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	04/18/2024

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on record review and interview, the facility failed to ensure at the time residents were admitted they had physician orders for the resident's immediate care for 1 (Resident #74) of 5 residents reviewed for admission orders. The facility failed to enter physician's orders for Resident #74's hospice and catheter care. This failure could cause the residents to have incomplete care with hospice and improper incontinent care and urinary tract infections. Findings included: Review of Resident #74's undated Admission Record revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Dementia, Type 2 Diabetes (high blood sugar), Hypothyroidism (lack of thyroid hormones), Hypertension (high blood pressure). Review of Resident #74's MDS, dated [DATE], revealed Resident #74 had a BIMS of 14 indicating cognition was intact. Resident #74 required use of indwelling suprapubic catheter. The MDS did not indicate Resident #74 entered the facility on hospice or was on hospice during his stay. Review of Resident #74's baseline care plan, dated 02/27/24, indicated Resident #74 was admitted with a suprapubic catheter due to incontinence of the bladder, and there was no mention of the resident being on hospice care. Review of Resident #74's interim care plan dated 02/28/24 indicated No to him having a catheter and Yes to him having hospice/end of Life care. Review of Resident #74's progress notes dated 02/27/24 at 7:33 PM revealed Resident #74 arrived to the facility with a family member from hospital. Resident #74 would be admitted to hospice per hospital. Resident #74's assessment revealed he was not ambulatory and had a suprapubic catheter in use since September 2024, incontinent of bowel. Review of Resident #74's orders on 04/16/23 revealed orders dated 03/25/24 revealed an order to secure tubing with anchor and check placement every shift two times a day for suprapubic catheter. Resident #74's orders also revealed there was no order for hospice care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a list provided by the facility on 04/16/24 of residents on hospice revealed Resident #74 was not included. Observation of Resident #74 on 04/17/24 at 10:06 AM revealed staff were completing incontinent care. Interview on 04/17/24 at 4:20 PM with LVN C revealed Resident #74 entered the facility a couple of months ago, February or early March 2024. According to LVN C Resident #74 entered the facility with hospice care and with the use of a suprapubic catheter. LVN C stated she had not noticed whether there was an order for Resident #74 regarding his hospice or catheter care. According to LVN C the admitting nurse was responsible for entering orders upon admission. LVN C stated there was no risk involved for Resident #74's care with hospice or his catheter because he was seen by the hospice aide 5 days a week, nurse 1-2 days a week. LVN C stated they could observe Resident #74 with catheter therefore provided care for it. LVN C stated physician and nurse practitioners were in the building constantly and did rounds with Resident #74 and could provide care instructions if needed. Interview on 04/17/24 at 4:54 PM with the ADON, ADON reviewed her list of hospice residents and stated Resident #74 was not on hospice. Upon further review, the ADON stated after speaking with staff Resident #74 was in fact on hospice and his order was missed by the admitting nurse. The ADON stated it was the admitting nurse's responsibility to receive all orders and enter them. The ADON stated it was the responsibility of the ADON and DON to review all new orders. The ADON stated Resident #74 was not at risk because he had not missed any care. Interview on 04/17/24 at 5:30 PM with the DON revealed the admitting nurse was responsible for entering all orders from the hospital discharge paperwork. The DON stated the admitting nurse would enter and verify orders, enter any monitoring, appointment follow ups and triggers. The admitting nurse would then notify the physician of any changes or new orders needed. The DON stated ADONs were responsible for reviewing new orders daily. According to the DON, Resident #74's hospice orders were missed by the admitting nurse and the ADON's review. The DON stated Resident#74's catheter orders were completed later after discovering the orders were not entered. The DON stated admitting orders should have been entered immediately after admission to provide proper care and needs of the residents. Record review of catheter orders 04/18/24 12:00 PM revealed catheter orders were present. Review of facility policy titled Admission Notes reflected: .Preliminary information shall be documented upon a resident's admission to the facility. When a resident is admitted to the nursing unit, the admitting nurse must document the following information . Reason for admission The admitting diagnosis The time the physician's orders were received and verified. The presence of a catheter, dressings, etc

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to revise and review the care plan for 1 of 5 residents (Resident #74) reviewed accuracy of assessments. The facility failed to indicate on Resident #74's Minimum Data Set that he entered the facility on Hospice care. These failures could lead to the residents not receiving the care they require, resulting in injuries. Findings included: Review of Resident #74's undated Admission Record revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Dementia, Type 2 Diabetes (high blood sugar), Hypothyroidism (lack of thyroid hormones), Hypertension (high blood pressure). Review of Resident #74's MDS dated [DATE], revealed Resident #74 had a BIMS of 14 indicating cognition was intact. MDS did not indicate Resident #74 entered the facility on Hospice or was on Hospice during his stay. Review of Resident #74's baseline care plan, dated 02/27/24, indicated Resident #74 was admitted with no mention of resident on Hospice care. Review of Resident #74's interim care plan dated 02/28/24 indicated Yes to him having Hospice/End of Live Care. Review of Resident #74's updated comprehensive care plan revealed hospice services were entered on 03/26/24. Goal: Resident will be kept comfortable and will receive support from hospice team including nursing care, activities of daily living assistance, social services, and spiritual services. Resident will have adequate pain control and all optimum comfort measures in place. Interventions: 11th hour referral: If available at the time Resident #74 becomes imminent, services will be provided by facility to ensure he is not alone during last hours of life. Coordinate care with hospice company and notify hospice for any change in condition, unmet need requiring hospice intervention, requests from family. Observation of Resident #74 on 04/17/24 10:06 AM revealed staff were completing incontinent care. An attempt to contact the admitting nurse revealed the interview unsuccessful. Interviewed on 04/17/24 at 4:20 PM with LVN C revealed Resident #74 entered the facility a couple of months ago, February or early March 2024. According to LVN C Resident #74 entered the facility with hospice care. LVN C stated she had not noticed whether there was an order for Resident #74 regarding his hospice. According to LVN C the admitting nurse was responsible for entering orders upon admission. LVN C stated there was no risk involved for Resident #74's care with hospice or his catheter because he was seen by the hospice aide 5 days a week, nurse 1-2 days a week. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviewed on 04/17/24 at 4:54 PM with the ADON revealed she was the MDS Coordinator. The ADON stated she was not aware Resident #74's care plan did not show hospice on his MDS assessment. The ADON stated once a resident admits to the facility the orders for care are entered by admitting nurse. She stated once the order was entered the resident's MDS would then be triggered. The ADON stated she was responsible for ensuring resident MDS assessments were accurate and completed. Interviewed on 04/17/24 at 5:30 PM with the DON revealed the admitting nurse was responsible for entering all orders from the hospital discharge paperwork. The DON stated the admitting nurse would enter and verify orders, enter any monitoring, appointment follow ups and triggers. The DON stated an assessment was completed upon admission creating the baseline care plan. The DON stated 21 days later an interdisciplinary team met to enter areas for care for the comprehensive care plan. The DON stated the MDS Coordinator was the last to review care plan and make any updates or changes to ensure proper care will be provided to the resident. DON stated the MDS Coordinator was responsible for ensuring resident's MDS assessments were accurate. Interviewed on 04/18/24 at 3:10 PM with the Social Worker revealed she was working with Resident #74 and his family after his admission and realized Resident #74's care plan did not include care for hospice. The Social Worker stated she knew that he was on hospice care and that it needed to be documented. The Social Worker stated it was about a month later that she updated the care plan to reflect that Resident #74 was on hospice. The Social Worker stated she was not responsible for updating the care plan but thought it was appropriate to include his care for hospice.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to revise and review the care plan for 2 of 5 residents (Residents #2 and #74) reviewed for comprehensive care plans. 1. The facility failed to ensure Resident # 2's care plan after he was unable to use the call light system to call for help. 2. The facility failed to revise and review Resident #74's care plan after admission to include Hospice in a timely manner. 3. The facility failed to revise and review Resident #74's use of suprapubic catheter. These failures could lead to the residents not receiving the care they require, resulting in injuries. Findings included: Review of Resident #2's undated Admission Record revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, diabetes, muscle weakness, and repeated falls. Review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 3 indicating he was severely cognitively impaired. His Functional Status indicted he required a wheelchair for mobility, and he required substantial assistance with all his ADLs. Resident #2 was also always incontinent of bowel and bladder. Resident #2's Pain Assessment indicated he had no chronic pain. Review of Resident #2's care plan, dated 04/17/24, revealed he had quarter bed rails for safety and repositioning, he required assistance with meeting physical needs due to dementia, he suffered from insomnia, he only came out of his room for meals, and he had mobility issue s related to contractures of his legs. Review of Resident #2's EHR revealed his Morse Fall Scale scores indicated he was a high fall risk since he was admitted . Resident #2 also suffered falls on: 11/8/22 - no injuries 11/29/22- no injury 12/3/22- no injury 1/10/23- no injury 1/28/23- no injury (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/2/23- no injury 4/9/23- no injury 4/25/23 - no injury 9/08/23- no injury 9/17/23- no injury 10/24/23-unwitnessed fall, no injury 12/3/23-unwitnessed fall 1/31/24 - witnessed fall - no injury. Observation and interview on 04/16/24 at 11:26 AM revealed Resident #2 was on his left side in bed. Resident #2's call light button was located on the bedrail behind him. Resident #2 was asked how he called for help when he needed it and he pointed at the ceiling. The resident's call light was moved to the bedrail in front of him and he was asked to call for help. The resident pointed to the surveyor's watch. Resident #2's bed was in the low position, and he had fall mats on both sides of his bed. Interview on 04/17/24 at 1:36 PM with CNA A revealed Resident #2 did not know how to use his call light, even when it was placed in his hand. CNA A stated she checked on Resident #2 every two hours as he spent almost all his time in his bed. CNA A stated she had not witnessed any falls by Resident #2, but understood he was usually found on the floor beside his bed except his last fall (03/21/24) happened in the hallway when he fell out of his wheelchair. CNA A stated Resident #2 had been unable to use his call light for at least three months. Interview on 04/17/24 at 1:42 PM with LVN B revealed Resident #2 only came out of his room for meals, and occasionally to watch a movie on television. Staff knew he was a fall risk and would check on him every two hours. LVN B agreed that Resident #2 was not able to use his call light to request help. LVN B stated resident care plans were updated by the Care Plan Coordinator. Review of Resident #74's undated Admission Record revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Dementia, Type 2 Diabetes (high blood sugar), Hypothyroidism (lack of thyroid hormones), Hypertension (high blood pressure). Review of Resident #74's MDS, dated [DATE], revealed Resident #74 had a BIMS of 14 indicating cognition was intact. MDS indicated Resident #74 required use of indwelling suprapubic catheter. MDS did not indicate Resident #74 entered the facility on Hospice or was on Hospice during his stay. Review of Resident #74's baseline care plan, dated 02/27/24, indicated Resident #74 was admitted with Suprapubic Catheter due to incontinent of the bladder, no mention of resident on Hospice care. Review of Resident #74's interim care plan dated 02/28/24 indicated No to him having a catheter and Yes to him having Hospice/End of Live Care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #74's updated comprehensive care plan revealed hospice services were entered on 03/26/24. Goal: Resident will be kept comfortable and will receive support from hospice team including nursing care, activities of daily living assistance, social services, and spiritual services. Resident will have adequate pain control and all optimum comfort measures in place. Interventions: 11th hour referral: If available at the time Resident #74 becomes imminent, services will be provided by facility to ensure he is not alone during last hours of life. Coordinate care with hospice company and notify hospice for any change in condition, unmet need requiring hospice intervention, requests from family. Resident #74's care plan did not reflect his use of a suprapubic catheter. Observation of Resident #74 on 04/17/24 at 10:06 AM revealed staff were completing incontinent care. An attempt to contact the admitting nurse revealed the interview unsuccessful. Interview on 04/17/24 at 4:20 PM with LVN C revealed Resident #74 entered the facility a couple of months ago, February or early March 2024. According to LVN C Resident #74 entered the facility with hospice care and with the use of a suprapubic catheter. LVN C stated she had not noticed whether there was an order for Resident #74 regarding his hospice or catheter care. According to LVN C, the admitting nurse was responsible for entering orders upon admission. LVN C stated there was no risk involved for Resident #74's care with hospice or his catheter because he was seen by the hospice aide 5 days a week, nurse 1-2 days a week. LVN C stated they could observe Resident #74 with catheter therefore provided care for it. LVN C stated physician and nurse practitioners were in the building constantly and did rounds with Resident #74 and could provide care instructions if needed. Interview on 04/17/24 at 4:54 PM with the ADON revealed she was the MDS Coordinator. The ADON stated she was not aware Resident #74's care plan did not show hospice or with use of a catheter on his care plan. The ADON stated once a resident admits to the facility the orders for care are entered by admitting nurse. She stated once the order was entered the resident's MDS and care plans are then triggered. The ADON stated care plans were updated by outside staff, by a third party. Interview on 04/17/24 at 5:30 PM with the DON revealed the admitting nurse was responsible for entering all orders from the hospital discharge paperwork. The DON stated the admitting nurse would enter and verify orders, enter any monitoring, appointment follow ups and triggers. The DON stated an assessment was completed upon admission creating the baseline care plan. The DON stated 21 days later an interdisciplinary team met to enter areas for care for the comprehensive care plan. The DON stated the MDS Coordinator was the last to review care plan and make any updates or changes to ensure proper care will be provided to the resident. Interview on 04/18/24 at 3:10 PM with the Social Worker revealed she was working with Resident #74 and his family after his admission and realized Resident #74's care plan did not include care for hospice. The Social Worker stated she knew that he was on hospice care and that it needed to be documented. The Social Worker stated it was about a month later that she updated the care plan to reflect that Resident #74 was on hospice. The Social Worker stated she was not responsible for updating the care plan but thought it was appropriate to include his care for hospice. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/18/24 at 1:24 PM with the Care Plan Coordinator revealed she was responsible for updates to resident care plans as she gets the information, usually at their morning meetings. She stated it was important to keep the care plans up to date to ensure residents received the appropriate care. The Care Plan Coordinator stated she knew of other residents that were care planned for inability to use the call light to summon help. The Care Plan Coordinator stated residents having a way to ask for help, use of catheter, and hospice care included on the care plan was important to prevent risk of diminished way of life. Review of the facility's policy Care Plans, dated April 2009, reflected: .3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: a. is resident oriented. b. is behaviorally stated. c. is measurable; and d. contains timetables to meet the resident's needs . 4. Goals and objective are entered on the resident's care plan so that all disciplines have access to such information and can report whether the desired outcomes are being achieved . 5. Goals and objectives are reviewed and/or revised: a. when there has been a significant change in the resident's condition .