STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675817	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Worth Southwest Nursing Center	5300 Alta Mesa Blvd Fort Worth, TX 76133

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews and record reviews the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 10 (Residents #5, #19, #24, #44, #54, #60, #78, #99, #101, #354) of 29 residents reviewed for Pressure ulcers/injuries. ADON A failed obtain more wound care training, her Wound care certification was from 2016. The facility failed to properly assess and treat Resident #60's skin infected wounds who had abnormal labs with an elevated white blood CBC on 07/13/21 and not sent to the hospital until 07/25/21. The facility failed to properly assess and treat Resident #354, when he had a documented deterioration of his wounds on 06/15/21 and was not sent to the hospital until 07/08/21. The facility failed to properly identify, treat and document resident's with skin conditions such as bruises, skin tears, abrasions and ulcers/injuries for residents (#5, #19, #24, #44, #54,# 60, #78, #99, #101, #354). ADON A failed to accurately document the actual condition of Residents (#5, #19, #24, #44, #54, #78, #99, #101) skin conditions until HHSC surveyors conducted skin assessments with ADON A and DON. These failures placed residents at risk of increased pain, infections, wounds, abuse which could decrease their psycho-social well-being and quality of life. An Immediate Jeopardy (IJ) was identified on 7/16/21 at 9:17 PM and while the IJ was lowered on 7/27/21 at 5:10 PM the facility remained out of compliance at a severity level of Actual harm that was not Immediate Jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of their plan of correction to prevent further concerns. Findings included: 1)Review of Resident #60's Face Sheet dated 07/16/21 revealed a [AGE] year-old male who admitted [DATE] with diagnoses Quadriplegia, Insomnia, Neuromuscular Dysfunction, Type II diabetes mellitus, hypertension, osteomyelitis of vertebra, cervical region and spinal stenosis lumbosacral region and etc. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #60's Quarterly MDS (minimum data set) dated 06/14/21 revealed a BIMS (Brief interview for mental status) score was 13 with intact cognition, extensive two person ADL assistance, a catheter and always incontinent to bowel .at risk of developing pressure ulcers with unhealed ulcers (one stage III pressure ulcer and 4 stage IV pressure ulcers) . Review of Resident #60's Care plan dated 07/08/21 revealed, Care plan for pressure ulcers including one The resident has a stage IV pressure ulcer to sacrum or potential for pressure ulcer development r/t (related to) disease process, Goal: BLANK, Interventions/Tasks: an healing progress .Report declines to the MD (medical doctor). Review of Resident #60's Nurses Progress Notes by ADON A dated 06/30/21 at 2:44 PM revealed, Received a call from facility doctor regarding continued use of antiretroviral medication was instructed to follow up with specialist if continued use was necessary .call was placed to specialist and new order to discontinue antiretroviral medication, facility doctor and resident notified of change. Review of Resident #60's Order Summary Report dated 07/19/21 revealed, No antiretroviral medication the resident's medication profile . Review of Resident #60 Lab results report dated 07/13/21 at 12:22 PM revealed, (WBC) 19.8 (H) Normal values on scale 3.8 - 10.1 k/mm3 and (RBC) 3.02 (L) Normal values on scale 4.40 - 5.80 M/mm3. Review on 07/16/21 of the facility's binders of shower sheets revealed, they were three to four months old and Resident #60 had no shower sheets in any of the binders. Review of Resident #60's ADL Care Tasks in the facility's Electronic Medical Record revealed the last documented shower was system generated on 03/13/21. Review of Resident #60's showers sheets were requested on 07/27/21 at 11:36 AM and Administrator said at 4:50 PM she could not locate them because the former DON and ADON A kept up with them. Review of Resident #60's Facility's Wound care Doctor Progress note dated 12/31/20 revealed six unstageable wounds and two diabetic wounds and one initial encounter stage IV sacrum pressure injury (moderate amount of serous drainage no odor) measurements: 5.5 cm length x 3.5 cm width x 1 cm depth. Review of Resident #60's Facility Wound care Doctor Progress note dated 07/17/21 revealed, Two abrasions, two trauma ulcers and three stage IV pressure ulcers: Sacrum (coccyx to the bone exposed) measurements: 7.5 cm length x 4.3 cm width x 3.0 cm depth. Review of Resident #60's Nurse's Progress notes from 05/20/21 at 9:21 AM to 07/25/21 at 6:15 AM, the resident had taken several antibiotics by mouth and IV antibiotics for wound infections and (UTI) Urinary tract infections. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of Resident #60 on 07/17/21 at 2:34 PM, Resident #60 assessment of wounds revealed, wound #1 large open area with yellow slough approximately the size of a dollar bill left lateral buttocks. Wound #2 large open area to right medial buttock open wound with crust and eschar present and uneven wound edges approximately the size of a dollar bill. Wound #3 right lower buttocks fold appeared to be a split or a cut appearance was bloody in appearance no drainage noted. ADON A stated, oh this is new, it appears like it is an abrasion. Wound #4 left clavicle area more medial to spine crusty area. Wound #5: Right lower clavicle region with dry crusty skin with redness surrounding crust. Wound #6: Sacral wound very large in size appeared to be a stage IV pressure in (in my professional opinion), approximately size of a dollar bill. Wound #7: left lateral upper calf region, scabbed area approximately 3 long. Wound #8: left medial buttocks a cluster of 4 open areas each lesion being approximately the size of a dime. Wound #9: large open area just below sacral wound, approximately 6 in diameter, wound exposed the bone a small bit, wound bed with yellow slough, small edge of eschar, granulation present to wound bed. Wound #10: right medial lower buttocks, quarter size open area wound bed red in appearance. Wound #11: Medial buttocks dressing removed, wound blue in color approximate size of half dollar. Wound #12: Sheering red (blood tinged) area to bilateral scrotum. Wound #13: Small open area to (abrasion) to rt. Medial distal foot. Wound #14: Nickel size red area to anterior/lateral right knee. Wound #15: Right lateral malleolus, 1/2 dollar size open area with white slough, area appears to be a stage IV pressure wound, wound edges uneven and red (inflamed appearance), tender to touch for resident as he grimaced and said ouch when ADON A touched it. Wound #16: Right anterior foot at bend of foot, small scabbed area approximately 2 in length. Wound #17: Right lateral foot, small scabbed area with eschar present, approximately size of a dime. Wound #18: Right foot on top of small toe (5th digit), dime size scabbed area. Wound #19: left medial heel size of 1/2 dollar size, crusted wound. Wound #20: Ulceration to front of right testicle 2cm x 2.3cm in size (ADON A measured this, stating this was new too). Review of Resident #60's Nurses Note dated 07/22/21 at 3:51 PM revealed, Wound care Doctor here to resident Right lateral malleolus 1.4 x 1.4 x 0.5 40 slough 20 necrotic 40 granulation with moderate drainage, continue same treatment. Sacrum 7.5 x 4.3 x 3.0 30 slough 40 necrotic, 30 granulation with coccyx bone exposed, moderate green purulent drainage, undermining 4.5 3-9 o'clock. Continue same treatment. Left ischium 7.8 x7.5 x 1.0 80 slough, 10 granulation 10 epithelial with moderate draining. Treatment changed to calcium alginate and a dry dressing daily. Right ischium 8.0 x 5.5 x.0.4 20 slough 70 necrotic 10 granulation with moderate drainage. Treatment changed to calcium alginate daily. Right med heel 4.0 x4.5x 0.2 100 necrotic with no drainage. Continue with same treatment. Right 5th lateral toe 4.0 x1.5 x0.2 60 necrotic 40 epithelial with no drainage. Continue same treatment . Review of Resident #60' Weekly Skin Checks dated 07/13/21 revealed, Sacrum wound treatment in progress, right ankle (outer) treatment in progress, right 5th toe abrasion treatment in progress, right ischium treatment in progress, left ischium treatment in progress, right heel medial heel blood blister. Review of Resident #60's Skin/wound note dated 07/21/21 at 9:16 AM revealed, Resident seen yesterday by Wound care Doctor for weekly wound evaluation. Wound care Doctor reporting that despited [sic] good and consistent wound care and bedside debridement resident would further benefit from a OR debridement and would like to have them referred to a specialty hospital for an evaluation. Facility Doctor notified and agreed with the recommendation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #60's Skin/Wound note dated 07/21/21 at 3:46 PM revealed, Spoke with specialty hospital representative regarding possible admission for in-patient wound care, after review of benefits/insurance she reports the resident does not have a payor source for specialty hospital admission . call Wound care doctor for further instruction and or other options. Review of Resident #60's Skin/Wound note dated 07/21/21 at 3:58 PM revealed, Spoke to Wound care doctor about with the resident not having a payor source for specialty hospital admission, Doctor is recommending since this is a non-urgent situation we could contact county hospital and get them set up in their clinic for an appointment with general surgeon for evaluation and assessment and possible surgical debridement of sacral wound Scheduler in facility notified of appointment need. Resident educated. Review on 07/26/21 of Resident #60's Electronic Medical Record dated 07/25/21 at 6:00 PM revealed, The Change in condition's reported . skin wound or ulcer .at 6:15 PM may transfer pt. to hospital for eval and treat for possible osteomyelitis . Interview on 07/27/21 at 3:09 PM, Resident #60's Hospital Nurse said Resident #60 came from a healthcare facility on 07/25/21 and had an incision and debridement procedure of sacral and bilateral ischium decubitus ulcer and placement of a wound vac on 07/26/21. She stated the hospital physician noted some foot wounds and noted Resident #60 had this sacral wound for the past nine months, that was treated at the healthcare facility, but now had significant infection, necrosis and sepsis. She said Resident #60's treatment plan was ordered for a wound vac and two IV antibiotic medications with dressings to his wounds . Review of Resident #60's Hospital Records dated 07/25/21 revealed, Hospitalist History and Physical - Chief complaint: I have a wound and they aren't turning me .Labs: (WBC) [NAME] Blood Count: 22.08 (H) [scale 4. 00 -11.00 k/ul], Red Blood Count: 3.08 (L) [4.00 -5.80 M/ul]- .Plan: Paraplegia, turn patient q 2 hours, boot heel protectors, wound care, consult with doctor, a/w sepsis .will start broad spectrum antibiotics .seen by specialist doctor .Sepsis (HCC) Thrombocytosis (HCC), suspected source is skin soft tissue .severe sepsis is thought possibly present with evidence of acute injury .Radiology: Final diagnosis: Nonhealing non-surgical wound, paraplegia, pressure injury of skin of contiguous region involving back, buttock and hip, unspecified injury stage, unspecified laterally . Interview on 07/27/21 at 2:50 PM, Resident #60 while at the hospital, stated they had surgery yesterday 07/26/21 on the wound of their bottom and the hospital staff said a fist could fit into it and said they did not know their wounds were this bad. 2)Review of Resident 354's Face Sheet dated 07/16/21 revealed a [AGE] year-old male who admitted [DATE] with diagnoses other acute osteomyelitis, left ankle foot, other specified depressive episodes, rash and other non-specific skin eruption, type II diabetes, end stage renal disease, hemiplegia, muscle wasting and atrophy, anemia and etc. Review of Resident #354's Quarterly MDS assessment dated [DATE] revealed resident had a BIMS score of 07 extensive assist with ADL's .always incontinent to bowel and bladder .at risk of developing pressure ulcer/injuries .unhealed pressure ulcer/injuries: BLANK . Review of Resident #354's Care Plan dated 05/06/21 revealed, Extensive one person assist, always incontinent to bowel and bladder and at risk for pressure ulcer/injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #354's Wound care Doctor's progress noted dated 03/23/21 revealed, On 10/22/20 Resolved scrotum wound today .On 03/21/21 asked to assess a recently discovered wound on a previous wound care patient .Assessment: Wound left buttock is an abrasion and has received a status of not healed. Subsequent wound encounter measurements are 2.5 cm length x 3 cm width x 0.2 cm depth. Review of resident #354's Skin/wound by ADON progress note dated 06/15/21 at 2:45 PM revealed, Resident seen by wound Medical Doctor for weekly evaluation .Left stage III heel deteriorated from previous week. New treatment order given to start .dressing to wound bed qday . Review of Resident #354's Skin/wound note by ADON dated 07/06/21 at 4:38 PM revealed, Resident seen by Wound Medical Doctor for weekly visit. Wound to Left heel is deteriorating and is noted with purulent drainage as well as peri wound erythema, suspected cellulitis .call placed to doctor . Review of Resident #354's Wound care Doctor note dated 07/06/21 Wound #13 Left Heel is a Stage IV Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are: 1.5cm length x 1cm width x 0.5cm depth, with an area of 1.5 cm and a volume of 0.75 cubic cm. There is a heavy amount of drainage noted which has no odor. Wound bed has 5% slough, 95% granulation. General Notes: Cellulitis and bone exposed Wound #15 Left Fifth Toe Clustered is a Diabetic Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 1cm length x 2cm width x 0.3cm depth, with an area of 2 cm and a volume of 0.6 cubic cm. There is a moderate amount of drainage noted. Wound bed has 50% epithelialization, 10% slough, 40% granulation. Review of Resident #354's Skin/wound note by ADON A dated 07/08/21 at 4:30 PM revealed, Resident noted with increased erythema, increased drainage with odor and increased pain to wound that is extending up the back his leg. Despite the start of antibiotic this wound is showing rapid deterioration from previous day .send resident to ER for further evaluation for deteriorating wound and MRI for further diagnosis or rule out osteomyelitis . Review of Resident 354's Hospital Discharge paperwork dated 07/16/21 revealed, the resident had been on IV Vancomycin since 07/09/21, for seven days and Assessment: 1. Left heel ulceration with necrosis of the bone, left calcaneal osteomyelitis, left heel abscess s/p, left foot incision and drainage through the bone cortex, partial excision of the left calcaneus done on 07/11/21 .2. Left heel infection-surgical left heel deep soft tissue cultures positive for MRSA, group A Strep .3.ESRD .4. Afib .5. Diabetes type 2, hypertension .6. Old CVA with right hemiplegia .7. History of COVID .8. History of C-diff colitis .Vancomycin 750 mg IV x1 after each hemodialysis on Mondays, Wednesdays and Fridays .stop date 08/22/2021. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation of Resident #354' Skin assessment on 07/20/21 at 1:55 PM revealed, Left heel pressure wound . Stage IV with bone and muscle showing .4 sutures at proximal end of the wound. 7.0 x 4.0 x 0.5 cm with serosanguinous scant drainage. No undermining, no tunneling. No odor. Peri-wound blanchable. Pain evident by resident's facial grimacing . DON said dietary interventions included shakes and I'll have to see Low air loss mattress. DON stated the wound was debrided today . Cluster of bruising on left forearm (large areas of ecchymosis). 17.5 x 18cm Cluster of bruising on left hand (ecchymosis) 8cm x 6.0 cm Left upper arm scar. Lest wrist purple. Double lumen port. Resident gets dialysis . Dressing undated and DON stated that is a dialysis dressing. Faint Left thigh bruise 3.0 x 3.5 cm Scab on Right knee 0.2 x 0.3 cm Hernia right of umbilicus. Red excoriated line on right upper thigh/groin area that goes toward the back of right buttock (shape of a Foley catheter). 18.5 x 1.0. Left toes red around nails and red skin between toes. Left 5th toe 1.5 x 1.5cm. lateral 5th toe 1.0 x 1.0 cm. Left top of foot and ankle cluster. Left lateral foot DTI. 0.5 x 1.3 cm gray. PAD diagnosis. Discoloration on lower left leg. Right groin line mentioned extended to right buttock and had another thin red line 5.5 x 0.5 cm. Right side upper back with what appeared to be a broken blood vessel. Open Right buttock 0.5 x 1.3 x 0. Right lower buttock pealing 1.0 x 1.0 x 0. Left upper thigh discoloration. Left lower back with pink area. Left buttock scar. Right ankle on outer side cluster of reddened areas (1.0 x 1.0, 1.0 x 0.2, 0.3 x 0.2, 0.2 x 0. 2) . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Right hand brace. Bruises on dorsal side of hand. Cluster of bruises 6.0 x 7.5 cm. Bruise and scrape 2.5 x 2. 0 on right forearm . Resident #354's Wound vac was observed hanging at the foot of the bed, not connect to the resident. DON stated the wound vac was not connected because they knew surveyor were coming to see the wound and the dressing will have to be taken off. 3)Review of Resident #5's Face Sheet dated 07/22/21 revealed an [AGE] year-old male who admitted [DATE] with diagnoses Sequelae of cerebral infarction, muscle wasting and atrophy, lack of coordination, peripheral vascular disease, etc. Review of Resident #5's Quarterly MDS dated [DATE] revealed, BIMS score 00 with severely impaired cognition, extensive 2-3 person ADL assistance, always incontinent to bowel and bladder, at risk for pressure ulcer/injuries Review of Resident #5's Care Plan dated 06/25/21 revealed, The resident has potential for pressure ulcer development r/t history of pressure ulcers, limited mobility and incontinence .Bowel and bladder incontinence and at risk for pressure ulcer/injuries. Review of Resident #5's Weekly Skin Sheet dated 07/04/21, 07/11/21 and 07/13/21 revealed, no skin impairments. Review of Resident #5's Weekly Skin Sheet dated 07/17/21 revealed, Vertebrae upper mid Moisture Associated Skin Damage 1.0 cm x 1.0 cm x 0.1 cm and vertebrae upper mid Moisture Associated Skin Damage 10.0 cm x 10.0 cm x .01 cm. Observation on 7/20/21 at 8:51 AM, Resident #5's skin assessment revealed, ADON A began the residents assessment at resident's feet and the resident had dried bowel movement that extended up their buttocks and onto sheet underneath the resident. ADON A wiped bowel movement away with her gloved hand as she continued to push the soiled brief out of the way, again surveyor asked her to remove the brief and clean the resident for better viewing, at which time she obtained some wipes from the bedside table and cleaned the resident's buttocks. There still remained dried bowel movement on his upper buttocks, and ADON A had visibly soiled gloves at this point. Resident #5's right hand was contracture, nails very long possibly digging into hand, unable to open his hands for viewing his palm. Resident #5 had five yellow bruises to upper left arm, various stages of healing. ADON A and Regional Nurse then assisted to turn resident onto his left side exposing resident's back and right buttocks. Sheets completely soaked and brief completely soaked and wet with dark urine and dried dark blood on the upper part of the sheet, ADON A reached behind Resident #5 and her hand came out with red [NAME] blood. ADON A rolled him to his left side, once resident was on his left side his back was exposed and there were three open soft reddish areas to right upper back, Dry flaky skin to entire back and a yellow crust that covered the entire back with a blue tint that ADON A stated was epithelial,. ADON A then then used her soiled gloved hands with visible bowel movement on her gloves, to touch and measure the open areas to Resident #5's back. 4)Review of Resident 19's Face Sheet dated 07/22/21 revealed an [AGE] year-old female who admitted on [DATE] with diagnoses Muscle wasting, cognitive communication deficit, abnormal gait and mobility, infectious disease, muscle weakness, symbolic dysfunction, type II diabetes, etc. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #19's MDS dated [DATE] revealed BIMS score 00 with severely impaired cognition, extensive 1-2 person assist with ADL's, always incontinent with bowel and bladder and at risk for pressure ulcers/injuries . Review of Resident #19's Care plan dated 06/17/21 revealed, Resident has potential for pressure ulcer development r/t limited mobility and incontinence Review of Resident 19#'s Weekly Skin check dated 07/05/21 and 07/12/21 revealed, No skin issues. Review of Resident 19's Weekly Skin check dated 07/20/21 revealed, Sacral Fissure between the middle of buttock . Review of Resident 19's Physician's orders revision dated 07/20/21 and start date 07/21/21 revealed, Fissure to coccyx: apply Calmoseptine topically .everyday shift for fissure. Interview and observation of Resident #19 on 07/20/21 at 9:21 AM, upon HHSC Surveyor observation of two coccyx open areas while Resident #19 was laying on a standard bed, the DON stated this was a crack and then said it was a fissure. Full depth opening. Pink wound bed. No odor, no signs/symptoms of infection, no exudate. Blanchable. One measured 0.5 x 0.2 x 0. Another wound measured 2.0 x 0.5 x 0. Interview on 07/20/21 at 9:38 AM, when asked if Resident #19's wounds had already been identified the DON responded, Identified already but have to verify. Review of Resident #19's Weekly Skin Check dated 07/05/21 and 07/12/21 revealed, No skin impairments. Review of Resident #19's Weekly Skin Check dated 07/20/21 revealed, Sacrum: Fissure between the middle of buttocks .Callous to right lateral heel. 5)Review of Resident #24's Face Sheet dated 07/22/21 revealed [AGE] year-old male who admitted [DATE] with COVID-19, Insomnia, Abnormalities of gait and mobility, repeated falls, contracture, joint, type II diabetes, hypertensive heart and chronic kidney disease with heart failure, hemiplegia and hemiparesis following cerebral infarction, overactive bladder, etc. Review of Resident #24's Quarterly MDS dated [DATE] revealed, BIMS score 09 with severely impaired cognition, extensive one to two person ADL assistance, at risk for developing pressure ulcer/injuries, skin conditions: BLANK. Review of Resident #24's Care Plan dated 07/22/21 revealed, Risk of skin breakdown .non-compliance will encourage . Review of Resident #24's Weekly Skin check sheet dated 07/05/21 revealed, No skin impairments. Review of Resident #24's Weekly Skin check sheet dated 07/09/21 revealed, Vertebrae (upper-mid) rash. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #24's Weekly Skin check sheet dated 07/13/21 revealed, Vertebrae (upper-mid) rash treatment continued. Review of Resident # 24's Weekly Skin Check Sheet dated 07/17/21 at 12:50 AM revealed, This resident did not have any skin impairments. Review of Resident #24's Weekly Skin Check Sheet dated 07/17/21 at 9:35 AM revealed, Left toe scab around nail, Vertebrae rash with current treatment, Left lower (front) leg small scabs, no redness, dry no pain. Review of Resident #24's Physician's order dated 07/20/21 revealed, Apply barrier cream to buttock qshift . apply miconazole cream topically to left underarm qday and prn . Observation on 07/20/21 at 10:50 AM of Resident #24 skin assessment revealed, the resident was complaining of their back itching, there was a very large rash on their back that was scaly and scabbed skin in the left shin area. Resident's groin area was very moist and oily, ADON A stated it was an skin barrier ointment. Resident #24 had a large Bowel movement in their brief and ADON A attempted to pull the resident's brief down around and the HHSC surveyor asked ADON A to obtain some wipes to clean the resident up for better viewing of the buttocks. ADON A left room and returned with a brief and wipes and began to clean the resident and once she was done cleaning him she left bowel movement on his bottom. Resident was asked how long he had been dirty and he replied since breakfast. Regional Nurse whispered to ADON A to wash her hands which ADON A did however but there was dried bowel movement still on the resident's skin so ADON A had to wipe harder to remove it. Resident #24 Left buttock crease had a darkened area that was 5 cm x 0.5 cm and tender to touch the resident stated it is from the dirty brief, they always put it on too tightly. After ADON A finished cleaning the resident she did not change gloves and proceeded to move the resident then a small piece of bowel movement was on draw sheet then ADON A picked up and stated it is bowel movement. Resident #24 had a small scratch in the upper buttocks/hip region, nontender. Red under left under arm, red and moist and resident complained of the area hurting . resident denied anyone putting anything on the area and stated he did not have any deodorant to use. Resident #24 stated he had a boil under his left under arm area. ADON A used same gloves to place clean linen on bed, gloves were soiled from cleaning bowel movement then ADON A carried the trash with dirty brief to her trash on the side of her treatment cart and the linen was taken to the soiled utility room with ungloved hands and after she left the utility room she did not wash her hands or perform hand hygiene. 6)Review of Resident #44's Face Sheet dated 07/16/21 revealed a [AGE] year-old female who admitted [DATE] with diagnoses Seizures, Mild Cognitive impairment, pseudobulbar affect, repeated falls, Mild protein-calorie malnutrition, overactive bladder, abnormal gait and mobility, cognitive communication deficit, anemia, etc. Review of Resident #44's Quarterly MDS dated [DATE] revealed, BIMS score 00 with severely impaired cognition, extensive two person ADL assistance, always incontinent to bowel and bladder, at risk of developing pressure ulcers/injuries, and no unhealed pressure ulcers/injuries. Review of Resident #44's Care Plan undated revealed, The resident has the potential for pressure ulcer development r/t limited mobility and incontinence. (continued on next page)

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	675817	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #44's Weekly Skin Check dated 01/22/20 revealed, The resident had no skin impairment. Review of Resident #44's Wound care Doctor note dated 07/06/21 revealed, Right anterior ankle is an arterial ulcer and has received a status of not healed. Measurements:1 cm x.0.9 cm x 0.3 cm, no odor .and Right anterior leg is a skin tear and has received a status of not healed. Measurements: 6 cm x 2 cm x .03 cm, no odor. Review of Resident #44's Weekly Skin Check dated 07/13/21 revealed, Right lower leg (front) skin tear treatment continues and right anterior ankle wound treatment continues. Review of Resident #44's Wound care Doctor note dated 07/13/21 revealed, Right anterior ankle is an arterial ulcer and has received a status of not healed. Measurements: 2 cm x1 cm x 0.3 cm, no odor .and right anterior leg is a skin tear and has received a status of not healed. Measurements: 4 cm x 2 cm x 0.3 cm. Observation and Interview on 07/18/21 at 10:39 AM with HHSC State Surveyor, Resident #44 was severely hard of hearing in both ears but used a whiteboard for communication to staff, ADON A began assessment, noted: resident's socks (which left indentions to bilateral ankle area. Noted scabbed red and inflamed dime size area extending up from left ankle, ADON A said, this is from their socks. Resident had a cluster of four open areas to left anterior ankle, and cluster of approx. eight small open areas to right lower lateral shin. Resident #44 had multiple ecchymosis areas to right lower extremity from knee down through ankle. Resident stated pointing to their ankles that hurts, pointed to area of pressure from socks, where visible indentations were seen. Left lower extremity (shin area) scabbed area approximately 3 in length. Multiple scabbed areas to bilateral knees (ADON A stated that resident crawled on floor that caused wounds to their knees). In between 4th and 5th digit on left foot, large amount of grime and dirt build up in between those two digits. Fingernails on both hands were dirty and appeared to have dirt underneath them. Observation under bilateral breasts revealed white residue, in which resident stated, I put deodorant under my breasts. Large dollar bill size red, blanchable area to upper right buttocks. Resident has a red blanchable area to right posterior ankle approximate size of a nickel. Right lateral foot at 5th digit lateral, large (approximately 4) very red and inflamed, small crusted center to this area, this redness extended down the lateral side of the 5th digit, possibly a stage 1 pressure wound with a stage 2 in the center. 7)Review of Resident #54's Face Sheet dated 07/22/21 revealed an [AGE] year-old female who admitted [DATE] with diagnoses Dementia, muscle weakness, dysphagia, cognitive communication deficit, etc. Review of Resident #54's Quarterly MDS dated [DATE] revealed, BIMS score 00 with severely impaired cognition, extensive 2 person ADL assistance, always incontinent to bladder and bowel, at risk of pressure ulcers/injuries. Review of Resident #54's Care Plan dated 06/24/21 revealed, Resident at risk for pressure ulcer or potential for pressure ulcer development r/t red and yeast like area . Review of Resident #54's Weekly Skin Check dated 07/06/21 and 07/13/21 revealed, No skin impairments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #54's Weekly Skin Check dated 07/16/21 revealed, Dry abrasion to left lower leg . Perianal and buttock blanchable redness .red area to left groin. Observations and Interviews of Resident # 54 on 07/16/21 at 10:57 AM with HHSC Surveyor revealed, 3 bruises in various stages of healing to right lower leg. ADON A started with feet peeling skin on top of 2nd right toe, g-tube, breakdown under abdomen fold left side 4 cm x 0.3cm, breakdown to coccyx 9cm x 6cm blanchable, scabbed area left lower leg 0.5cm x 3.5cm x 2 scratches, had wound on right heel. 8)Review of Resident # 78's Face sheet dated 07/22/21 revealed, a [AGE] year-old male who admitted [DATE] with diagnoses pseudomonas, lack of coordination, cognitive communication deficit, muscle weakness, abnormal gait and mobility, paraplegia, osteoarthritis, scoliosis, intervertebral disc degeneration, etc. Review of Resident #78's Admission MDS dated [DATE] revealed, BIMS score 15 with intact cognition, extensive two person assist, occasionally incontinent to bladder and always incontinent to bowels, at risk for pressure ulcer/injuries and no unhealed ulcer/injuries. Review of Resident #78's Quarterly MDS dated [DATE] revealed, BIMS score 11 with moderately impaired cognition, extensive 2 person assist with ADL care, occasionally incontinent to bladder and always incontinent to bowels and at risk of pressure ulcer/injuries and two unhealed ulcer/injuries. Review of Resident #78's Care Plans dated 07/27/21 revealed, The resident has stage IV pressure ulcer to left post knee r/t disease process, immobility and wound deterioration noted, treatment order changed. Interview and observation of Resident #78 skin assessment on 07/20/21 at 8:55 AM with HHSC State Surve [TRUNCATED]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44365 Based on observation, interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for three (Residents #105 #106 and #354) of 13 residents reviewed for Medical records. 1.Resident #106's progress notes indicated he was out of the building from [DATE] at 3:00 p.m. through [DATE] at 3:30 p.m. Medication administration records and point of care [CNA documentation] indicated he received care and services during those times. Progress notes did not indicate if he returned after [DATE] and no progress notes were made on his discharge date , [DATE]. Per discharge summary, resident discharged as against medical advice (AMA), but there was no signed AMA documentation on file. 2.The facility failed to document follow-up when progress notes indicated Resident #105 reported a missing checkbook and credit/debit card on [DATE]. 3. The facility failed to ensure Resident #354's hospital discharge documents were thoroughly reviewed to reflect Resident #354 MRSA (Methicillin Resistant Staphylococcus Aureus) diagnosis in his chart. Resident #354 was readmitted to the facility on [DATE] with MRSA in a wound to his left heel and the facility staff and the physician were not aware until [DATE], when HHSC state surveyors told them. These failures could cause all residents to be at risk of inadequate care/treatment and financial exploitation and serious infection, which could result in acute illness, distress, decreased psycho-social well- being and quality of life. Findings include: A)1.Review of the face sheet for Resident #106 revealed he was a [AGE] year-old male, admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident #106's MDS, dated [DATE], revealed his diagnoses included Human Immunodeficiency Virus (HIV) Disease and paranoid personality disorder. He was moderately cognitively impaired and required supervision for most ADLs. Record review of Resident #106's progress notes, dated [DATE] at 4:18 a.m., reflected, Resident left building at 3pm [DATE]. has not returned at this time. The progress note from the following day, [DATE] at 3:33 p.m. reflected, resident has not returned at this time. Remains out of building. No further notes regarding his leave or discharge were reflected. Record review of a discharge summary for Resident #106, dated [DATE], revealed he discharged at 12:00 p. m. that day. The discharge summary reflected, left facility AMA (against medical advice). No AMA documentation was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #106's Medication Administration Record (MAR) for [DATE] revealed medications were signed as given by the nurse on [DATE] at 5:00 p.m. and [DATE] at 6:00 a.m., 8:00 a.m., 9:00 a.m., 12:00 p. m., 1:00 p.m., dates and times his progress notes indicated he was out of the facility. The MAR also reflected medications were administered on [DATE] at 5:00 p.m. and 6:00 p.m., a day after his discharge. Record review of the Point of Care report for [DATE] - [DATE] revealed CNAs had charted as providing ADL care to Resident #106 on the evening of [DATE] and the morning of [DATE], dates when his progress notes indicated he was out of the building. An interview with Receptionist A on [DATE] at 4:25 p.m. revealed she was working the day Resident #106 left the building. She stated the resident told her he checked out with his nurse and would be back [to the facility] in a couple of hours. The receptionist stated she saw him walk across the street towards the bus stop and had not seen him since. Interview with the Administrator on [DATE] at 4:30 p.m. revealed she was unsure why Resident #1's progress notes reflected Resident #106 left the faciity on [DATE] but he was discharged from the system on [DATE]. Interview with MDS Coordinator A on [DATE] at 4:35 p.m. revealed Resident #106 left the faciity on [DATE], returned to the facility, then left again on [DATE] and did not return. She stated there was no documentation showing when he returned, except for the Medication Administration Record showing he had medications administered on [DATE]. The MDS Nurse stated there was clear documentation errors in the resident's record and she expected nurses to document more thoroughly. An interview with the DON on [DATE] at 4:55 p.m. revealed she had documented a respiratory assessment on Resident #106 on [DATE]. She stated the note must have been a transcription error on her part. In an interview with CNA A on [DATE] at 5:53 p.m. revealed she remembered Resident #106 leaving, because it was right before another resident died . Record review at this time reflected the resident she was speaking of passed on [DATE] and CNA A stated that date sounded right. She stated she was very certain Resident #106 left before the other resident passed away. CNA A stated when a resident was out of the facility they would chart activity did not occur in the point of care system instead of documenting that ADL assistance was provided. An interview with the Administrator on [DATE] at 10:12 a.m. revealed she believed there was poor documentation in Resident #106's record. She stated staff should have done a way better job documenting and felt the record could be more accurate. The Administrator stated the nurses also had 24 hour reports they documented on. A request was made for any relevant 24-hour reports and none were received at the time of exit. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview with the DON on [DATE] at 7:00 p.m. revealed the nurses who documented that Resident #106 left the building on [DATE] at 3:00 p.m. worked the 10:00 p.m. - 6:00 a.m. shift and would not have direct knowledge of when he left the building. She confirmed there were no other notes in the resident's record that reflected him returning or leaving again from the facility. The DON stated based on the Medication Administration Record, Resident #106 did not receive medication on [DATE], indicating he was out of the building, but medications were documented as given on [DATE] - [DATE] so she believed he was in the building on those dates. She stated there was a failure in system process regarding documentation. The DON stated due to discrepancies in documentation, nobody knew the exact time Resident #106 left the facility. She said missing documentation in Resident #106's record included when he left, where he went, what phone number he could be reached at, and what his intention was when he left the building. The DON was unable to tell if Resident #106 left with his medications on either the [DATE] or [DATE] because the documentation did not say. Record review of the facility's Discharge Against Medical Advice policy, dated [DATE], reflected, .Nursing staff will document in the progress notes all pertinent information concerning the resident's actions, including the resident's stated reasons for his/her desire to leave the facility. Record review of the facility's Establishing and Closing the Record policy, dated [DATE], revealed the facility should record the discharge date in the Admission/Discharge Register and the location to which the resident was discharged . Additionally, the policy reflected if discharged , verify completion of a discharge note by nursing and an Interdisciplinary Team discharge summary. 2.Closed resident record review of Resident #105's file revealed a general progress note created on [DATE] that reflected, Resident reported that his check book, credit/debit card are missing. Resident could not tell nurse when exactly his items are missing. ADON notified and went to notify administrator as she was on a conference call. Review of the [DATE] grievance/concern log revealed Resident #105 was not listed on the log. During an interview on [DATE] at 10:15 a.m., the Administrator revealed she did not consider self-reporting, to Texas Health and Human Services, as it was only minutes from the time she found out about Resident #105's missing items until the resident told her the items had been found. The Administrator also revealed she expected her staff to complete a grievance in this type of situation, but a grievance was not completed for Resident #105's missing items. The Administrator stated this situation had poor documentation because there was no documentation, in the chart or otherwise, to follow-up on Resident #105's missing items. Record review of the facility policy titled grievances and complaints, dated [DATE], revealed grievances and/or complaints may be submitted orally or in writing. [.] When a facility staff member overhears or receives a complaint from a resident [.] will assist the resident, or person acting on the resident's behalf, in filing a written complaint with the Facility. B) Review of Resident #354's face sheet, dated [DATE], revealed a [AGE] year-old male who re- admitted to the facility [DATE] with diagnoses, other acute osteomyelitis, left ankle foot, other specified depressive episodes, rash and other non-specific skin eruption, type II diabetes, end stage renal disease, hemiplegia, muscle wasting and atrophy, anemia and etc. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #354's Quarterly MDS assessment dated [DATE] revealed resident had a BIMS score of 07 which indicated severe cognitive impairment, required extensive assist with ADL's, was always incontinent of bowel and bladder, was at risk of developing pressure ulcer/injuries. The MDS further reflected the unhealed pressure ulcer/injuries was left blank. Review of Resident #354's hospital discharge paperwork, dated [DATE] revealed, Assessment: 1. Left heel ulceration with necrosis of the bone, left calcaneal osteomyelitis, left heel abscess s/p, left foot incision and drainage through the bone cortex, partial excision of the left calcaneus done on [DATE] .2. Left heel infection-surgical left heel deep soft tissue cultures positive for MRSA, group A Strep .3.ESRD .4. Afib .5. Diabetes type 2, hypertension .6. Old CVA with right hemiplegia .7. History of COVID .8. History of C-diff colitis Vancomycin 750 mg IV x 1 after hemodialysis on Monday Wednesday and Friday .stop date [DATE] Review of Resident #354's Progress note by MDS Coordinator LL and printed [DATE] and dated [DATE] at 1:33 PM, revealed Late entry effective Type: Skilled evaluation: Resident admitted on [DATE] receiving skilled nursing services with skilled diagnosis: Other Acute Osteomyelitis, Left ankle and foot, skilled care being provided .vitals . Review of Resident #354's Doctor Order Summary Report dated [DATE] revealed no Contact Isolation Order or MRSA added to diagnoses listing noted. Review of Resident #354's Nurse Progress Notes printed [DATE] revealed, from [DATE] to [DATE] there was no documentation about the resident's MRSA or contact isolation precautions. Review of Resident #354's Nurse Progress Note printed [DATE] and dated [DATE] at 8:28 AM Late Entry Effective: by MDS Coordinator LL revealed, General Progress note: Resident continues contact isolation for mrsa to wound to left heel, continues eating and doing activities alone in room. Interview on [DATE] at 12:50 PM with the DON revealed she was responsible for reviewing and approving hospital discharge records. She stated she reviewed Resident #354's the discharge records r Resident #354 and did not recall he had MRSA of a wound. She stated she was told he was receiving vancomycin for an infection but did not ask the reason for the antibiotic usage. She stated the receiving nurse also took the report from the hospital. She denied knowledge of his diagnosis of MRSA, and that was the reason why he was not put on contact isolation. Observation on [DATE] at 2:05 PM revealed in the quarantine unit/warm zone did not have any boxes of gloves on the PPE kits or stations. Observation on [DATE] at 2:06 PM revealed Resident #354's private room door was open and the resident was not in the room and no contact isolation precaution measures were in place. There was no signage reflecting isolation precautions on the door and no hazard bags in the room. It was later determined Resident #354 went to a Doctor's appointment. Interview on [DATE] at 2:07 PM, LVN H (in the warm zone) stated they had no contact isolation residents with MRSA and if a resident admitted with MRSA they would need contact isolation. LVN H stated staff would have to use full PPE, meaning gown, gloves, face make and face shield, to enter their room to care for the resident and dispose of all PPE once care was completed to that resident and a notice would be put on the resident's door reflecting See the nurse before entering. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 2:20 PM, Medication Aide MM (in the warm zone) stated they did not have any contact isolation residents and the residents in the warm zone were on droplet precautions. Medication Aide MM stated contact isolation was different because the staff had to wear full PPE and change everything before they left the resident's room and a sign would be placed on the resident's door. She stated it had been awhile since they had someone with contact isolation precautions. Interview on [DATE] at 2:51 PM, Central Supply/Transportation Director stated they had no residents on contact isolation but knew that if she passed by and saw the notice on the Resident's door to See the nurse. She stated she was not notified in advance about residents admitting with infectious diseases. Interview on [DATE] at 4:13 PM, the Administrator stated she was not aware Resident #354 came from the hospital with an MRSA diagnosis and said she would get with the nursing department to address. Interview on [DATE] at 4:30 PM, the Medical Records Director stated there were no issues or complaints about medical records not being accurate, deleted or altered and said she was not aware of any residents on contact isolation precautions. Interview on [DATE] at 12:50 PM with the DON revealed she was responsible for reviewing and approving hospital discharge records. She stated she did review the discharge records for resident #354 and did not recall he had MRSA of a wound. She stated that she was told he was receiving vancomycin for an infection but did not ask the reason for the antibiotic usage. She stated that the receiving nurse also took the report from the hospital. She denied knowledge of his diagnosis of MRSA, and this was the reason why he was not put on contact isolation. Interview on [DATE] at 11:04 AM, MDS Coordinator LL stated she was told about Resident #354's pending to re-admit from the hospital during the morning meeting [DATE] and stated in addition, the Admissions Director or Marketing Director sent emails to all department heads. She stated she was told Resident #354 would be readmitted at night and she reviewed his hospital documentation on the same day [DATE] and the next day after he returned [DATE] and Resident #354's hospital admitting diagnosis was osteomyelitis and only taking one antibiotic unless the doctor made changes this morning, [DATE]. She stated Osteomyelitis was the resident's skilled diagnosis, they treated Resident #354 for whatever the hospital was treating him for and said she was not aware Resident #354 had IV Vancomycin orders with an MRSA diagnosis. Interview on [DATE] at 9:04 AM and 9:15 AM, CCO accompanied by the Administrator stated the former DON was terminated and no longer worked at this facility and the Interim DON would work in her place. CCO stated there was a compromise in the facility's infection control services. Interview on [DATE] at 9:15 AM, CCO, accompanied by the Administrator both stated they were not sure how Resident #354's MRSA diagnosis was missed by the nursing staff and added, the former DON was responsible for reviewing Resident #354's hospital records and not sure why she did not. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 9:44 AM, ADON R stated they received hospital reports that were usually given to the Admissions Director and then given to the former DON who reviewed all admission documents. She stated once the DON approved the resident's information, the hospital called the facility with a report about the resident's condition. She stated once the resident arrived then the orders were transcribed within two hours and if a resident had an order for IV antibiotics it was important to know why. She stated the standard admission process was for the DON to review the hospital documents, then a contact isolation notice to See the nurse placed on the resident's door and document the contact isolation notice in the resident's records to ensure the staff had the proper PPE and MRSA procedures in place. She stated although the DON was responsible for reviewing all the admissions, the charge nurses were also responsible. She stated it was brought to her attention today by their Regional Nurse that Resident #354 returned to the facility with an MRSA diagnosis. She stated the Regional Nurse discussed what they needed to do and precautionary measures to prevent this from happening again. She said she was not sure what caused the nurses to miss Resident #354's MRSA's diagnosis but stated they were in the process of re-training staff. Interview on [DATE] at 11:04 AM, MDS Coordinator LL stated she was told about Resident #354's pending re-admit from the hospital during the morning meeting [DATE] and stated in addition, the Admissions Director or Marketing Director sent emails to all department heads. She stated she was told Resident #354 would be readmitted at night and added she reviewed his hospital documentation on the same day, [DATE], and the next day after he returned [DATE]. She stated Resident #354's hospital admitting diagnosis was osteomyelitis (bone infection) and only taking one antibiotic unless the doctor made changes this morning [DATE]. She stated osteomyelitis was the resident's skilled diagnosis, they treated Resident #354 for whatever the hospital was treating him for and said she was not aware Resident #354 had IV Vancomycin orders with an MRSA diagnosis. Interview on [DATE] at 10:58 AM, the Admissions Director stated Resident #354 readmitted to the facility on [DATE] at 12:01 AM and was not aware Resident #354 had MRSA and was not sure how that was missed. She stated she did not get Resident #354's hospital discharge papers and she was sure they came physically with the driver who then gave them to the charge nurse to review the clinical information. She stated the former DON and ADON A reviewed hospital reports and added if she received information of a resident with contact isolation precautions she would let the nurse know so they could put a sign on the door and get the contact isolation kit. Interview on [DATE] at 12:00 PM, LVN NN stated if a resident had MRSA they would have to be in an empty room with isolation kit with the gowns, gloves, stethoscope, sign on the door to see the nurse with biohazard boxes red and yellow bags inside the resident's room, because it was a contagious infection. Observation on [DATE] at [DATE] at 2:39 PM revealed, Resident #354's room door closed with a notice on the door Visitors please report to the nurses station before entering .PPE usage signage was on the door for contact precautions and droplet precautions and the PPE cart was stocked with gowns and a box of gloves. Review of the facility's General Provisions: Medical Records policy, date revised [DATE], revealed, Purpose: To ensure the accurate documentation and maintenance of medical records by the facility .Policy: Clinical records, paper or electronic, will be kept for each resident admitted for care. Content will be in compliance with licensing and certifying governmental agency requirements and professional standards (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675817	A. Building B. Wing	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Worth Southwest Nursing Center	5300 Alta Mesa Blvd Fort Worth, TX 76133

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Infection Prevention and Control Program date Revised:,d+[DATE] revealed, Policy: The facility must establish an infection Prevention and Control Program under which it - 1. Identifies, investigates, controls, and prevents infections in the Facility .2. Decides what procedures, such as isolation, should be applied to an individual resident .3. Maintains a record of incidents an and corrective actions related to infections .Programs and Procedures: The infection preventionist coordinates the development and monitoring .Reporting information related to compliance .Awareness of changes .designating other employees to assist .collects, analyzes and provides infection data and trends .consults on infection risk assessment and prevention .provides education and training to facility staff . Review of the facility's Multi-drug Resistant Organisms dated ,d+[DATE] revealed, Purpose: To ensure that Facility staff take the precautions needed for caring of residents known or suspected of having an infection or colonization, with a MDRO. Review of the former DON's Corrective action memo dated [DATE] revealed, Type of violation: Unsatisfactory Performance .Employers statement: See IJ (immediate jeopardy) template .Action being taken: Termination signed by Administrator and CCO. Review of former DON's RN Annual Competency Review dated [DATE] revealed she had been trained by CCO on , Communication: Shift report, Treatments: Maintains aseptic techniques, maintains Infection control protocols .Admission process: Initial nursing assessments, Chart Set-up, Diagnosis for medications, adhere to policy for charting .Core competencies: Hand Hygiene Procedures, Eternal feeding competency, wound care competency .Skin Integrity and Wound Management Skills .Met: washes hands, puts on new gloves, maintains aseptic techniques, discards contaminated supplies per infection control policy, etc. Review of the DON Job description undated 2000 Director of Nursing revealed, Principal Responsibilities: Establishes, implements, and monitors the infection control program designed to provide a safe, safe, sanitary and comfortable environment designed to prevent the devilment and transmission of disease and infection. Prepares or reviews infection control surveillance reports to identify trends and develop effective actions to control and prevent infections. Submits an infection control report to the QA committee .