STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745019	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James L West Center for Dementia Care	1111 Summit Ave Fort Worth, TX 76102

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview and record review, the facility failed to, based on the comprehensive assessment of a resident, ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one of eight residents (Resident #1) reviewed for quality of care. Resident #1, who was on aspirin, had an unwitnessed fall with head injury and a significant amount of bleeding from his head. He was transferred into the wheelchair and showered by LVN D and CNA E prior to the completion of a full assessment. Resident #1 was subsequently sent to the hospital and diagnosed with a displaced hip fracture which required surgery. An Immediate Jeopardy (IJ) was identified on 04/25/24. While the IJ was removed on 04/26/24 at 3:30 PM, the facility remained out of compliance at a scope of isolated with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of impairment or serious harm. Findings included: Record review of Resident #1's face sheet, dated 04/26/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: alcohol-induced dementia (decline in memory, thinking, and behavior), major depressive disorder (mood disorder), pulmonary fibrosis (scarring of lungs), chronic pain, dysphasia (difficulty swallowing), and muscle weakness. Record review of Resident #1's annual MDS, dated [DATE], reflected the resident had severe cognitive impairment with a BIMS score of 2. The resident was usually understood by other and usually understood others. The resident required moderate assistance with all activities of daily living. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, revised on 11/12/23, reflected the resident had limited physical mobility related to confusion and dementia with interventions to encourage participation in activities that promote mobility and to monitor/document/report and s/sx of immobility, contractures forming or worsening, thrombus (blood clots) formation, skin-breakdown, fall related injury. Resident #1 was high risk for falls related to confusion and dementia with interventions that included anticipating and meeting resident needs, ensuring call light was within reach, encouraging the resident to participate in activities that promote exercise/improved mobility, ensure resident had on appropriate footwear, following the facilities fall protocol, maintain a safe environment (floors free from spills, clutter, adequate light, bed in lowest position at night, handrails on walls), and provide activities that minimize the potential for falls. Further review reflected Resident #1 was on anticoagulant therapy (aspirin 81 mg daily for heart health) with interventions that included administering anticoagulant medications as ordered and monitor for side effects and effectiveness. Record review of Resident #1's medical records, dated 04/22/24, from the local hospital reflected in part the following: [Resident #1] presents to the hospital due to a fall with head injury . CT scan findings included: -no acute intracranial abnormality -Right parietal scalp (side of head) hematoma (bruise) -mildly impacted and displaced sub-capital right femoral neck (hip) fracture. Hip fracture was treated with open reduction and internal fixation (surgery). Record review of Resident #1's incident report, dated 4/22/24, and completed by LVN D reflected: [CNA E] notified that [Resident #1] was found on the floor in his bedroom, near his roommate's bed . [Resident #1] was found on the floor on his left side. There was a puddle of blood on the floor, and it was apparent that he hit his head on the right back side of his head. Large laceration noted to the back of his head. [Resident #1] left side of his body appears to be sore by [Resident #1] saying 'ouch'. Assessment completed, no changes or abnormalities noted in extremities. [Resident #1] was transferred from floor to wheelchair and taken to shower room to be cleaned up. Record review of Resident #1's progress note by LVN D, dated 4/23/22 at 12:09 AM, reflected: [LVN D]: Writer was notified by [CNA E] that [Resident #1] was on the floor upon her entering the bedroom. Nurse went to assess and observe that resident was on the floor on his left side. There was a puddle of blood on the floor, and it was apparent that he hit his head on the back right side of his head. Large laceration noted to the back of his head. Resident's left side of body appears to be sore by hearing the resident saying 'ouch'. Resident was picked up by writer and [CNA E] and placed in wheelchair. We then took him to the shower room to get him cleaned up and to further assess him. No other bleeding from current fall noted. On-call for MD was contacted, and a message was left of findings and that he would be transferred to [local hospital] due to him hitting his head. [RP] was phoned twice with no answer. [family member] was phoned twice with no answer . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation on 04/25/24 at 10:25 AM, Resident #1 was sitting in the dining area with staff and other residents. Resident #1 could not be interviewed due to cognition. Resident #1did not have any visible marks/bruises other than the laceration to the right side of his head. In an interview on 04/25/24 at 9:30 AM, the DON stated it was reported to her that staff were assisting the resident to bed and doing rounds when Resident #1 was found on the floor. The DON stated Resident #1 was transferred to the hospital where it was found that his right hip was fractured, and he had to undergo a closed surgical procedure for treatment. The DON stated she asked LVN D to describe the position Resident #1 was lying in so she could get an idea of how the fall occurred and it was reported Resident #1 was lying near his roommate's bed with his feet towards the door. The DON stated LVN D reported Resident #1 was lying in a pool of blood coming from behind his head, with no other injuries observed. The DON stated LVN D reported Resident #1 grabbed his left side and said ouch but till did not show signs his hip was fractured. The DON stated sometimes residents with dementia don't feel pain due to pain transmitters not functioning. She stated LVN D reported Resident #1 was able to stand and be transferred into a wheelchair to be taken to the shower room and cleaned up. The DON stated the resident was a fall risk but was ambulatory and had not had any recent falls. In an interview on 04/25/24 at 12:04 PM, LVN D stated she worked for the facility for 1 year. She stated she worked overnight with Resident #1 on 4/22/24 when he had a fall. LVN D stated CNA E put Resident #1 to bed for the night and when she went back to assist his roommate, she found Resident #1 on the floor. LVN D stated CNA E notified her, and she went to the room to assess Resident #1. LVN D stated when she got in the room, she saw a lot of blood that appeared to be coming from the back right side Resident #1's head. LVN D stated there was so much blood it scared her. LVN D stated Resident #1 took aspirin which might have caused the excessive bleeding. LVN D stated she asked Resident #1 if she and CNA E could pick him up and he replied yes. LVN D stated Resident #1 did not bear any weight on his legs while she and CNA E lifted him into a wheelchair. LVN D stated Resident #1 was covered in blood, and she felt she needed to strip his clothing and clean him off to do a thorough assessment. LVN D stated before removing Resident #1 from the floor, the only assessing she did was taking his vitals, which were normal. LVN D stated she was unable to do any further assessing due to the excessive blood, so Resident #1 was then taken to the shower room to be cleaned off. LVN D stated once Resident #1 was cleaned off, there were no other injuries noted besides a laceration to the back of his head. LVN D stated Resident #1 remained responsive and was talking at his normal baseline, which was confused. LVN D stated she notified the MD and sent Resident #1 out to the local hospital. LVN D stated Resident #1 did not indicate being in any pain until the EMTs transferred him from the wheelchair onto the stretcher and he said ouch. When asked if a resident was supposed to be moved without a full assessment if there was an obvious head injury, LVN D paused then stated, You're right, I should not have moved him. LVN D stated she should have called someone before moving Resident #1 and allowed the EMTs to move him in case of unknown head/neck injuries. LVN D stated she was so shocked by all the blood and must have forgotten protocol in the moment, which was to not move the resident and call emergency services and MD. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In an interview on 04/25/24 at 12:24 PM, CNA E stated she worked at the facility for almost 2 years. She stated she worked with Resident #1 on 4/22/24 when he had a fall with a head injury. CNA E stated she was assisting Resident #1 and his roommate to bed, then she had to step out for a second to grab an extra pillow and when she returned, she found Resident #1 on the floor. CNA E stated Resident #1's bed was in the lowest position, and he was fine when she left him, so she was unsure of how he fell . She stated Resident #1 got out of bed on his own and wandered often. CNA E stated she immediately notified LVN D. CNA E stated LVN D came into the room and tried to assess Resident #1 while he was on the floor but there was too much blood for her to see properly, so she told CNA E to grab a wheelchair for them to place Resident #1 in. CNA E stated LVN D took Resident #1's vitals once they got him in the wheelchair, then they took him to the shower room to clean him off so LVN D could assess him. CNA E stated Resident #1 was still acting like himself and talking while they were moving him. She stated Resident #1 did not indicate being in any pain initially and was even able to stand and help them transfer him into the wheelchair. CNA E stated LVN D got Resident #1 cleaned up and saw the wound to the back of his head and stated he needed to be sent out to the hospital. CNA E stated EMTs arrived shortly after LVN D notified the MD and when EMTs were putting Resident #1 on the stretcher he yelled ouch.

An attempted interview on 04/25/24 at 12:51 PM with Resident #1's RP was unsuccessful due to no response to phone call.

In an interview on 04/25/24 at 1:04 PM, ADON A stated she worked at the facility since September 2022. ADON A stated at the start of her shift on 04/23/24, she checked incidents and found Resident #1 had a fall with a laceration to his head and was sent out to the hospital. ADON A stated she spoke with LVN D, and she reported Resident #1 had a fall, he was assessed, and sent out to the local hospital. ADON A stated LVN D did not report that she was unable to complete an assessment on Resident #1 before moving him. ADON A stated staff were in-serviced very frequently on fall protocols, and the trainings included proper assessments and notification. ADON A stated a proper assessment for an unwitnessed fall or a fall with an obvious head injury would be to do neurological checks, check head-to-toes for injuries, and assess for pain before moving to prevent further injury if any. ADON A stated if a nurse was unable to complete an assessment, they would be expected to leave the resident on the floor and call another nurse or the MD for further instructions.

In an interview on 04/25/24 at 4:15 PM, the DON stated LVN D reported following fall protocols by assessing Resident #1 before moving him into the wheelchair. The DON stated LVN D did not report she was unable to complete an assessment on Resident #1, otherwise, corrective action would have been taken then. The DON stated the protocol for an unwitnessed fall with an injury was to assess the resident head-to toe before moving him/her, check for obvious injuries, complete neurological checks including assessing eyes for alertness and focus. The DON stated the risk of not completing an assessment before moving a resident after an unwitnessed fall or a fall with an injury could be causing further harm to the resident.

Record review of the facility's policy titled Assessing Falls and their Causes revised March 2018 reflected in part the following:

Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Steps in the procedure After a fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone This was determined to be an Immediate Jeopardy (IJ) on 04/25/24 at 4:20 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 04/25/24 at 5:39 PM. The following Plan of Removal submitted by the facility was accepted on 04/26/24 at 11:30 AM: Date: 4/25/24 Plan of Removal For Immediate Jeopardy [Nursing Facility] To Whom it may concern, Summary of Details which lead to outcomes: On 4/25/24, a surveyor provided an IJ Template notification that the Survey Agency has determined that conditions at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: F 684 Quality of Care: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to provide treatment and care in accordance with professional standards of practice for a resident who had sustained a head injury from a fall and was moved by the nurse without proper assessment. Corrective actions for those found to have been affected by the deficient practice: All residents have the potential to be affected. Identified resident returned to the facility with no adverse outcomes. The facility census on 4/25/24 was 89. The identified licensed nurse will be suspended (with possible termination with HR approval) and the nurse license will be referred to the Texas Board of nursing. Resident head to toe competencies will be completed for all licensed nurses by the end of day on 4/26/24. The following in services will be completed by 4/25/24 by the following nursing staff from the following administrative staff [DON], [ADON A], [ADON B], and [ADON C]. All current nursing staff (Nurses and CNAs), agency staff, new hires, and/or PRN Nurses and CNAs that work in the facility will have in servicing completed by end of day 4/26/24 and all other nursing staff to include nurses and CNAs that are out on leave, vacations, etc ., agency staff, new hires and/or PRN nurses and CNAs prior to working the floor by the DON/Designee. The training provided will be the following: Head to toe assessments - how and when to complete the assessment. Staff will understand initial assessments to rule out injury must be completed prior to moving a resident. For all unwitnessed falls and obvious head injury, neurological assessment must be completed in addition to head-to-toe assessment prior to change in position. Significant changes in status - when a resident has a change who to report it to Incidents and accidents and how to report and complete. Reporting to the physicians - reporting any significant changes or incident that occur with a resident and in a timely manner. Reporting to the administrative staff - any significant changes or incidents that has been reported, observed, or noted. Abuse and neglect - who to report to, types of abuse, prevention strategies. Fall management - intervention to put in place and what to do when a fall occurs. suspected injury or unwitnessed fall by the staff member while the resident is not in the facility - if/when the nurse is made aware of the alleged incident the physician will be notified, incident report completed, and assessment will be completed. Agency staff, new hires, and/or PRN Nurses and CNA's that work in the facility will have in servicing completed prior to working the floor by the DON/Designee. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ongoing monitoring: All components of this plan of correction will be submitted to the facility QAPI committee meeting and additional recommendations will be made until substantial compliance has been achieved. An Emergency QAPI meeting was conducted on 4/25/24. The Medical Director was notified and agrees with the plan. Current and past falls for the last 30 days will be reviewed for compliance to ensure that regulatory guidelines have been met. Who is responsible for implementing of processes? The administrative nurses (ADON and DON) and Administrator. Monitoring of the POR included the following: Interviews on 04/23/24 between 12:45 PM-3:10 PM were conducted with the DON, ADON A, RN F (7:00 AM-7:00 PM shift), LVN G (7:00 PM-7:00 AM shift), CNA H (7:00 AM-7:00 PM shift), LVN I (7:00 AM-7:00 PM shift), CNA J (7:00 AM-7:00 PM shift), LVN K (7:00 AM-7:00 PM shift), CNA L (7:00 AM-7:00 PM shift), CNA M (7:00 PM-7:00 AM shift), CNA N (7:00 PM-7:00 AM shift), LVN O (7:00 PM-7:00 AM shift) and LVN P (7:00 PM-7:00 AM). All nurses were able to provide competency regarding in-services regarding protocol for unwitnessed falls and falls with obvious injuries. The nurses stated after an unwitnessed fall or fall with injury, they would complete a head-to-toe assessment of the resident before moving them, then assist the residents to a comfortable position only after injuries were ruled out. The nurses stated if the assessment determined the resident had a serious injury and could not be moved or if the assessment was notable to be completed for any reason, the MD and/or emergency services would be notified immediately, and appropriate documentation would be completed. The aides stated if a resident had an unwitnessed fall or a fall with an injury, they would leave the resident in the position they were found in and immediately notify the nurse for the resident to be assessed. Record review of Residents #1, #2, #3, #4, #5, #6, #7 and #8 who were all at risk for falls, electronic health records reflected interventions were in place for fall prevention and fall protocols were followed appropriately for any documented falls. Record review of in-services on 04/25/24-04/26/24, conducted by the DON, reflected all staff were trained during or prior to their shift on fall protocols which included assessing the resident, monitoring for significant changes in status, reporting to the physician/family, and completing incident reports. Record review of a document provided by the DON reflected an audit of resident falls from the past 30 days to ensure compliance was started. Record review of the QAPI sign-in sheet, dated 04/25/24, provided by the Administrator reflected the QAPI committee was notified of the identified immediate jeopardy and interventions were implemented. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator and the DON were informed the Immediate Jeopardy was removed on 04/26/24 at 3:30 PM. The facility remained out of compliance at a severity level of no actual harm with the potential or more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.