Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676339	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Dallas, LP	3350 Bonnie View Road Fort Worth, TX 76161

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observation, interview and record review, the facility failed to ensure there were sufficient nursing staff on a 24-hour basis to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care on 12 of 60 days (02/01/24 - 03/31/24) reviewed for sufficient staffing. The facility failed to have sufficient licensed nurse staff for adequate staffing on: 02/16/24, 6A - 2P shift. 02/16/24, 10P - 6A shift. 02/23/24, 2P - 10P shift. 02/23/24, 10P - 6A shift. 02/24/24, 6A - 2P shift. 02/24/24, 2P - 10P shift. 02/24/24, 10P - 6A shift. 02/25/24, 6A - 2P shift. 02/28/24, 6A - 2P shift. 02/29/24, 2P - 10P shift. 03/01/24, 6A - 2P shift. 03/04/24, 6A - 2P shift. 03/05/24, 6A - 2P shift. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	03/05/24, 10P - 6A shift. 03/06/24, 2P - 10P shift. 03/07/24, 6A - 2P shift. 03/09/24, 6A - 2P shift. 03/09/24, 10P - 6A shift. The facility failed to ensure there was sufficient staff available to provide timely incontinent care for Resident #2 on 03/04/24. These deficient practices placed residents at risk of not getting needed care and services, a decrease in quality of care and quality of life and/or injury. Findings included: A record review of the Facility Assessment Plan, updated March 2024, indicated Based on our resident population and their needs for care and support, our general approach to staffing to ensure sufficient staffing to meet the needs of the residents at any given time, [the Facility] utilizes a proprietary staffing model with a quick reference guide (Staffing Grid). Method 1. Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff [2 Licensed nurses per shift] are available to meet each resident's needs. Method 2. The [facility] staffing philosophy is designed to flex with the needs of [the residents]. When high acuity patients flex upward, licensed staffing is flexed accordingly. For example: DON: 1 DON RN full-time Days; if has other responsibilities, add additional RN/LVN as Asst. DON per Staffing Grid [Method 1] RN or LVN Charge Nurse: by shift .skilled: 1- 20 Residents .LTC: 1-30 Residents .DON/ADON may act as Charge Nurse if census under 120. Follow Staffing Grid [Method 1] for total Licensed Nurses required. Record review of February 2024 and March 2024 clock in/out reports, and a handwritten missed punch form dated 02/24/24, provided by the NFA reflected: On Friday, 02/16/24: LVN D worked 7:25 AM - 10:38 PM with a half hour break. LVN D worked 14.72 overtime hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LVN H worked 3:13 PM - 10:42 PM with a half hour break. LVN K worked 4:28 PM - 10:40 PM. LVN I worked 10:35 PM - 8:12 AM. LVN I worked 7.20 overtime hours. RN F clocked in for the 10P - 6A shift at 2:07 AM and clocked out at 2:43 AM. On Friday, 02/23/24: LVN C worked 5:54 AM - 12:00 AM with a half hour break. LVN D worked 7:15 AM - 2:58 PM with a half hour break. LVN D worked 7.22 overtime hours. RN F worked 9:55 PM - 7:22 AM with a half hour break. On Saturday, 02/24/24: LVN C worked 5:45 AM - 3:45 PM with a half hour break. RN E worked 11:22 AM - 10:00 PM with a half hour break. A handwritten missed punch form reflected RN E worked 02/24/24 from 5:00 AM - 9:00 AM. The clock in/out reports and handwritten missed punch forms did not reflect a licensed nurse working the 10P - 6A shift. On Sunday, 02/25/24: RN E worked 5:00 AM - 10:00 PM with a half hour break. The WCN worked 1:59 PM - 10:00 PM with a half hour break. The WCN worked 7.52 overtime hours. LVN C worked 9:45 PM - 10:00 AM with a half hour break. LVN C worked 6.87 overtime hours. RN L worked 10:37 PM - 6:53 AM with a half hour break. On Wednesday, 02/28/24: LVN C worked 6:09 AM - 2:22 PM with a half hour break. LVN J worked 1:45 PM - 11:16 PM with a half hour break. LVN H worked 2:45 PM - 11:05 PM. LVN H clocked out for a fifteen-minute break. RN L worked 10:18 PM - 6:00 AM with a half hour break. LVN I worked 10:53 PM - 8:15 AM with a half hour break. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On Thursday, 02/29/24: LVN M worked 7:36 AM - 2:00 PM. LVN M clocked out for a two-minute break. LVN D worked 7:52 AM - 10:54 PM with a half hour break. RN L worked 10:03 PM - 7:30 AM with a half hour break. LVN I worked 10:36 PM - 6:36 AM with a half hour break. On Friday, 03/01/24: LVN D worked 8:01 AM - 9:49 PM with a half hour break. LVN H worked 4:30 PM - 10:42 PM. LVN N worked 10:10 PM - 8:50 AM with a half hour break. LVN I worked 10:22 PM - 7:27 AM with a half hour break. LVN I worked 5.90 overtime hours. On Monday, 03/04/24: LVN J worked 1:44 PM - 11:56 PM with a half hour break. LVN D worked 3:35 PM - 9:55 PM. RN L worked 10:42 PM - 5:59 AM with a half hour break. RN F worked 11:50 PM - 8:06 AM with a half hour break. On Tuesday, 03/05/24: LVN D worked 8:47 AM - 9:52 PM with a half hour break. LVN J worked 12:13 PM - 12:12 AM with a half hour break. LVN I worked 10:02 PM - 10:05 AM with a half hour break. On Wednesday, 03/06/24: RN E worked 6:15 AM - 2:15 PM with a half hour break. LVN M worked 7:30 AM - 2:27 PM. LVN M clocked out for a two-minute break. LVN D worked 7:42 AM - 2:30 PM. LVN J worked 1:48 PM - 12:15 AM with a half hour break. (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

LVN I worked 6:42 PM - 8:20 AM with a half hour break.

RN F worked 12:13 AM - 8:09 AM with a half hour break.

On Thursday, 03/07/24:

LVN D worked 9:00 AM - 11:58 PM with a half hour break. LVN D worked 0.18 overtime hours.

LVN C worked 3:31 PM - 10:22 PM.

LVN I worked 10:10 PM - 9:30 AM with a half hour break.

RN F worked 12:15 AM - 8:57 AM with a half hour break.

The WCN worked [8:30 AM - 10:19 PM] 5.32 hours over her regular shift to help with direct resident care and services.

On Saturday, 03/09/24:

LVN C worked 6:10 AM - 8:07 PM. LVN C was relieved for break and returned at 11:28 PM. LVN C clocked out at 12:00 AM and back in at 12:01 AM - 7:17 AM. LVN C worked 20.75 hours.

LVN D worked as a MA 10:57 AM - 9:27 PM with a half hour break. LVN D worked 10.00 overtime hours.

Two LVNs from an affiliated facility entered the facility around 3:00 PM [03/09/24] to work the 2P - 10P shift and help with staffing and returned 03/10/24 to work from 6:00 AM - 2:00 PM.

A record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female admitted on [DATE]. The most recent re-entry date, 01/30/24, revealed an acute diagnosis of Hemiplegia (complete paralysis) and Hemiparesis (partial weakness) following cerebral infarction ([Ischemic Stroke] a result of disrupted blood flow to the brain) affecting right dominant side; Aphasia (loss of ability to understand or express speech) following cerebral infarction; Dysphagia (difficulty swallowing) following cerebral infarction. Resident #2 had an history of T2DM (a chronic condition that affects the way the body processes glucose [blood sugar]); Epileptic seizures (a result of abnormal electrical brain activity, also known as a seizure); CKD (kidneys have mild to moderate damage); and a colostomy status (an opening for the colon [large intestine]). Resident #2's BIMS score was 06, which suggested severely impaired cognition. Resident #2 had no behavioral symptoms or rejection of care behavior during the MDS review period. Resident #2's functional status reflected one-person substantial/maximal assistance with ADLs. Resident #2 was always incontinent of bladder and had a colostomy appliance for bowel. Resident #2's family assisted with ADLs when present and required assistance with turning resident from side to side for incontinent care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #2's care plan, review start date 02/20/24, revealed the following: Resident #2 had a colostomy bag; had a communication problem related to aphasia; had a potential for pressure ulcer development r/t immobility; at risk for skin breakdown r/t bladder incontinence; had a seizure disorder; had a cerebral vascular accident (stroke) that affected the right dominant side; had impaired visual function; had potential for pain; require one-person assistance with meals; and had an ADL self-care performance deficit. The care plan interventions included: observation, monitoring, educating, following protocol, assess, eval, and treatment. Person-centered interventions included staff to get Resident #2 out of bed to chair by 10:30 AM on shower days [T/Th/Sat] and returned to bed by 1:00 PM to prevent recurrence of pressure ulcers; transfer with mechanical lift; ask questions that require one- or two-word answers; two-person assist with transfers, positioning, and showers; and anticipate need for pain relief and respond immediately to any complaint of pain. During an interview on 03/01/24 at 1:55 PM, LVN D indicated that she worked at the facility for less than 1 year during the day shift (6A - 2P), Monday - Friday. LVN D said that typically there were two nurses scheduled each shift. LVN D said that her assignment included Hall 500 and the odd side of Hall 200. LVN D said that she was responsible for approximately 25 residents. LVN D said her responsibilities included passing some routine and all PRN medications, overseeing, and assisting the CNA(s), providing G-tube, IV, and foley catheter care. LVN D stated she was the only nurse to provide direct patient care (03/01/24) and was glad that no unforeseen events occurred, and residents were safe, and care provided. LVN D said that an ADON was present on-site but was not assigned resident care. LVN D said it was possible to meet the minimal care needs with the assistance of a CNA and HA. During an interview on 03/02/24 at 2:51 PM, RN E indicated that she worked PRN on the weekends as RN coverage and as a resource to the nurses. RN E stated she may pick up other shifts when needed, but not often. RN E stated when she worked on the weekends, she would randomly select charts for review to ensure orders were written correctly, medication reconciliation was done for a new admit or readmit, ensure daily skilled documentation was completed, labs that were ordered had been drawn, and physician orders and care plan interventions were implemented. RN E said that she would perform wound care and weekly skin assessments to help the nurses to allow them to be thorough in their nurse responsibilities. RN E said that staffing issues were a concern due to nurses that call in right before their shift starts or they do not call and do not show up. RN E said that she worked as a floor nurse today (03/02/24) when received a call the day before to come in. RN E said that she worked as a floor nurse alone or once a nurse agreed to come in to work over the weekend when staff walked out or did not show up because they did not receive their paycheck on Friday (02/23/24). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/02/24 at 5:49 PM, LVN C indicated that his schedule was Saturday and Sunday doubles. LVN C stated that he picked up shifts when a nurse called out on other days of the week. LVN C said that there are at least 2 nurses (RN/LVN) scheduled every shift with 3 - 5 certified nurse assistants (CNAs), 1 - 2 hospitality aides (HA), and 2 med aides (MA). LVN C said that the facility staffed by census and not by acuity. LVN C said he was placed in situations a couple of times when he was the only nurse on shift. LVN C recalled a Friday (02/23/24) when he picked up a 6A - 2P shift and ended up working until midnight. LVN C said he was the only licensed nurse on the 2P - 10P shift after staff walked out or did not show up for work. LVN C said that he was placed in a way that he did not have time to follow up with resident(s) after administering a PRN medication. LVN C said on a regular shift with another nurse, it was 3, 200 steps from one end of his assigned hall and to the other end of the hall that was split between the 2 nurses (even/odd rooms). LVN C described walking from one end of a hall to round on his residents and cross over to the split hall to round on his assigned residents (approximately 26 residents) was almost like walking 3 football fields. LVN C said that the situation was pretty heavy on him with his medical injuries and using a cane as an ambulatory assistive device. LVN C said that the resident assignments and working with limited staff is not efficient or productive. LVN C said that he placed himself in the resident shoes . not many people in the profession have empathy anymore. LVN C said that there is poor communication about staffing issues and never relieved on time at the end of his shift. LVN C said that on-coming nurses come in late or off-going nurses take their time to give report that interfere with his time management. LVN C said that staff often are a no call, no show. LVN C said that he could not continue to work these marathon shifts. An outbound call placed on 03/04/24 at 4:30 PM to RN F was unanswered and not returned. During an observation and interview on 03/04/24 at 7:40 PM, Resident #2's family member stated that [Resident #2] had not been touched for ADL care. The family member repositioned Resident #2 to her left side to show the sheet and brief was soaked through with urine to the blue mattress. A wet spot was noted on the mattress and a strong urine odor was noted. The family member stated that she comes in every morning to feed, provide incontinent care, provide bed bath and dress on opposite days of shower days, leave for work, and return in the late afternoon and evening to feed and prepare Resident #2 for bedtime. The family member stated she did not feel that there was enough staff to meet her concerns or [Resident #2] needs. The family member stated that she participated in care plan meetings to ensure appropriate interventions were in place to protect Resident #2 and to prevent skin breakdown or harm. The family member stated that she and her father are present daily to not only assist Resident #2, but to also help the staff. The family member indicated that (Monday, 03/04/24) was not the first time she has found that Resident #2 had not received care during the day. The family member stated she has brought the concerns to the NFA attention. The family member stated that she had to remind staff that Resident #2's blood sugar had not been checked before her meal or medications had not been administered. The family member stated that the nurse would be busy but would assist as soon as possible. The family member stated that she worried about medications administered on time because of the risks to Resident #2 if seizure medications are not received as scheduled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/09/24 at 3:13 PM, LVN J indicated that she worked PRN Monday - Friday, 2P - 10P, when available. LVN J said that she worked less often than before because of minimal staff and inconsistency with getting paid. LVN J said that she worked a couple of times as the only nurse for a few hours. LVN J was selected to interview when her med cart was discovered unlocked, although she was standing in the nursing station with the med cart in line of sight. LVN J said that she had given her keys to the MA to get tape out of the drawer and the MA left the cart unlocked. LVN J said that small things like a cart being unlocked could lead to serious incidents or mistakes as a nurse. LVN J indicated that working alone for just a couple of hours or with minimal staff is a concern for her and the residents. During an interview on 03/09/24 at 3:28 PM, CNA O indicated that he worked Monday - Friday, 6A - 2P shift and some weekends. CNA O stated that he was usually assigned to Hall 400. CNA O said he did not work on 03/04/24 and was not assigned to Resident #2 during this shift (03/09/24 6A - 2P). CNA O said that the risks to residents not receiving timely incontinent care was skin breakdown. During an observation of Hall 400 on 03/09/24 between 5:15 PM - 5:45 PM revealed 3 call lights unanswered. No staff was observed responding to the call lights on the hall during the on-going observation. A resident was heard calling out for the Staffing Coordinator by name (reflected on schedule as CNA 2P - 10P shift) and repeating that he needed to be changed. At 5:27 PM, a family member exited a room, approached the surveyor, and stated, we need a CNA to come in and change my dad . we have waited since 3:45 PM and no one has come in to check on him or change him. The NFA turned onto the hallway at that time and addressed the family member concerns. At 5:39 PM, LVN D was observed walking down the hall with supplies to provide peri-care and entered the room the family member needed incontinent care for her dad. LVN D said that she would provide peri-care at the NFA request. LVN D was assigned to passing medications as the Medication Aide for the 2P - 10P shift. At 5:44 PM, the Staffing Coordinator exited from a room and indicated she was feeding a resident. The Staffing Coordinator indicated that she put her name on the schedule as the CNA for 03/09/24, 2P - 10P shift and did not know resident call lights were not answered. During an interview on 03/09/24 at 9:01 PM, the Staffing Coordinator indicated she still had an active nurse assistant certification and would help with resident care when a CNA called in. The Staffing Coordinator stated when a nurse called in or a nurse position was open on a shift, she would send a text to the NFA, ADON, and DON before he left, to inform that a nurse was needed. The Staffing Coordinator denied calling nurses to come in to fill open shifts, she notified leadership so that they could convince nurses to come in. The Staffing Coordinator stated that staff walked out or did not return to work when they did not receive their paycheck on Friday, 02/23/24. The Staffing Coordinator stated that nurses scheduled to work the 2P - 10P shift on that Friday (02/23/24) walked out when they were not paid. LVN C was the only nurse agreed to work because he was already on-site and worked the 6A - 2P shift. The other nurse scheduled to work the 2P - 10P shift did not show and 1 of the 2 nurses scheduled for 10P - 6A shift showed up. The Staffing Coordinator said that there are possible new hires. An attempt to interview RN F on Sunday, 03/10/24 at 6:45 AM was unsuccessful when informed that RN F did not call in or show up to work for her 03/09/24, 10P - 6A scheduled shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/10/24 at 2:30 PM, the NFA indicated he was aware of the sufficient staffing concerns. The NFA stated that PRN nurses were depended on to accommodate for staff call ins or open positions. The NFA indicated that the regional leadership and owners did not want to use agency or contract nurses. The NFA stated that there was a staffing grid to determine the staffing levels needed for day-to-day resident care and services or during an emergency. The NFA indicated that the facility census impacted or determined staffing levels. On 04/02/24, the NFA stated that he did not have access to the PBJ Staffing Data Report when requested, but provided nursing staff (LVN/RN, CNA, HA, and MA) clock in/out reports for February 2024 and March 2024. Review of the Staffing policy and procedure revised 2021, indicated: - Our facility provides adequate staffing to meet needed care and services for our resident population. - Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44405 Based on observation, interviews and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 24 of 39 days (02/01/24 - 03/10/24) reviewed for RN coverage. The facility failed to ensure they had a registered nurse (RN) to serve as the director of nursing (DON) on a full-time basis from 02/16/24 - 03/10/24. The facility failed to use the services of a RN for at least 8 consecutive hours a day, 7 days a week on duty on 02/01/24, 02/02/24, 02/06/24, 02/08/24, 02/09/24, 02/14/24, 02/15/24, 02/16/24, 02/22/24, 02/26/24, 02/27/24, 02/28/24, 03/04/24, 03/06/24, and 03/08/24. The facility failed to use the services of a RN within a 24-hour period on 02/05/24, 02/07/24, 02/13/24, 02/19/24 - 02/21/24, 03/01/24, 03/05/24, and 03/09/24. This failure placed residents at risk of missed nursing assessments, interventions, care, and treatments. Findings included: Record review of February 2024 and March 2024 clock in/out reports, and a handwritten missed punch form dated 02/24/24, provided by the NFA reflected: RN E was not a staff nurse, did not fill the role as a weekend RN supervisor or DON. RN E was on-site as RN coverage for less than 8 hours on 02/02/24, 02/06/24, 02/08/24, 02/15/24, 02/26/24, and 03/06/24. RN F worked less than 8 hours on 02/01/24, 02/02/24, 02/06/24, 02/09/24, 02/14/24, 02/16/24 (clocked in for the 10P - 6A shift at 2:07 AM and clocked out at 2:43 AM), 02/22/24, 03/04/24, 03/06/24, and 03/08/24. RN L worked less than 8 hours on 02/22/24, 02/27/24, 02/28/24, 03/04/24, and 03/08/24. During an interview on 03/02/24 at 2:51 PM, RN E indicated that she worked PRN on the weekends as RN coverage and as a resource to the nurses. RN E stated when she worked on the weekends, she would randomly select charts for review to ensure orders were written correctly, medication reconciliation was done for a new admit or readmit, ensure daily skilled documentation was completed, labs that were ordered had been drawn, and physician orders and care plan interventions were implemented. RN E said that she would perform wound care and weekly skin assessments to help the nurses to allow them to be thorough in their nurse responsibilities. RN E said that she worked as a floor nurse today (03/02/24) when received a call the day before to come in. RN E said any day that she worked as a floor nurse she worked 8 or more hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Dallas, LP	3350 Bonnie View Road Fort Worth, TX 76161

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Outbound calls were placed on 03/04/24 at 4:30 PM to RN F and RN L. The calls were unanswered and not returned before exited facility on 03/10/24. During an interview on 03/09/24 at 3:20 PM, the RCNO indicated that she was considered the interim DON until a DON was hired. The RCNO stated that a new DON was scheduled to start on Monday 03/11/24. The RCNO stated that she was unsure when the previous DON left, but she [RCNO] had not been in the building anytime in February or before [03/09/24]. An attempt to interview RN F on Sunday, 03/10/24 at 6:45 AM was unsuccessful when informed that RN F did not call in or show up to work for her 03/09/24, 10P - 6A scheduled shift. During an interview on 03/10/24 at 2:30 PM, the NFA indicated the RCNO was expected to fill the position of DON when there was a vacancy. The NFA indicated RN coverage was important and nurses should expect to work 8.5 hours to cover their lunch break. The NFA stated that a half hour lunch was mandatory for fulltime staff scheduled for 8-hour or longer shifts. The NFA indicated a new DON was scheduled to start on Monday, 03/11/24, and felt positive that staffing would improve. Review of the Staffing policy and procedure revised 2021, indicated: - The facility will follow federal guidelines to ensure that an RN is on staff for a minimum of eight (8) hours per twenty-four (24) hour period.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on interview, observation, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to reconcile Resident #1's medications when readmitted to the facility on [DATE] after an acute hospital inpatient stay. Resident #1 did not receive medications or medications were not discontinued per hospital discharge orders on 02/16/24. The facility failed to provide Resident #1 20 of 40 doses of Pregabalin 100 mg capsule scheduled three times a day for nerve pain as ordered to start on 02/23/24. The medication was not ordered from the pharmacy. The staff did not retrieve the medication from the e-kit where it was available on the days missed. The facility failed, in collaboration with the consultant pharmacist, to implement a system to handle and dispose of controlled medications in compliance with the federal and state laws and regulations consistently and accurately. The pharmacist consultant failed to conduct a complete MRR (a thorough evaluation of the medication regimen of a resident), at least monthly (or more frequently, as indicated by the resident's condition) for every resident of the facility. These failures could place residents at risk of serious harm, not receiving their medications as ordered, illnesses, hospitalization s, exacerbation of their disease processes, coma, and death. Findings included: A record review of Resident #1's Entry MDS assessment dated [DATE] revealed a [AGE] year-old female readmitted on [DATE]. Resident #1 had diagnoses of CRF (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (when there is not enough oxygen in the blood); acute and CHF (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), COPD (a group of diseases that cause airflow blockage and breathing-related problems), T2DM (a chronic condition that affects the way the body processes glucose [blood sugar]), MDD (a mood disorder that causes a persistent feeling of sadness and loss of interest), Osteoarthritis (a degenerative joint disease that can affect the many tissues of the joint), other chronic pain and OSA (a blockage in the airway keeps air from moving through the windpipe while asleep). Resident #1's BIMS score was 15, suggested Resident #1 was cognitively intact. Resident #1 required limited assistance with ADLs and used a power wheelchair independently as a mobility device. The MDS assessment revealed Resident #1 received scheduled pain medication regimen. A record review of Resident #1's active physician orders indicated: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Start date 02/22/24: Cyclobenzaprine 5 mg tablet, 1 tablet by mouth every 12 hours as needed for muscle spasms. Discontinued 02/22/24: Hydrocodone-Acetaminophen Oral Tablet 5-325 mg, 1 tablet two times a day for pain. Start date 02/23/24: Pregabalin Capsule 100 mg, 1 capsule by mouth three times a day for nerve pain. Start date 02/28/24: Tramadol 50 mg, 1 tablet by mouth every 6 hours as needed for pain. A record review of Resident #1's hospital discharge orders dated 02/16/24, reflected medication stop orders, medications to continue, and medications to start as followed: Stop taking: . Flexeril (Cyclobenzaprine) . Hydrocodone-Acetaminophen . Alprazolam . gabapentin 600 mg Change how you take these medications: Metformin 500 mg tablet. What changed how much to take. Take 1 tablet (500 mg total) by mouth two (2) times daily with meals. Continue these medications. Pregabalin 100 mg capsule. Take 1 capsule, 100 mg, by mouth three (3) times daily . Aspirin 81 mg by mouth one time a day. Review of Resident #1's February 2024 MARs revealed: - Alprazolam Oral tablet 1 mg. Give 1 mg by mouth one time a day for anxiety was administered on 02/17/24, 02/18/24 and 02/19/24. The medication was NOT DISCONTINUED as indicated on the hospital discharge orders dated 02/16/24. - Cyclobenzaprine 5mg tablet. Give 1 tablet by mouth two times a day for muscle spasms was administered on 02/17/24, 02/18/24 and 02/19/24. The medication was NOT DISCONTINUED as indicated on the hospital discharge orders dated 02/16/24. - Gabapentin 600 mg. Give 1 tablet by mouth three times a day for neuropathy (diabetic complication causing injury to some body nerves) was administered on 02/17/24, 02/18/24 and 02/19/24. The medication was NOT DISCONTINUED as indicated on the hospital discharge orders dated 02/16/24. - Pregabalin 100 mg capsule. Take 1 capsule, 100 mg, by mouth three (3) times daily did not reflect on the MAR as indicated on the hospital discharge orders dated 02/16/24. Resident #1 did not receive this medication on 02/17/24, 02/18/24 and 02/19/24. - Aspirin 81 mg capsule one time a day did not reflect on the MAR as indicated on the hospital discharge orders dated 02/16/24. Resident #1 did not receive this medication on 02/17/24, 02/18/24 and 02/19/24. - Metformin 500 mg. Give two (2) tablets by mouth two times a day for DM was administered on 02/17/24, 02/18/24 and 02/19/24. The medication was not CHANGED to one (1) tablet as indicated on the hospital discharge orders dated 02/16/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hydrocodone-Acetaminophen 5-325 mg. Give 1 tablet by mouth two times a day for pain was administered on 02/17/24, 02/18/24 and 02/19/24. The medication was NOT DISCONTINUED as indicated on the hospital discharge orders dated 02/16/24. A record review of Resident #1's hospital discharge orders dated 02/22/24, reflected medication stop orders, medications to continue, and medications to start as followed: - Start taking these medications: Amoxicillin-clavulanate on 02/23/24 Sitagliptin 25 mg on 02/23/24 Torsemide 40 mg on 02/23/24 - Change how you take these medications: (This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully .) Albuterol sulfate-ipratropium nebulizer solution, take 3 mLs by nebulization every 4 hours as needed for Wheezing. Insulin lispro 100 unit/mL injection. Inject 5 units under the skin 3 times daily with meals. (What changed: You were already taking a medication with the same name, and this prescription was added.) Metformin 500 mg. Take 1 tablet (500 mg total) by mouth two (2) times daily with meals. Valsartan 320 mg tablet. Take 1 tablet (320 mg total) by mouth daily (start taking on 02/23/24) - Stop taking these medications: Alprazolam . gabapentin . Hydrocodone-acetaminophen 5-325 mg per tablet . - Continue taking these medications . Pregabalin 100 mg. Take 1 capsule, 100 mg, by mouth three (3) times daily for neuropathy. Review of Resident #1's February 2024 and March 2024 MARs revealed: - Pregabalin 100mg, 1 capsule was not administered on 02/23/23 at 9A, 3P, or 9P; 02/24/24 at 9A; 02/26/24 - 02/28/24 at 9A, 3P, or 9P; 02/29/24 at 3P and 9P; 03/1/24 at 9A, 3P, or 9P; 03/02/24 at 9A; and 03/04/24 at 9P. - Cyclobenzaprine 5mg tablet. Give 1 tablet by mouth two times a day for muscle spasms was discontinued on the MAR but was still packaged with other medications in the multi-dose packaging for 7:00 AM and in a single-dose package to be administered at 3:00 PM. - Aspirin 81 mg capsule one time a day was entered on the February 2024 MAR. The first dose was administered on 03/24/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Metformin 500 mg. Give two (2) tablets by mouth two times a day for DM reflected on the February 2024 and March 2024 MARs and was administered at 9:00 AM and 5:00 PM on 02/24/24 through 03/09/24. A record review of Resident #1's comprehensive care plan, initiated 01/04/24, reflected medical, nursing, mental, psychosocial needs as identified in the physician orders and problems/risks identified in the MDS assessment. Areas of focus in Resident #1's comprehensive care plan reflected: Pain medication therapy - Hydrocodone/Acetaminophen, Altered respiratory status, and DM management. An interview on 03/01/24 at 11:45 AM, the ADON said that she retrieved the Pregabalin 100 mg capsule from the Omnicell (e-Kit) when informed by MA A that the medication was not available on the cart. The ADON stated that she was not aware the medication was not ordered and was the reason not available. The ADON stated that medications were reconciled when a resident admitted /readmitted to the facility. The ADON said that the nurse reviews the orders received on the admission, hospital discharge orders with the attending physician; enter the medications into the resident's chart and retrieve medications from the e-kit for first dose until the medication is retrieved from the pharmacy. The ADON said that the protocol is for the nurse or MA to notify leadership (ADON or DON) if a dose was not available, or a narcotic prescription needed to be refilled. An interview on 03/01/24 at 2:43 PM, MA B stated the Pregabalin 100 mg capsule was not available on the med cart to administer. MA B said that medications were packaged in a cycle roll (all routine medications scheduled at a certain time are packaged together in one pack for administration.) MA B said that she would document not available. MA B said that the appropriate steps to take would be to notify the charge nurse who would retrieve the medication if stocked in the e-kit. An observation and interview on 03/02/24 at 3:49 PM revealed Resident #1 sitting up in power wheelchair received oxygen at 4L via NC by concentrator with call light in hand. Resident #1 was alert and oriented to self, time, and surrounding. Resident #1 stated a generalized pain level of 10. Resident #1 was observed attempting to reposition for comfort. Resident #1 denied receiving Pregabalin for nerve pain or that she spit it out on 02/28/24 as indicated on the MAR. During an interview on 03/08/24 at 3:08 PM, the Consultant Pharmacist stated she had to follow up with the pharmacy to find out why the Pregabalin was never delivered to the facility. The Consultant Pharmacist indicated she reviewed each resident's medication regimen monthly in November 2023, January 2024, and February 2024. The Consultant Pharmacist said she had to locate the reports. The Consultant Pharmacist indicated she performed a drug destruction on February 20, 2024, with the facility staff. The Consultant Pharmacist said that the destruction log was not signed by witnesses because the staff told her that they did not have time to sign. The Consultant Pharmacist could not recall the names of the staff that witnessed the drug destruction. Record review of Omnicell transactions printout dated 03/08/24 revealed Pregabalin 100 mg capsule was pulled form the Omnicell for administration on the days the MAR reflected the medication was administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Policy for Medication Therapy revised April 2007, reflected, All medication orders will be supported by appropriate care processes and practices. Policy interpretation revealed Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen . The Consultant Pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected. Record review of in-services the facility initiated: Pharmacy Review of Medication Not Available and Medication Administration (dated 03/08/24) and New Admission Checklist Review (dated 03/09/24) were on-going. The in-service training reports reflected signatures of various department staff in attendance. The following nursing staff completed the knowledge check, Medication Administration Quiz: MA O, MA B, MA G, ADON, LVN D, LVN C and the two nurses assisted with staffing from the sister facility. Interviews conducted with nursing staff [LVN C, ADON, and LVN D] indicated they participated in an in-service training about medication administration and when medications are not available. The nursing staff summarized the topic of discussion specific to ordering and administering medications. Each staff member stated in their own words the facility expectation and protocols. During an interview and record review on 03/25/24 at 3:41 PM, the DON indicated a drug destruction was conducted with the Consultant Pharmacist. The DON provided a signed Statement for Destruction of Dangerous and Controlled Drugs for Long Term Care Facilities dated 03/25/24. The Consultant Pharmacist, DON, and NFA signatures reflected on the form. The DON stated she conducted an on-going in-service about controlled substance storage and disposal. The DON stated that she was responsible in collaboration with the consultant pharmacist for controlled medications. The DON stated that the controlled substance count sheets and the destruction log should reflect information such as destruction date, resident name, the drug name and strength, the prescription number, the number of pills/amounts of medication wasted, and should always have witness signatures. The DON said that she started auditing charts for accuracy and would review every admission/re-admission order for accuracy and completeness. The DON said that she asked the Consultant Pharmacist to provide a current MRR and indicated she expected a MRR every month and as needed to identify duplicative therapy, avoid significant medication interactions and to ensure parameters are indicated.