN A stated she could complete a weight check for Resident #28.</p> <p>Observation and interview on 01/30/25 at 10:19 AM of LVN A completing a weight check with Resident #28 revealed LVN A pushing wheelchair to the scale, asking Resident #28 if she was able to stand on the scale. Resident #28 stated yes, I can stand and preceded to hold the handlebars on the scale. The scale was observed to read 102.4. Surveyor asked if resident could also be weighed while sitting in her wheelchair; that weight revealed to be 144.8. LVN A relocated Resident #28 to sit on the couch so that she could weigh the wheelchair. The wheelchair weight revealed to be 40.6 on the scale. According to LVN A she did the math $144.8 - 40.6 = 104.2$, LVN A stated she was not sure where the 2 pounds resulted from. LVN A stated she was not aware of the weight loss and had Resident #28 been weighed according to physician orders the weight loss could have been noted prior to today. LVN A stated the aides were supposed to weigh according to schedule and alert her so she could enter the weekly weight. LVN A stated she was responsible to ensure the weight checks were done by the aides or herself, not doing so placed Resident #28 at risk of weight loss.</p> <p>Interview on 01/30/25 at 10:30 AM with the Physician revealed he had not been alerted to Resident #28 losing weight, as he noted her to be on a trend upwards. The Physician stated the facility should be following orders and weighing Resident #28 weekly and reporting any concerns. The Physician stated Resident #28 was on a supplement. The Physician stated the nursing staff was responsible for monitoring resident weights, and not doing so placed residents at risk of weight loss without staff knowing. The Physician stated, if we are monitoring the weekly weights correctly something may have come up and we could have consulted nutrition to come up with a plan to prevent weight loss. The Physician stated he was not concerned with Resident #28's weight because she does what she wants to do, and she will tell you what she is not going to do. The Physician stated not following orders for Resident #28 to be weighed placed her at risk of weight loss, and not monitoring her appropriately for maintaining her weight.</p> <p>(continued on next page)</p>		

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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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/30/25 at 11:05 AM with Dietician revealed Resident #28 was on a puree diet and was doing well, however she did not like it. The Dietician stated a speech evaluation was completed and she was able to upgrade to a mechanical soft diet. The Dietician stated I checked in with her on 12/04/24 and noted she was doing fine but needed to get used to the mechanical soft texture. Resident #28's last assessment with me was 01/23/24 and she weighed 113 pounds, I see that her weight was taken today, and she has dropped to 102.4 pounds. The Dietician stated, I am at the facility weekly, when I returned to the facility I would do an assessment, check with her to see how she was doing, and make any recommendations as I saw fit. According to The Dietician the facility has not notified her of the weight loss yet, and further stated since she was there weekly, she would have seen the drop in Resident #28's weight on her own. The Dietician stated if Resident #28 had orders to be weighed weekly, then she should have been weighed weekly. I was concerned she did not like the diet when she was on the puree diet and wondered how she was doing with the mechanical soft diet, being weighed weekly could have given us knowledge if she was maintaining a consistent weight. According to the Dietician she was not concerned at this time because her baseline weight was in the 90's.</p> <p>Observation and Interview on 01/30/25 at 12:39 PM with ADON Z revealed Resident #28's lunch was 25 percent eaten, according to ADON Z although Resident #28 only ate 25 percent of her lunch she ate better during breakfast. ADON Z stated, Resident #28 is a snacker and really enjoyed salads and sandwiches. ADON Z stated, Resident #28 was on puree diet, and did not do well on it but now she was on a mechanical soft diet, which was preferred, which was a process that we had been watching. ADON Z stated weight checks were completed by CNAs, nurses were responsible for ensuring this task was being done. ADON Z stated, not following physician orders to weigh Resident #28 on a weekly basis placed her at risk of weight loss, skin breakdown, and dehydration.</p> <p>Interview on 01/31/25 at 3:32 PM with the DON revealed Resident #28 was on a puree diet but recently changed to mechanical soft and was doing better. The DON stated Resident #28 was a big snacker and will continue to improve. The DON stated she was notified by ADON Z Resident #28 was measured with weight loss, and this was definitely a process they had been watching. According to the DON at the end of the day it was me and nursing leadership's responsibility to make sure physician orders to complete weekly rates were being done, not doing so placed residents at risk of weight loss, skin breakdown, dehydration and not being able to have early intervention.</p> <p>Record review of the facility's undated policy titled Weight Monitoring revealed Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.</p> <p>Weight can be useful indicator of nutritional status. Significant unintended changes in weight (loos or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.</p> <ol style="list-style-type: none"> 1. The facility will utilize a systemic approach to optimize a resident's nutritional status to included monitoring the effectiveness of interventions and revising them, as necessary. 2. Assessments should include weight, food, and fluid intake. 3. Interventions will be identified, implemented, monitored, and modified as appropriate. <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. A weight monitoring schedule, residents with significant weight loss, monitor weight weekly.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 2 of 3 residents (Residents #44 and #54) reviewed for oxygen.</p> <ol style="list-style-type: none"> 1. The facility failed to have accurate physician orders for Resident #44's oxygen use. 2. The facility failed to ensure Resident #54, who was ventilator dependent, was repositioned every two hours to assist the resident in expectorating secretions. <p>This failure could place residents who received oxygen therapy at risk for inadequate or inappropriate amounts of oxygen delivery and possible infection.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of Resident #44's Admission Record dated 01/08/25 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. <p>Review of Resident #44's quarterly MDS, dated [DATE], revealed the resident was not able to completed the BIMS due to cognitive impairment. The resident's diagnoses included severe intellectual disabilities (limitations in mental abilities affecting intelligence, learning, and everyday life skills), dysphagia (difficulty swallowing), epilepsy (brain disorder that causes recurring, unprovoked seizures), muscle wasting and atrophy (wasting or loss of muscle tissue), contracture (permanent tightening of the muscles), other lack of coordination. The MDS reflected Resident #44 had no shortness of breath, and she used oxygen therapy.</p> <p>Review of Resident #44's undated care plan reflected Resident #44 had continuous oxygen therapy ordered. The care plan goal reflected: will have no signs and symptoms of poor oxygen absorption. The care plan interventions included: Give medications as ordered by physician. Monitor/document side effects and effectiveness. Suction as needed. The care plan reflected Resident #44 had altered respiratory status/difficulty breathing related to excessive secretions; requires frequent oral suctioning, scopolamine patch ordered. The care plan goal reflected: Resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern. The care Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Monitor for signs and symptoms of respiratory distress and report to physician as needed. Increased Respirations; Decreased Pulse oximetry; Increased heart rate; Restlessness; Headaches; Lethargy; Confusion; Cough; Pleuritic pain; Monitor /document/report abnormal breathing patterns to physician; increased rate; decreased rate, periods of apnea (sleep disorder), prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring.</p> <p>Record review of Resident #44's physician orders revealed: has continuous oxygen therapy ordered. Oxygen at 2LPM via nasal cannula. Date Initiated: 07/09/2021 Revision on: 10/13/2021</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #44's Medication and Treatment Administration Record for the month of January 2025 indicated staff were administrating:</p> <p>Oxygen at 2 liters are needed for shortness of breath every shift started 07/08/21 discontinued 01/27/25.</p> <p>Oxygen at 2 liters per nasal canula continuous every shift start 01/27/25</p> <p>Observation and interview on 01/28/25 at 12:12 PM revealed Resident #44 was on 3 liters of oxygen by nasal canula. Resident #44 was wake and alert, when speaking to Resident #44 revealed she was unable to communicate with the ability to be understood.</p> <p>Observation of Resident #44 on 01/30/25 at 9:15 AM revealed oxygen rate at 3 liters water bottle dated 01/30/25.</p> <p>Observation and interview on 01/30/25 at 1:07 PM with LVN A revealed she worked with Resident #44 on 6:00 -2:00 PM shift on rotating days. LVN A stated Resident #44 is on 2 liters of oxygen per her order. LVN A checked the order and confirmed she was on 2 liters. When asked to observe Resident #44, LVN A stated Resident #44 was currently on 3 liters of oxygen. LVN A stated Resident #44 was having a cough that was concerning, I did not adjust the oxygen, LVN A then lowered Resident #44's oxygen and checked her pulse oxidation stating she is low at 91 when on 2 liters, and 99 on 3 liters. According to LVN A whomever increased the oxygen to 3 should have had an order to do so and documented about it. LVN A stated she did not see any documentation on the order being increased. LVN A pointed out the progress note and stated she reached out to the Hospice to have a nurse come and assess her, and followed up with ADON Z, and she did not recall if the nurse came in. LVN A stated not following the physician order and increasing oxygen without an order, and not documenting on Resident #44's coughing or need for increased oxygen placed her at risk for decline, something missed or lost, and not getting the treatment she needed.</p> <p>Interview on 01/30/25 at 2:39 PM with the DON revealed nurses were responsible for assessing residents and contacting physician for orders. The DON stated she was not aware Resident #44 was currently administered 3 liters of oxygen with an order for 2 liters. The DON stated her expectation was that the nurse staff who increased the oxygen should have gotten an order to maintain Resident #44's oxygen level to 3liters, not communicating with staff, hospice and family placed Resident #44 at risk of not getting the treatment she needed.</p> <p>On 01/31/25 at 4:00 PM the DON was asked for a policy on following physician orders, and oxygen use the facility revealed after reaching out to their corporate office they did not have a policy.</p> <p>2. Record review of resident #54's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes, chronic respiratory failure requiring a tracheostomy, and Parkinson's disease.</p> <p>Record review of Resident #54's quarterly MDS reflected his BIMS score was not calculated. His Functional Status indicated he required total assistance with all his ADLs.</p> <p>Record review of Resident #54's care plan, dated 01/24/25, reflected he had a self-care deficit, limited physical mobility, and facility acquired pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #54's physician orders reflected an order to reposition the resident every two hours.</p> <p>Observation on 01/28/25 at 10:28 AM revealed Resident #54 was positioned on his back, and his legs were contracted to the left. Resident #54 had pillows between his knees.</p> <p>Observation on 01/28/25 at 12:05 PM revealed Resident #54 remained in the same position on his back.</p> <p>Observation on 01/29/25 at 8:10 AM revealed Resident #54 remained in the same position on his back.</p> <p>Observation on 01/29/25 at 12:18 PM revealed Resident #54 was positioned on his left side after wound care was provided.</p> <p>Interview on 01/28/25 at 11:33 AM with LVN K revealed repositioning Resident #54 to his right side induced a lot of secretions and coughing. LVN K would not agree the order to turn the resident every two hours was for that reason, to expectorate secretions. When asked why Resident #54 was never taken out of bed and put into a chair, LVN K stated it would be difficult to do so as the resident would have to be disconnected from his ventilator to move him. LVN K stated she did not do passive ROM with bedridden residents because she needed training by Physical Therapy, so she did not cause any further injury to the resident. LVN K would not answer if she had been trained on ROM during her LVN training.</p> <p>Interview on 01/29/25 at 12:21 PM with the DON revealed getting a resident out of bed and into a chair should not be prevented just because it was difficult to do. The DON stated she was not aware Resident #54 had an order to reposition every two hours. The DON would not agree placing pillows to offload pressure was different from turning or repositioning the resident side to side.</p> <p>Observation on 01/29/25 at 1:15 PM revealed Resident #54 was transferred to a reclining chair using a lift device with three staff members assisting. The resident was transferred without having to be removed from his ventilator.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781</p> <p>Based on observation, interview, and record review, the facility failed to attempt to use alternatives prior to installing a side or bed rail, obtain informed consent prior to installation, ensure correct installation, use and maintenance of bedrails for 1 (Resident #22) of 3 residents reviewed for bedrails.</p> <p>The facility failed to obtain a bed rail assessment and physician's order prior to the installment of Resident #22's bedrails.</p> <p>This failure could place residents at risk of entrapment or injury.</p> <p>Findings included:</p> <p>Review of Resident #22's Admission Record, dated 01/31/25, reflected he was a [AGE] year-old male who admitted to the facility on [DATE].</p> <p>Review of Resident #22's Admission MDS Assessment, dated 01/08/25, reflected he had a BIMS score of 03, indicating severe cognitive impairment. His active diagnoses included non-Alzheimer's disease, malignant neoplasm of prostate, and diabetes mellitus. His MDS did not address that he was receiving hospice services or utilized bed rails.</p> <p>Review of Resident #22's Order Summary Report, dated 01/31/25, reflected the following:</p> <p>- Mobility bars to each side of bed for increased bed mobility, every shift with a start date of 01/30/25</p> <p>Review of Resident #22's care plan reflected the following:</p> <p>Problem: [Resident #22] has an ADL self-care performance deficit r/t memory loss/confusion, hx of chemo/ radiation [sic], prostate cancer .Interventions: Mobility bars to each side of bed for increased bed mobility, Date Initiated: 01/30/2025.</p> <p>Review of Resident #22's Side Rail Evaluation, dated 01/30/25, reflected it was completed.</p> <p>Observation on 01/28/25 at 9:46 AM of Resident #22 revealed he was in his bed and had half bedrails to the side of his bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/31/25 at 12:10 PM with the DON revealed Resident #22 had bedrails on his bed but did not have an evaluation or order until yesterday (01/30/25) when the surveyors started asking questions about it. The DON said Resident #22 was fairly new to the building but any time any light was shown on something they perform an audit to see what system was in play and make sure they have everything needed and that nothing would be lacking. The DON said the failure was that Resident #22's hospice company brought a bed that automatically had bedrails on it without notifying the facility of this. The DON said she noted Resident #22 had bedrails on his bed so went ahead and completed his evaluation and order. The DON said Resident #22 should have had those things in place before the bedrails were put in place. The DON said staff should have noticed the bedrails before and notified her so that she could have completed the evaluation and received the order for them. The DON said the hospice company also should have communicated with the facility staff that they were going to add bedrails to the resident's bed. The DON said the purpose of having the evaluation and order for bedrails for a resident was to make sure they were appropriate for them. The DON said if those were not already in place for a resident, the facility could not be sure they were appropriate for them. The DON said the nursing department would have been responsible for ensuring there was an order and evaluation for the bedrails .</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781</p> <p>Based on observation, record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for one resident (Resident #56) of five residents whose medications were reviewed.</p> <p>The facility's Pharmacy Consultant recommended the physician should consider a gradual dose reduction for Resident #56's Duloxetine (used to treat depression) and Zolpidem (used to treat insomnia) on 08/19/24. The facility failed to ensure this was communicated to the resident's primary care physician regarding the recommendation.</p> <p>This failure could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition.</p> <p>Findings included:</p> <p>Review of Resident #56's Admission Record, dated 01/30/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE].</p> <p>Review of Resident #56's Quarterly MDS Assessment, dated 12/03/24, reflected she had a BIMS score of 13 indicating no cognitive impairment. Her active diagnoses included anxiety disorder, depression, and psychotic disorder. The medications she had taken were antipsychotics, antidepressants, and hypnotics. For the medication review, it was noted Resident #56 received antipsychotics on a routine basis, but a gradual dose reduction had not been attempted or documented by a physician as clinically contraindicated.</p> <p>Review of Resident #56's undated care plan, reflected the following: Problem: The resident is on sedative/hypnotic therapy r/t primary insomnia .Goal: The resident will be free of any discomfort or adverse side effects of hypnotic use through the review date .Interventions: Administer sedative/hypnotic medications as ordered by physician .Problem: The resident uses antidepressant medication r/t major depressive disorder .Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date .Interventions: Administer Antidepressant medications as ordered by physician.</p> <p>Review of Resident #56's Order Summary Report reflected the following:</p> <ul style="list-style-type: none"> - Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG (Duloxetine HCl), Give 60 mg by mouth one time a day for major depressive disorder unspecified - Zolpidem Tartrate Oral Tablet 10 MG (Zolpidem Tartrate), Give 10 mg by mouth at bedtime for insomnia <p>Review of Resident #56's January 2025 MAR reflected she received duloxetine and zolpidem every day as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #56's Medication Regimen Review Report, dated 08/19/24, reflected: Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction.</p> <p>Duloxetine 60mg QD -> Duloxetine 40mg QD</p> <p>Zolpidem 10mg QHS</p> <p>If dose reduction is contraindicated or resident failed previous reduction attempt, please document below.</p> <p>Review of Resident #56's Consultant Pharmacist/Physician Communication form, dated 08/19/24 reflected:</p> <p>[At the top right corner of the page had a message of 'Not our patient']</p> <p>Dear [Physician J], Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction.</p> <p>Duloxetine 60mg QD -> Duloxetine 40mg QD</p> <p>Zolpidem 10mg QHS</p> <p>If dose reduction is contraindicated or resident failed previous reduction attempt, please document below.</p> <p>[The bottom part of the form was blank where the Physician/Prescriber Response].</p> <p>Observation and interview on 01/28/25 at 11:00 AM with Resident #56 revealed she was in her room laying in her bed; she was fully dressed and groomed. Resident #56 said she was doing okay today.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/30/25 at 3:21 PM with ADON G revealed she vaguely remembered seeing something in the pharmacy recommendations regarding Resident #56's medications. ADON G said a lot of times doctors will write notes about the recommendations and sometimes they agreed with the pharmacy recommendations and sometimes they did not. ADON G said there should have been a note that the facility received back from them and the facility followed whatever was needed for the resident. ADON G said the doctor would write they disagreed for this reason on the note. ADON G said she was not sure if she was the only one responsible for checking and following up on the pharmacy recommendations. ADON G said the purpose of the pharmacy recommendations was to try and see if some of the medications could be weaned down or if they were still necessary for the resident to keep taking. ADON G said she had a file that the pharmacy recommendations go into so the doctors could review them when they came to the building. ADON G said she looked for any notes that came from the pharmacy recommendations and followed up to see what the doctor decided on. ADON G said the attending physician or NP were notified when there was paperwork that needed to be reviewed or required their signature, and they were responsible for checking and following up on the paperwork in the folder for them. ADON G said if a GDR was not completed timely or assessed for a lot of things could happen. ADON G said if pharmacy recommendations were not followed up on her answer was pharmacy recommendations [did] not always mean the doctor would agree to it. ADON G said that while the pharmacist completed their review and made a recommendation, the attending physician was the one who would give the order to change a medication. ADON G was not sure how often a GDR was supposed to be considered. ADON G said she just went off the list of when a GDR needed to be considered.</p> <p>Interview on 01/31/25 at 8:59 AM with the DON revealed she found no evidence that the doctor reviewed Resident #56's medications for a GDR or that it was noted to be contraindicated. The DON said the only thing she could say was that ADON G was still learning the process and since then has improved. The DON said it appeared that the GDR was not attempted, and she had no further information other than that.</p> <p>A follow-up interview on 01/31/25 at 12:06 PM with the DON revealed she was not sure when ADON G took over the pharmacy recommendations responsibility, but at the end of the day as the DON for the building she was ultimately responsible. The DON said the purpose of following up on the pharmacy recommendations was that the medications needed to be reviewed and GDRs attempted. The DON said any resident on a psychotropic or anti-psychotic needed to have a GDR attempted if possible or at least reviewed for a GDR attempt. The DON said GDR attempts were done annually if not contraindicated. The DON said if a pharmacy recommendation was not followed up on or a GDR was not attempted, a resident would continue on that medication regimen. The DON said the doctor reviewed the medications as well as the pharmacist. The DON said the pharmacist would also follow up for the next month on any recommendations that were missed by the doctor or facility because the recommendation would still reappear to the next month.</p> <p>Review of the facility's policy, revised 01/16, titled Psychoactive Medications and Behavior Monitoring reflected: 4. Drug Regimen reviews will be conducted by the pharmacist for unnecessary use, excessive doses or duration in absence of acceptable medical diagnosis according to standard of practice. Recommendations will be communicated to the attending physician with recommendations either reduce or eliminate drug usage as appropriate.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41781</p> <p>Based on observations and interviews, the facility failed to ensure the menus were followed for 1 (the lunch meal on 01/28/25) of 2 meals reviewed for menus.</p> <p>The facility did not serve the posted lunch menu of roast beef, red cabbage, dill potatoes, or ice cream on 01/28/25.</p> <p>This failure could affect all residents in the facility, who eat from the kitchen, by placing them at risk of not knowing what was going to be served for that meal.</p> <p>Findings included:</p> <p>Observation on 01/28/25 at 12:00 PM of the monthly menu posted near the dining room reflected for Tuesday, January 28th the following: Roast Beef, Dill Potatoes, Red Cabbage, Wheat Bread, Margarine, Ice Cream, Coffee or Tea, Garnish Parsley Sprig.</p> <p>Observation on 01/28/25 at 12:17 PM revealed an unknown dietary aide brought the daily menu posting to the 3rd floor dining room area which listed the following: beef tips, season potatoes, cabbage, roll with butter, and pears.</p> <p>Interview on 01/28/25 at 12:22 PM with Resident #22 revealed the menu was not usually posted or followed. Resident #22 said she never knew what was going to be served for the day.</p> <p>Observation and interview on 01/28/25 at 12:45 PM with the Head [NAME] revealed the following items were being served for lunch today: beef tips, green cabbage, rosemary potatoes, a roll, and pears.</p> <p>Interview on 01/28/25 at 2:07 PM with the Head [NAME] revealed she knew the DM would not be at the facility today but his absence did not interrupt anything with the lunch service earlier. The Head [NAME] said the beef tips, rosemary potatoes, red cabbage, and pears were all substituted during the lunch meal service because the other items were not provided by the supplier from the week's order. The Head [NAME] said the menu was posted upstairs to let residents know what they were going to be served for that meal. The Head [NAME] said normally the DM makes sure the daily menu was posted at the beginning of the day but if he was not at the facility one of the dietary aides could post it instead. The Head [NAME] said the residents did not know what they were being served until they received their plate today because it did not match the posted menu. The Head [NAME] said the purpose of following the menu was so that residents would know what they were being served for that day and if they were going to like it or not. The Head [NAME] said that substitutions happen on the fly sometimes and sometimes they knew about them in advance.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/31/25 at 1:04 PM with the DM revealed while he was not here on Tuesday (01/28/25) his staff should have still been able to continue the normal procedures of the kitchen and meal service. The DM said the menu should be posted daily and if things on the menu were not available that needed to be communicated to the residents. The DM said the posted menu should always match what was being cooked for the residents for that meal. The DM said the purpose of serving what the menu said was so the residents know what they were being served so if they did not like something they can ask for something else. The DM said if residents were not served what was posted on the menu it could be misleading to them .</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>41781</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received meals at regular times comparable to normal mealtimes in the community or in accordance with resident needs and preferences for one meal (the lunch meal on 01/28/25) of three meals reviewed for frequency of meals.</p> <p>The facility failed to ensure residents received meals at regularly scheduled times for lunch on 01/28/25.</p> <p>This failure could place residents who eat from the facility's kitchen at risk of increased hunger.</p> <p>Findings included:</p> <p>Review of a piece of paper provided by the facility, titled [Facility Name] Meal Service Time are as Follows . Lunch: 12:00 pm-1:00 pm .</p> <p>Interview on 01/28/25 at 12:22 PM with Resident #22 revealed lunch was served late often and they did not have a choice because they could not get food anywhere else. Resident #22 said she was getting very hungry having to wait for them to start serving lunch.</p> <p>Observation on 01/28/25 at 12:40 PM of the 3rd floor's satellite kitchen's steamtables revealed the dietary staff began taking the temperatures of the food. One of the food items, the rosemary potatoes only got to 130 degrees Fahrenheit. The Regional Dietitian took the rosemary potatoes downstairs to the kitchen to be reheated immediately.</p> <p>Observation and interview on 01/28/25 at 12:45 PM with the Head [NAME] revealed the following items were being served for lunch today: beef tips, green cabbage, rosemary potatoes, a roll, and pears.</p> <p>Observation on 01/28/25 at 1:05 PM revealed the Regional Dietitian brought the rosemary potatoes back up to the 3rd floor's satellite kitchen to start being served to the residents.</p> <p>Interview on 01/28/25 at 1:00 PM with Resident #17 revealed she was starving, and the food was always served late.</p> <p>Observation on 01/28/25 at 2:00 PM of the 3rd floor hallway revealed the last resident had just been served their meal tray.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/28/25 at 2:07 PM with the Head [NAME] revealed she knew the DM would not be at the facility today but his absence did not interrupt anything with the lunch service earlier. The Head [NAME] said today the lunch meal was not served on time because it was supposed to be served between 12:00 PM and 1:00 PM. The Head [NAME] said residents who were ordered a regular diet began being served at 1:05 PM. The Head [NAME] said she would have to ask the DM about the purpose, risk, and what could happen to residents if their meal was not served in a timely manner. The Head [NAME] said she was not put in charge of the kitchen in the DM's absence but was responsible to cook and serve good quality food.</p> <p>Interview on 01/31/25 at 1:04 PM with the DM revealed while he was not here on Tuesday (01/28/25) his staff should have still been able to continue the normal procedures of the kitchen and meal service. The DM said he heard the lunch service on Tuesday (01/28/25) was extremely late and he was shocked. The DM said lunch was supposed to be served between 12:00 PM and 1:00 PM. The DM said serving the lunch meal late could affect anything such as medications, therapy, and their diagnosis like diabetes.</p> <p>Review of the facility's policy, approved 10/01/18, titled Meal Times reflected: Policy: The facility provides three meals daily at regular times which are comparable to meal times in the community setting. Meals are served at the specified times except in emergency situations .Procedures: 2. There will be at least a four-hour interval between breakfast and lunch and between lunch and dinner.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41781</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 3rd floor's satellite kitchen.</p> <p>1.The facility failed to ensure drinks leaving the 3rd floor's satellite kitchen were covered before being put on the hall cart to be delivered to residents eating in their rooms.</p> <p>2.The facility failed to ensure the five steamtable compartments on the 3rd floor's satellite kitchen were clean and free of debris before food was placed in them.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.</p> <p>Findings included:</p> <p>1.Observation on 01/28/25 at 1:45 PM of the lunch tray cart on the 3rd floor revealed there were 21 resident's trays on the cart. Each tray on the cart had a drink on it filled with liquid but was not covered with anything.</p> <p>Interview on 01/28/25 at 1:45 PM with CNA I and CNA H revealed they never knew that the drinks on the trays were supposed to be covered leaving from the kitchen area. CNA I and CNA H said they had never been told about that or provided anything from the kitchen to be able to cover the resident's drinks with.</p> <p>Interview on 01/28/25 at 2:07 PM with the Head [NAME] revealed she knew the DM would not be at the facility today, but his absence did not interrupt anything with the lunch service earlier. The Head [NAME] said the kitchen aides bring pitchers of drinks to the 3rd floor of the facility so the CNAs can pour the residents their drinks and put them on the residents' trays. The Head [NAME] said the kitchen aides do provide lids to the drinks served to residents that were usually on the drink cart. The Head [NAME] said she was not sure if the lids were on today's drink cart or not. The Head [NAME] said the kitchen aides and CNAs all knew that drinks leaving the kitchen area required a lid. The Head [NAME] said the purpose of having drinks covered was so that no debris got in them and no contamination occurred. The Head [NAME] she was not responsible for ensuring that drinks were covered before leaving the kitchen area, she was only responsible for providing the lids to the CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/31/25 at 1:04 PM with the DM revealed while he was not here on Tuesday (01/28/25) his staff should have still been able to continue the normal procedures of the kitchen and meal service. The DM said the CNAs should have been provided lids for resident's drinks during the lunch service. The DM said the kitchen was responsible for providing the lids for resident's drinks. The DM said the purpose of having drinks that leave the kitchen area covered was to prevent any cross contamination. The DM said depending on the environment and location, transporting uncovered drinks from the kitchen area to the resident's rooms could have something drop into it. The DM said if the drink was covered the resident would not be at risk of consuming an unwanted item and potentially getting ill if it accidentally fell into the uncovered drink.</p> <p>2.Observation on 01/28/25 at 12:00 PM of the monthly menu posted near the dining room reflected for Tuesday, January 28th the following: Roast Beef, Dill Potatoes, Red Cabbage, Wheat Bread, Margarine, Ice Cream, Coffee or Tea, Garnish Parsley Sprig.</p> <p>Observation on 01/28/25 at 12:17 PM an unknown dietary aide brought the daily menu posting to the 3rd floor dining room area which listed the following: beef tips, season potatoes, cabbage, roll with butter, and pears.</p> <p>Observation on 01/28/25 at 12:21 PM of the 3rd floor's satellite kitchen's steamtables revealed cloudy water with yellow and white debris floating in each compartment.</p> <p>Observation on 01/28/25 at 12:45 PM of the 3rd floor's satellite kitchen's steamtables revealed the following: beef tips were in the first compartment; cooked cabbage was in the second compartment; rosemary potatoes were in the third compartment; pureed bread and mashed potatoes were in the fourth compartment; mechanical meat, pureed meat, pureed vegetables, renal carrots , chicken alternative, and gravy were in the fifth compartment.</p> <p>Interview on 01/28/25 at 2:07 PM with the Head [NAME] revealed she knew the DM would not be at the facility today but his absence did not interrupt anything with the lunch service earlier. The Head [NAME] said she placed food in containers on the 3rd floor satellite kitchen's steamtables but did not see the water that was already in them. The Head [NAME] said there should have been clean water with no food debris in them before food was placed on the line. The Head [NAME] said she only noticed how dirty the water was after she pulled the food containers off the line after the lunch service was over. The Head [NAME] said usually the cook after dinner will drain the steamtables and the next cook at breakfast would add new water to them. The Head [NAME] said she normally checked the steamtables before putting the food on the line but did not today. The Head [NAME] said contamination could happen if the dirty water from the steamtables got into the food being served. The Head [NAME] said keeping the steamtable water clean each time ensured there would not be any debris getting into the food that was about to be served to residents.</p> <p>Interview on 01/31/25 at 1:04 PM with the DM revealed while he was not here on Tuesday (01/28/25) his staff should have still been able to continue the normal procedures of the kitchen and meal service. The DM said the steamtables should always be drained and cleaned every night because food and debris can get in there, or worse case, bugs. The DM said the dinner shift staff should have taken care of it after their meal service was over. The DM said the steamtables being cleaned was hygienic and healthier when debris could not get into the cooked food and contaminate it.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy, approved 10/01/18, and titled Meal Service reflected: Procedure: 4. Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in the preparation or storage of potentially hazardous food prior to each use. Clean and sanitize food-contact surfaces of equipment and multi-use utensils used for preparation of potentially hazardous foods on a continuous or production line basis at scheduled intervals throughout the preparation period based on food temperature, type of food and amount of food particle accumulation.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</p> <p>Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Residents #194) reviewed for clinical records.</p> <p>The facility failed to ensure LVN B documented on Resident #194's clinical record that he had a fall.</p> <p>This failure could affect residents that required assistance with transferring with the use of a mechanical lift device by placing them at risk of having inaccurate or incomplete clinical records.</p> <p>Findings included:</p> <p>Record review of Resident #194's Face Sheet reflected the resident was a [AGE] year-old male was admitted to the facility on [DATE].</p> <p>Record review of Resident #194's quarterly MDS dated [DATE] revealed Resident #194 was cognitively intact with a BIMS score of 15. Functional limitation in range in motion indicated there was no impairment for upper and lower extremities and a mobility device of a wheelchair. Resident #194 was dependent on staff for chair/bed-to-chair transfers, sit to lying, lying to sitting on side of the bed, toilet transfer, and tub/shower transfer. His active diagnoses included abnormalities of gait and mobility, muscle wasting and atrophy (wasting or loss of muscle tissue), lack of coordination, Type 1 Diabetes (chronic condition where the pancreas produces little or no insulin), Stroke (blood flow to an area in the brain is cut off), Renal Insufficiency/Failure or End Stage Renal Disease (poor function of the kidneys).</p> <p>Record review of Resident #194's Care Plan documented Resident #194 was at moderate risk for falls related to deconditioning and gait/balance problems. The care plan goals reflected: will be free of minor injury. The care plan interventions included: Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Provide resident with mobility device: Wheelchair, walker, or cane. Physical therapy evaluate and treat as ordered or as needed. Initiated 01/21/2025. The care plan reflected Resident #194 had an ADL self-care performance deficit related to recent hospitalization for critical illness myopathy. The care plan goal reflected: The resident will improve current level of function in toileting. The care plan interventions included: Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use the bell to call for assistance.</p> <p>Record review of Resident #194's progress Nurses Notes documented the following:</p> <p>01/15/2025 12:30 AM written by LVN C</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Note Text: Nurse was call by another nurse to answer a phone call, at this time this writer was on the floor making rounds. Patient's [family member] was on the phone requesting to speak with the nurse. Nurse answers the phone, introduced myself. Patient's family member asked why she was not call and when patient return from dialysis. I inform the [family member] that I was the night shift nurse and by the time I came in, the patient was already in bed. Then she requests to speak to the patient. This writer took her number return back to patient's room and call her to facilitate the conversation between the two. Approximately 5 minute later, nurse went returned to room to see if patient needed any further help and found my aide speaking to the patient's [family member] on the phone. The aide informed me that the [family member] inquired about a fall the patient had mentioned. At this time, I took over the phone from my aide and informed the [family member] that I was the night nurse and was not aware of any fall incident but would investigate and follow up. The [family member] consented to receive and update in the morning unless it was urgent.</p> <p>Upon review of the patient's chart, I found no documentation of a fall. I spoke with the aide who had worked a double shift, and he confirm that the patient was lowered on to the floor while he was transferring him to the bed. I inform my DON about the situation and proceeded to perform a physical assessment of the patient for any sign of injury related to the reported fall. No new finding from the assessment was found. Vital Signs 97/78, 97.6, 15, 104, saturate 96%. Patient stated that he feels like he has a cut to his anterior lower leg but denies any pain in that area. assessment reveal no cut in that area.</p> <p>Observation and interview on 01/28/25 at 1:07 PM with Resident #194 revealed him stating he had a fall. Resident #194 further stated there was a male aide that was helping him transfer to bed and he fell between the nightstand and the bed. Resident #194 stated he did not hit his head or go to the hospital but did have a skin injury to his elbow which was observed to be losing eschar. Resident #194 stated he did not have any further injuries and staff assessed him for pain and injury.</p> <p>Interview on 01/31/25 at 12:51 PM with LVN B revealed she worked with Resident #194 on 01/15/25 on 2:00 PM-10:00 PM shift and it was reported to her by aides that they had lowered Resident #194 to the floor while trying to get him ready for bed. LVN B stated it was reported to her that they saw Resident #194 about to fall out of the wheelchair, so they caught him and placed him softly on the floor. LVN B stated, I did not make a big deal about it because I did not think lowering him to the ground was a fall. LVN B stated she did not document or report to the DON, physician, Administrator, family, or next shift that Resident #194 had a fall or was lowered to the ground. According to LVN B she did do an assessment and she had no findings. LVN B stated it was her responsibility to document and update resident clinical records, and not doing so placed Resident #194 at risk of injury.</p> <p>Interview on 01/31/25 at 3:02 PM with the DON revealed she got report from LVN C that Resident #194 had a fall and responded for LVN C to complete assessment. According to the DON this was LVN B's last shift to work and because of that LVN B did not follow facility protocol to document, complete accident and incident report, and complete proper notification to the family, physician, and leadership. The DON stated charge nurses were responsible for documenting when residents have a change in their status, and not doing so placed Resident #194 at risk of staff not properly transferring him, with potential for injury.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43791</p> <p>Based on observation, interview, and record review the facility failed to 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 4 residents (Resident #32) observed for infection control.</p> <p>RN M failed to wear a gown and gloves while providing care for a resident on enhanced barrier precautions (EBP).</p> <p>This failure could lead to the resident being exposed to infections from other residents.</p> <p>Findings included:</p> <p>Observation on 01/29/25 at 7:24 AM of Resident #32's room revealed posting on the outside notifying staff and visitors the resident was on EBP, and it was required to wear a gown and gloves with all direct care of the resident.</p> <p>Observation on 01/29/25 at 7:24 AM revealed RN M administered seven medications via Resident #32's gastric tube, and one medication via subcutaneous injection while wearing gloves but no personal protective equipment (PPE) which included gown and gloves.</p> <p>Interview on 01/29/25 at 7:35 AM with RN M revealed she just forgot to wear her PPE. She stated the presence of the surveyor made her nervous.</p> <p>Interview on 01/29/25 at 2:20 PM with the DON revealed all residents on EBP required the staff to wear a gown and gloves when having direct contact with the resident such as turning, incontinence care, and providing medications via gastric tube. The DON stated the EBP were in place to protect the resident from exposure to infectious agents that might be on the provider's clothing, etc. The resident was on EBP precautions because the resident had an opening, (urinary catheter, gastric tube, open wound, etc.) that easily allowed the introduction of infections into the body.</p> <p>Record review of the facility's Enhanced Barrier Precautions policy, dated 04/05/24, reflected:</p> <p>Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.</p> <p>.4. High-contact resident care activities include:</p> <p>.g. Device care or use: central lines, urinary catheters, feedingtubes, tracheostomy/ventilator tubes</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 02/13/2025
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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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>44937</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of pests for 1 of 2 dining rooms (Third Floor dining room) reviewed for pest control.</p> <p>The facility failed to ensure the Third Floor dining room was free of roaches.</p> <p>This failure could affect residents by placing them at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life.</p> <p>Findings included:</p> <p>Observation and interview on 01/28/25 at 12:54 PM revealed there were two roaches along the baseboards in the dining room on the Third Floor while residents were waiting to be served lunch. According to Resident #22, there were roaches all over the facility. Resident #22 stated there were roaches in her room as well. Resident #22 said that roaches have been present for a long time and she did not feel whatever was being done was effective. Resident #22 stated there has been several times she has found roaches in her personal items and tried to kill them.</p> <p>In a confidential interview on 01/29/25 at 1:42 PM, residents said they had seen roaches in their rooms and restrooms. Residents stated it was not unusual to see a roach in their personal belongings, bathrooms, and dining room. Residents stated they felt uncomfortable having roaches in their rooms and in the dining rooms, it made them frustrated that the facility seemed not to care to get rid of the pest.</p> <p>Record review of the facility's Pest Control service summary for September 2024, October 2024, and November 2024 and January 2025 revealed the resident rooms on Second Floor and Third Floor, nursing stations, hallways, restrooms, kitchen, and common areas had been treated for roaches on a monthly basis.</p> <p>Record review of the facility's binders located at each nursing station, for the months of September, October, November 2024 and January 2025 revealed staff documented a request to have the floors serviced for pest control.</p> <p>Interview on 01/31/25 at 2:06 PM with CNA F revealed she worked on the Third Floor and had observed roaches in several resident rooms. According to CNA she had reported the roaches in resident rooms by documenting in the pest control book at the nursing station. According to CNA she was responsible for reporting the roaches because having roaches in resident rooms and dining room placed residents at risk of infections and contamination.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Maintenance Director on 01/31/25 at 1:40 PM revealed him saying he has definitely seen roaches in the facility however has not had any complaints from residents about roaches. The Maintenance Director stated the staff has asked him to come and spray for the roaches they have seen, and he responded I don't do pest control, we have a company. The Maintenance Director stated staff will document their concerns in their pest control book at the nursing station, and when pest control entered the building monthly, they reviewed the pest control books and treated according. The Maintenance Director stated he does not review the pest control logbooks and he does not spray; he stated their pest control company was responsible for ensuring there were no pests in the building, he further stated he did not think residents were placed at risk.</p> <p>Interview on 01/31/25 at 3:30 PM with the Administrator revealed during his observations he had never seen roaches in any resident rooms. The Administrator stated he talked to the pest control company on a monthly basis when they entered the facility and has been told they had never seen pests in resident rooms. According to the Administrator, staff were responsible for ensuring they documented any concerns in the pest control logbooks located at the nursing stations and informing the Maintenance Director. The Administrator stated if there was a significant concern the Maintenance Director was responsible for contacting pest control for any additional visits. The Administrator stated having roaches in the building could place residents at risk of contamination and infection.</p> <p>Record review of the facility's undated policy titled Pest Program Specifications. indicated We attempt to keep regular services scheduled for the same day each month. A brief meeting with primary contact is conducted upon arrival to discuss any particular concerns or request since the last service. A review of the sighting log is also made. Service protocols are implemented. A detailed service is performed on all pest devices scheduled for that particular service visit. A brief exit meeting with primary contact is conducted to review service report, including findings and treatments, and to discuss recommendations regarding structural, storage and sanitation issues.</p>		