STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER The Stayton at Museum Way		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Museum Way Fort Worth, TX 76107	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	 and neglect by anybody. **NOTE- TERMS IN BRACKETS F Based on interviews and record reabuse and neglect for 2 (Residents 1. CNA A neglected Resident #1 si which startled the resident and cau 2. The facility neglected to put meamedications, Fioricet (a barbituate the resident being unresponsive ar continued to visit four more times at These failures could result in resider Findings included: 1. Record review of Resident #1's if female admitted to the facility on [E repair, difficulty walking, muscle we 11/7/24. Record review of Resident #1's adwas cognitively intact. Her Function Record review of Resident #1's calinterventions of assisting with mobility of the section of the section was consistent with mobility of the section of the sec	ents receiving injuries. undated Admission Record reflected th DATE] with diagnoses which included b eakness, and unsteadiness on feet. Th mission MDS, dated [DATE], reflected nal Status reflected she required super re plan, dated 08/23/24, reflected she w	ONFIDENTIALITY** 43791 ents had the right to be free from r abuse and neglect. skeleton in the resident's doorway, nd bruising on her buttocks. after the resident injested a family member. This resulted in sived IV fluids. The family member he resident was an [AGE] year-old bleeding ulcer requiring surgical e resident was discharged home on a BIMS score of 13, indicating she vision with all mobility.

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

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE The Stayton at Museum Way Z501 Museum Way For 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 Nurse notified that resident sustained skin tear after she hit her hand on the backside table. staft resident sea at the resident sustained skin tear after she hit her hand on the backside table. staft resident sea at the she shot skin tears to the right wrist, minimal los blod noted, skin approximated, first aid rendered and dressing applied. denies any pain to the was attempting to stand without using walker, started to fall backward. She accidentally blod noted, skin approximated, first aid rendered and dressing applied. denies any pain to the was a skeleton on a stand approach Resident 14's doroway and place it in the doroway. CNA-A could a skeleton on a stand approach Resident 14's doroway and place it may share the hand of when she tried to get up and falls have was discovered to have the bar but tocks, and she was discovered to have bloc bloed notex. The resident admitted she had lallen to the forther previous ingit. She stated she someone at her doroway, she stod up to investigate it and was stafted by a skeleton in her doo fiel backwards, landing on her butonds, and have state the resident 14's family member revealed the facility 11/01/24 the resident was complaining of pain to her butonds, she save a skeleton in her doo fiel backwards, landing on the to wheelchair. X-rays were ordered and no injury was found. Si CNA-A was itemirmated for falling to follow facility policy afte	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
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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 Isch deficiency must be preceded by full regulatory or LSC identifying information) Level of Harm - Actual harm Nurse notified that resident sustained skin tear after she hit her hand on the bedside table. staff r resident was attempting to stand without using walker, started to fail backward, she accidentially 1 onto the table as she fell back into her chair. she has two skin tears to the right wrist, minimal los blod on ched. skin approximated, first aid rendered and dressing applied. denies any pain to the arm. Record review of the facility's investigation report reflected video footage revealed CNA-A could a skeleton on a stand approach Resident #1's doorway and place it in the doorway. CNA-A could use network the resident's room after a few moments. CNA-A then exited the room and continu utuies. Interview on 01/02/25 at 1:50 PM the DON stated Resident #1 called for help and the nurse disco bleeding from two skin tears on her hand. The resident is doarway can her as the facility 11/01/24 the resident admittd she head fallen to the floor the previous right. She stated she someone at her doorway, she stood up to investigate it and was startled by a skeleton in her doo fell backwards, landing on her bottom and hitting her hand on her bedside table. The resident table contain the regid up and back into her wheelchair. The skin tears were deted ender falling 1: CNA-A was interviewed and denied placing the skeleton in the doorway and the resident falling 1: CNA-A was interviewed and denied placing the skeleton in the doorway and the resident falling 1: CNA-A was interviewed of CNA-A value ther video footage was reviewed, an resident provided details about C				
(Each deficiency must be preceded by full regulatory or LSC identifying information) F 0600 Level of Harm - Actual harm Residents Affected - Few Residents Affected - Few Record review of the facility's investigation report reflected video footage revealed CNA-A could 1 a skeleton on a stand approach Resident #1's doorway and place it in the doorway. CNA-A could 1 a skeleton on a stand approach Resident #1's doorway and place it in the doorway. CNA-A could 1 a skeleton on a stand approach Resident #1's doorway and place it in the doorway. CNA-A could 1 see entering the resident's room after a few moments. CNA-A then exited the room and continu duties. Interview on 01/02/25 at 1:50 PM the DON stated Resident #1 called for help and the nurse discord bieeding from two skin tears on her hand. The resident informed the nurse she had hit her hand 0 when she tried to get up and fell back in her wheelchair. The skin tears were treated at the facility 11/01/24 the resident was complaining of pain to her bottocks, and she was discovered to have the bro buttocks. Interview on 01/02/25 at 1:00 PM two belchair. X-rays were ordered and no injury was found. St CNA-A was interviewed and back in her wheelchair. The skielden in the resident falling 1:00/12/24 the resident dor up to investigate it and was startled by a skeleton in her doored fell backwards, landing on her bottom and hitting her hand on her bedoside table. The resident falling 1:00/12/24 the resident dor fall the follow facility policy after the video footage was not and stored or the skeleton in the doorage was not avai viewing. Interview on 01/02/25 at 2:00 PM with Resident #1's family member revealed the resident table resident table is the had heard someone at her doorway, so so tog to up ocheck,	or information on the nursing home's pl	an to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
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anti-anxiety medication. She had impaired cognition related to dementia and impaired vision.		due to the resident's medical condit		
Review of a nursing note in Resident #2's FHR_dated 12/08/24_reflected:			-	-
		Review of a nursing note in Resider	nt #2's EHR, dated 12/08/24, reflected:	:
(continued on next page)		(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Stayton at Museum Way		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Museum Way Fort Worth, TX 76107	
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F 0600 Level of Harm - Actual harm Residents Affected - Few	[sic] room, the nurse tried to wake a done, v/s 180/104 [pulse] 68 [oxyge paramedics] came and took the ress Record review of Resident #2's hos 7:19 PM and was treated as a poss urine drug screen was positive for t to the ER and identified a purse that notified the nurse she usually had a family member thought the resident medications included a barbiturate. via a tube through her nose and int any medications in her stomach an the nursing home on 12/11/24. Record review of Resident #2's phy Interview on 1/02/25 at 2:46 PM the concerns about the resident's cond to take the medications from the fai admitted to the hospital with a diag Interview on 01/02/25 at 10:30 AM that none of the medications Reside Interview on 01/02/25 at 11:00 AM the resident on 12/07/24 and had a had left it until she saw it in the ER purse she noticed a plastic bag that ibuprofen, 5 benadryl, and 2 Fiorice nurse and thought the resident must Interview on 01/02/25 at 11:40 AM food had been cut up, using her left stand. RN-B stated she did not thin medication out of it since she had u observed any unusual interactions Interview on 01/02/25 at 11:50 AM assessment of the resident was sho stated the purse would had to have	mber that resident cannot wake up, the up the resident as well but still resident en saturation] 97 [temperature] 97.6, th sident on the a [sic] stretcher to [hospital spital records reflected the resident arri- sible stroke. The resident's work-up was parbiturates. Nursing notes indicated th at had been brought with the resident a a plastic bag with some medications in t might have gotten into her purse and Resident #2 was given IV fluids and h o her stomach, because she was not a d intestines to minimize their affects. T ysician orders reflected no barbiturate r e complainant stated she had been ma ition. The hospital medical staff felt the mily member's purse as described with nosis of intentional overdose. with the Pharmacist revealed after revi- ent #2 was prescribed would show up a with Resident #2's family member reve- ccidentally left her purse on the residen it (barbiturate headache medication). T at have got into her purse and taken the with RN-B revealed Resident #2 was c t sha kept some medications in was mi at (barbiturate headache medication). T at have got into her purse and taken the with RN-B revealed Resident #2 was c t hand, but she was not capable of mov k the resident would have been capable use of only her left arm and had poor ey between Resident #2 and her family me-	couldn't wake up, assessment e nurse called 911, pandemics [si al]. ved unresponsive on 12/08/24 at s negative for a stroke, but her e resident's family member arriver s her purse. The family member it, and the bag was missing. The taken the medications. The ad activated charcoal administerer lert enough to drink it, to absorb he resident was discharged back to nedications. de aware by hospital staff of their resident would have been unable out assistance. Resident #2 was ewing Resident #2's medication list as a barbiturate on a drug screen. valed the family member had visite ht's bed. She did not realize she stated when she looked in the ssing. The bag contained 10 'he family member notified the e medications. apable of feeding herself after her <i>i</i> ring herself, and was unable to e of getting into a purse and taking <i>i</i> vesight. RN-B stated she had not ember. ith Resident #2 and his not have fine motor skills. He esident #2. The skills of opening a

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F 0600 Level of Harm - Actual harm	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.		
Residents Affected - Few	hospital staff, but she did not think proof she had given Resident #2 th	with the DON revealed she was aware they could do anything about the famil e medications. The DON stated they count it did not matter because the family r pital on 12/11/24.	y member because there was no could not prevent the family member
	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 conversal family member specifically. He stated they did have conversations with all family members at medications from home. The family members were told they needed to give the medications to cleared before being given to the residents.		
	Review of the facility's Abuse, Negl	ect, and Exploitation policy, dated 07/	16/24, reflected:
	.Associates:		
	.2. Associates are in-serviced on A	buse Prevention in their initial orientat	ion and at least annually thereafter.
	3. Associates suspected of abuse will be suspended pending the outcome of any investigation found guilty of abuse will be terminated		
	Resident Rights:		
	.2. The Right to be free from verba and misappropriation of property.	l, sexual, physical, and mental abuse,	involuntary seclusion, exploitation,

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F 0609 Level of Harm - Minimal harm or potential for actual harm	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		
Residents Affected - Few	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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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES / full regulatory or LSC identifying information)	
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's hos 7:19 PM and was treated as a poss urine drug screen was positive for th to the ER and identified a purse that notified the nurse she usually had a family member though the resident medications included a barbiturate. via a tube through her nose and int any medications in her stomach an the nursing home on 12/11/24. Record review of Resident #2's phy Interview on 01/02/25 at 10:30 AM that none of the medications Reside Interview on 01/02/25 at 11:00 AM the resident on 12/07/24 and had a had left it until she saw it in the ER purse she noticed a plastic bag that ibuprofen, 5 benadryl, and 2 Fiorice nurse and thought the resident must Interview on 01/02/25 at 11:40 AM food had been cut up, using her left stand. RN-B stated she did not thin medication out of it since she had u observed any unusual interactions Interview on 01/02/25 at 11:50 AM assessment of the resident was she stated the purse would had to have purse, retrieving a plastic bag, oper resident did not have those skills. Interview on 01/02/25 at 2:46 PM w hospital staff of their concerns abou diagnosis of intentional overdose. T to take the medications from the far Interview on 01/02/25 at 3:15 PM w	spital records reflected the resident arri- sible stroke. The resident's work-up was parbiturates. Nursing notes indicated th that been brought with the resident as a plastic bag with some medications in it might have gotten into her purse and i Resident #2 was given IV fluids and ha o her stomach, because she was not a d intestines to minimize their affects. The visician orders reflected no barbiturate m with the Pharmacist revealed after revi- ent #2 was prescribed would show up a with Resident #2's family member reve ccidentally left her purse on the resider with the resident. The family member set t she kept some medications in was mi et (barbiturate headache medication). T st have got into her purse and taken the with RN-B revealed Resident #2 was c t hand, but she was not capable of mov k the resident would have been capable use of only her left arm and had poor ey between Resident #2 and her family me- with the OT revealed he had worked w e had no torso movement, and she did been within the immediate reach of Re- ning the bag, and taking the medication with the Hospital Case Manger revealed at the resident's condition. Resident #2 The hospital medical staff thought the re- mily member's purse as described with with the Social Worker revealed she had ware of the hospital staff's concerns. S	ved unresponsive on 12/08/24 at s negative for a stroke, but her e resident's family member arrived s her purse. The family member it, and the bag was missing. The taken the medications. The ad activated charcoal administered lert enough to drink it, to absorb he resident was discharged back to nedications. ewing Resident #2's medication list as a barbiturate on a drug screen. waled the family member had visited ht's bed. She did not realize she stated when she looked in the ssing. The bag contained 10 'he family member notified the e medications. apable of feeding herself after her ving herself, and was unable to e of getting into a purse and taking vesight. RN-B stated she had not ember. ith Resident #2 and his not have fine motor skills. He esident #2. The skills of opening a as were advanced skills, and the a sident would not have been able out assistance. d not been contacted by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER The Stayton at Museum Way		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Museum Way Fort Worth, TX 76107	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/02/25 at 4:00 PM w hospital staff, but she did not think i proof she had given Resident #2 th from visiting, or monitor the visit, bu resident had returned from the hosp HHSC because the hospital staff ha Record review of the facility's electr between 12/11/24 and 12/30/24, ar and 12/28/24. Interview on 01/02/25 at 4:50 PM w involving Resident #2 possibly bein hospital had already reported it. Review of the facility's Abuse, Negl .Investigating and Reporting 1. If abuse or neglect is suspected, 2. Appropriate reporting procedures Reporting/Response The facility must immediately repor	with the DON revealed she was aware of they could do anything about the family e medications. The DON stated they ut it did not matter because the family me pital on 12/11/24. The DON stated the ad reported it to Adult Protective Service ronic visitor log reflected the family men d the family member's prior visits were with the Administrator revealed he did n ig given by the barbiturate medication to lect, and Exploitation policy, dated 07/1 the Abuse Coordinator or a manager w is should always be followed t all alleged violations involving mistreat sappropriation of resident property to th	of the concerns voiced by the y member because there was no ould not prevent the family member nember had not visited since the facility did not report the incident to ces. mber had visited four times a on 12/12/24, 12/16/24, 12/23/24, not notify HHSC of of the incident by the family member because the 16/24, reflected: will be immediately notified.