STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676305	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stayton at Museum Way	2501 Museum Way Fort Worth, TX 76107

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interviews and record reviews the facility failed to ensure residents had the right to be free from abuse and neglect for 2 (Residents #1 and #2) of 7 residents reviewed for abuse and neglect. 1. CNA A neglected Resident #1 safety and well-being when he placed a skeleton in the resident's doorway, which startled the resident and caused her to fall sustaining a skin tear and bruising on her buttocks. 2. The facility neglected to put measures in place to monitor Resident #2 after the resident injested medications, Fioricet (a barbituate used for headaches), that belonged to a family member. This resulted in the resident being unresponsive and going to the hopsital where she received IV fluids. The family member continued to visit four more times after this incident. These failures could result in residents receiving injuries. Findings included: 1. Record review of Resident #1's undated Admission Record reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included bleeding ulcer requiring surgical repair, difficulty walking, muscle weakness, and unsteadiness on feet. The resident was discharged home on 11/7/24. Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 13, indicating she was cognitively intact. Her Functional Status reflected she required supervision with all mobility. Record review of Resident #1's care plan, dated 08/23/24, reflected she was a moderate fall risk with interventions of assisting with mobility and assisting with toileting. Record review of a nursing note in Resident #1's EHR, dated 10/31/24, reflected: (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 0600 Level of Harm - Actual harm Residents Affected - Few	Nurse notified that resident sustained skin tear after she hit her hand on the bedside table. staff report that resident was attempting to stand without using walker, started to fall backward. she accidentally hit her wrist onto the table as she fell back into her chair. she has two skin tears to the right wrist, minimal lose [sic] of blood noted. skin approximated, first aid rendered and dressing applied. denies any pain to the wrist/hand or arm. Record review of the facility's investigation report reflected video footage revealed CNA-A could be seen with a skeleton on a stand approach Resident #1's doorway and place it in the doorway. CNA-A could then be seen entering the resident's room after a few moments. CNA-A then exited the room and continued about his duties. Interview on 01/02/25 at 1:50 PM the DON stated Resident #1 called for help and the nurse discovered her bleeding from two skin tears on her hand. The resident informed the nurse she had hit her hand on a table when she tried to get up and fell back in her wheelchair. The skin tears were treated at the facility. On 11/01/24 the resident was complaining of pain to her buttocks, and she was discovered to have bruising to her buttocks. The resident admitted she had fallen to the floor the previous night. She stated she had heard someone at her doorway, she stood up to investigate it and was startled by a skeleton in her doorway and fell backwards, landing on her bottom and hitting her hand on her bedside table. The resident stated CNA-A helped her get up and back into her wheelchair. X-rays were ordered and no injury was found. She stated CNA-A was interviewed and denied placing the skeleton in the doorway and the resident falling. She stated CNA-A was terminated for failing to follow facility policy after the video footage was reviewed, and the resident provided details about CNA A's actions. The DON stated the video footage was not available for viewing. Interview on 01/02/25 at 2:00 PM with Resident #1's family member revealed the resident had relayed to him she had heard someone at her doorway, so she got up to check, and she saw a skeleton in the doorway. The resident told the family member she was startled and fell backwards to the floor. The family member stated Resident #1 was fond of CNA-A and did not want him to get in trouble, so she did not initially tell staff what happened. The resident stated the CNA helped her get up and into her wheelchair. Attempts were made to interview CNA-A via telephone on 1/02/25 at 12:05 PM and 1:25 PM, but the attempts were unsuccessful. 2. Record review of Resident #2' s undated Admission Record, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. She had diagnoses which included a chemical imbalance in the brain, and stroke resulting in right sided paralysis and inability to speak. Record review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score was not calculated due to the resident's medical condition. Her Functional Status indicated she required assistance with all of her ADLs. Record review of Resident #2's care plan, dated 12/02/24, indicated she used an antidepressant and an anti-anxiety medication. She had impaired cognition related to dementia and impaired vision. Review of a nursing note in Resident #2's EHR, dated 12/08/24, reflected: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The nurse was notified the staff member that resident cannot wake up, the nurse went to the resident's her [sic] room, the nurse tried to wake up the resident as well but still resident couldn't wake up, assessment done, v/s 180/104 [pulse] 68 [oxygen saturation] 97 [temperature] 97.6, the nurse called 911, pandemics [sic, paramedics] came and took the resident on the a [sic] stretcher to [hospital]. Record review of Resident #2's hospital records reflected the resident arrived unresponsive on 12/08/24 at 7:19 PM and was treated as a possible stroke. The resident's work-up was negative for a stroke, but her urine drug screen was positive for barbiturates. Nursing notes indicated the resident's family member arrived to the ER and identified a purse that had been brought with the resident as her purse. The family member notified the nurse she usually had a plastic bag with some medications in it, and the bag was missing. The family member thought the resident might have gotten into her purse and taken the medications. The medications included a barbiturate. Resident #2 was given IV fluids and had activated charcoal administered via a tube through her nose and into her stomach, because she was not alert enough to drink it, to absorb any medications in her stomach and intestines to minimize their affects. The resident was discharged back to the nursing home on 12/11/24. Record review of Resident #2's physician orders reflected no barbiturate medications. Interview on 1/02/25 at 2:46 PM the complainant stated she had been made aware by hospital staff of their concerns about the resident's condition. The hospital medical staff felt the resident would have been unable to take the medications from the family member's purse as described without assistance. Resident #2 was admitted to the hospital with a diagnosis of intentional overdose. Interview on 01/02/25 at 10:30 AM with the Pharmacist revealed after reviewing Resident #2's medication list that none of the medications Resident #2 was prescribed would show up as a barbiturate on a drug screen. Interview on 01/02/25 at 11:00 AM with Resident #2's family member revealed the family member had visited the resident on 12/07/24 and had accidentally left her purse on the resident's bed. She did not realize she had left it until she saw it in the ER with the resident. The family member stated when she looked in the purse she noticed a plastic bag that she kept some medications in was missing. The bag contained 10 ibuprofen, 5 benadryl, and 2 Fioricet (barbiturate headache medication). The family member notified the nurse and thought the resident must have got into her purse and taken the medications. Interview on 01/02/25 at 11:40 AM with RN-B revealed Resident #2 was capable of feeding herself after her food had been cut up, using her left hand, but she was not capable of moving herself, and was unable to stand. RN-B stated she did not think the resident would have been capable of getting into a purse and taking medication out of it since she had use of only her left arm and had poor eyesight. RN-B stated she had not observed any unusual interactions between Resident #2 and her family member. Interview on 01/02/25 at 11:50 AM with the OT revealed he had worked with Resident #2 and his assessment of the resident was she had no torso movement, and she did not have fine motor skills. He stated the purse would had to have been within the immediate reach of Resident #2. The skills of opening a purse, retrieving a plastic bag, opening the bag, and taking the medications were advanced skills, and the resident did not have those skills. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 01/02/25 at 3:15 PM with the Social Worker revealed she had not been contacted by the hospital, but the facility staff were aware of the hospital staff's concerns. She stated the facility staff thought it was unlikely that Resident #2 had taken the medications on her own. Interview on 01/02/25 at 4:00 PM with the DON revealed she was aware of the concerns voiced by the hospital staff, but she did not think they could do anything about the family member because there was no proof she had given Resident #2 the medications. The DON stated they could not prevent the family member from visiting, or monitor the visit, but it did not matter because the family member had not visited since the resident had returned from the hospital on 12/11/24. Record review of the facility's electronic visitor log reflected the family member had visited four times between 12/11/24 and 12/30/24, and the family member's prior visits were on 12/12/24, 12/16/24, 12/23/24, and 12/28/24. Interview on 01/02/25 at 4:50 PM with the Administrator revealed he did not have a conversation with the family member specifically. He stated they did have conversations with all family members about bringing medications from home. The family members were told they needed to give the medications to the nurse and cleared before being given to the residents. Review of the facility's Abuse, Neglect, and Exploitation policy, dated 07/16/24, reflected: .Associates: .2. Associates are in-serviced on Abuse Prevention in their initial orientation and at least annually thereafter. 3. Associates suspected of abuse will be suspended pending the outcome of any investigation. Associates found guilty of abuse will be terminated Resident Rights: .2. The Right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, exploitation, and misappropriation of property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately to the state survey agency but no later than 2 hours after the allegation was made for 1 of 7 residents (Resident #2) reviewed for abuse and neglect. The facility failed to report an allegation of neglect when Resident #2 was found to have taken barbituates (Fioricet [used to treat headaches]) that belonged to a family member, which resulted in the resident being unresponsive and being sent to the hospital where she received IV fluids. This failure could place the resident at risk of continued abuse. Findings included: Record review of Resident #2's undated Admission Record, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged from the facility on 12/20/24. She had diagnoses which included a chemical imbalance in the brain, and stroke resulting in right sided paralysis and inability to speak. Record review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score was not calculated due to the resident's medical condition. Her Functional Status indicated she required assistance with all of her ADLs. Record review of Resident #2's care plan, dated 12/02/24, indicated she used an antidepressant and an anti-anxiety medication. She had impaired cognition related to dementia and impaired vision. Record review of Resident #2's physician orders reflected no barbiturate medications were prescribed. Review of a nursing note in Resident #2's EHR, dated 12/08/24, reflected: The nurse was notified the staff member that resident cannot wake up, the nurse went to the resident's her [sic] room, the nurse tried to wake up the resident as well but still resident couldn't wake up, assessment done, v/s 180/104 [pulse] 68 [oxygen saturation] 97 [temperature] 97.6, the nurse called 911, pandemics [sic, paramedics] came and took the resident on the a [sic] stretcher to [hospital]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's hospital records reflected the resident arrived unresponsive on 12/08/24 at 7:19 PM and was treated as a possible stroke. The resident's work-up was negative for a stroke, but her urine drug screen was positive for barbiturates. Nursing notes indicated the resident's family member arrived to the ER and identified a purse that had been brought with the resident as her purse. The family member notified the nurse she usually had a plastic bag with some medications in it, and the bag was missing. The family member thought the resident might have gotten into her purse and taken the medications. The medications included a barbiturate. Resident #2 was given IV fluids and had activated charcoal administered via a tube through her nose and into her stomach, because she was not alert enough to drink it, to absorb any medications in her stomach and intestines to minimize their affects. The resident was discharged back to the nursing home on 12/11/24. Record review of Resident #2's physician orders reflected no barbiturate medications. Interview on 01/02/25 at 10:30 AM with the Pharmacist revealed after reviewing Resident #2's medication list that none of the medications Resident #2 was prescribed would show up as a barbiturate on a drug screen. Interview on 01/02/25 at 11:00 AM with Resident #2's family member revealed the family member had visited the resident on 12/07/24 and had accidentally left her purse on the resident's bed. She did not realize she had left it until she saw it in the ER with the resident. The family member stated when she looked in the purse she noticed a plastic bag that she kept some medications in was missing. The bag contained 10 ibuprofen, 5 benadryl, and 2 Fioricet (barbiturate headache medication). The family member notified the nurse and thought the resident must have got into her purse and taken the medications. Interview on 01/02/25 at 11:40 AM with RN-B revealed Resident #2 was capable of feeding herself after her food had been cut up, using her left hand, but she was not capable of moving herself, and was unable to stand. RN-B stated she did not think the resident would have been capable of getting into a purse and taking medication out of it since she had use of only her left arm and had poor eyesight. RN-B stated she had not observed any unusual interactions between Resident #2 and her family member. Interview on 01/02/25 at 11:50 AM with the OT revealed he had worked with Resident #2 and his assessment of the resident was she had no torso movement, and she did not have fine motor skills. He stated the purse would had to have been within the immediate reach of Resident #2. The skills of opening a purse, retrieving a plastic bag, opening the bag, and taking the medications were advanced skills, and the resident did not have those skills. Interview on 01/02/25 at 2:46 PM with the Hospital Case Manger revealed she had been made aware by hospital staff of their concerns about the resident's condition. Resident #2 was admitted to the hospital with a diagnosis of intentional overdose. The hospital medical staff thought the resident would not have been able to take the medications from the family member's purse as described without assistance. Interview on 01/02/25 at 3:15 PM with the Social Worker revealed she had not been contacted by the hospital, but the facility staff were aware of the hospital staff's concerns. She stated the facility staff thought it was unlikely that Resident #2 had taken the medications on her own. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/02/25 at 4:00 PM with the DON revealed she was aware of the concerns voiced by the hospital staff, but she did not think they could do anything about the family member because there was no proof she had given Resident #2 the medications. The DON stated they could not prevent the family member from visiting, or monitor the visit, but it did not matter because the family member had not visited since the resident had returned from the hospital on 12/11/24. The DON stated the facility did not report the incident to HHSC because the hospital staff had reported it to Adult Protective Services. Record review of the facility's electronic visitor log reflected the family member had visited four times between 12/11/24 and 12/30/24, and the family member's prior visits were on 12/12/24, 12/16/24, 12/23/24, and 12/28/24. Interview on 01/02/25 at 4:50 PM with the Administrator revealed he did not notify HHSC of of the incident involving Resident #2 possibly being given by the barbiturate medication by the family member because the hospital had already reported it. Review of the facility's Abuse, Neglect, and Exploitation policy, dated 07/16/24, reflected: .Investigating and Reporting 1. If abuse or neglect is suspected, the Abuse Coordinator or a manager will be immediately notified. 2. Appropriate reporting procedures should always be followed Reporting/Response The facility must immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the Healthcare Administrator, state agency, adult protective services, and all other required agencies