STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455891	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Park Multi Care Center	4252 Bryant Irvin Rd Fort Worth, TX 76109

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety in the facility's kitchen, reviewed for food safety The facility failed to correctly seal a bag of opened cake mix. The facility failed to separate a dented can of food.The facility failed to label and date a package of opened pasta noodles.The facility failed to defrost frozen ground beef under running water. These failures could place residents at risk for food-borne illness and cross contamination.Findings included:Observation of the dry storage room in the kitchen on 04/28/2026 at 9:15 a.m. revealedA dented can of fresh vegetables stored on the rack with other cans.A package of previously opened cake mix in a storage bag exposed to air. A package of opened powdered sugar with only one date 03/17/2026 indicating when it was placed in the storage bag was observed on the shelf. Observation of the hand dish washing area on 04/29/2026 at 10:35 a.m.Revealed a package of frozen meat siting in a pan of water in a sink with no water running over it. Observation of the dry storage area on 04/29/2026 at 10:37 a.m.Revealed a package of opened pasta noodles was observed in a storage bag with only one date 04/17/2026 written on the bag. In an interview and observation with the DM on 04/28/2026 09:15 a.m., he revealed that there was an area for dented cans. He pointed to a cart that contained more than 15 dented cans. He stated the vendor had always brought them dented cans and he recently removed dented cans in the previous days. He stated he sorted them out so that he could get credit for those dented cans. He was unaware of the single dented can left on the supply cart and was confused as how he could have missed that particular can. He stated both he and the dietitian had just gone through the inventory. He stated that someone forgot to add the discard date on the package of cake mix. In an interview with the Corporate Dietitian on 04/29/2026 at 10:35 a.m. she stated that someone must have turned the water off in the sink where the meat was defrosting. She stated that she was unaware of the labels on the pasta and powdered sugar did not list a discard date. She understood that food needed to be defrosted properly and that open packages needed dates indicating when they were opened and when they needed to be discarded. In an interview with the DM on 04/29/2026 at 10:50 a.m., he stated the the water had been running on the frozen meat before he left. He stated he was shocked someone turned the water off and began to ask who turned it off. He understood the requirement that water needed to be running to help maintain a safe temperature to help prevent food borne illness such as botulism.In an interview with the Administrator on 04/30/2026 at 2:45 p.m., she stated she was surprised with the finding in the kitchen. She stated that they have done a great job in the kitchen, food quality had improved and menu items were really good. She stated that they had an excellent health inspection and had no violations. She stated that she would look into the finding with the DM. She expected that there would have been no citations. She stated that she wanted a excellent review in the kitchen. Record Review of the facility policy .Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must legible and accurately labeled, including the date the package was opened.13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 2-3 days or (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	discarded.Review of the facility's policy, Chapter 5: Food Safety and Sanitation Food and Nutrition Services Manual, undated, revealed, Procedure1. Food is stored a minimum of six inches off the floor. 2. Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). ?Use by Date' is noted on the label or product when applicable. 3. The ?use by date' guide is easily accessible to all associates involved with resident food storage. 4. Packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water. 5. Food is stored away from all sewer and water lines, drains and condensation drippings from pipes or ceiling. 6. Dented, leaky, rusted and swelling cans that could affect food safety are returned to the vendor but stored in a designated area away from other food. These items will not be used .Thawing - Thawing some foods at room temperature may not be acceptable because it may be within the danger zone for rapid bacterial proliferation. Recommended methods to safely thaw frozen foods include:a. Thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross contamination.b. Thawing the item in a microwave oven, then cooking and serving it immediatelyafterward; orc. Thawing as part of a continuous cooking process.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, the facility failed to treat residents with respect and dignity and care for them in a manner and in an environment that promoted maintenance or enhancement of their quality of life for 1 (Resident #42) of 4 residents reviewed for resident rights. The facility failed to ensure staff did not stand while feeding Resident #42 on 04/28/26. This failure could place residents at risk for decreased quality of life, decreased self-esteem and increase anxiety. Review of Resident #42's face sheet, dated 04/30/2026, revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses that included: dementia, COPD (chronic obstructive pulmonary disease, a progressive lung disease that makes it difficult to breathe), and anxiety.Review of Resident #42's quarterly MDS assessment, dated 02/18/20263, revealed she had a BIMs score of 4 which indicated severe cognitive impairment.Observation on 04/28/2026 at 12:20 p.m. of the 2nd floor dining room revealed there were 3 staff members observed assisting or feeding residents. Resident #42 was observed sitting in a manual wheelchair while being assisted in dining by a staff member. The staff member was observed standing while feeding the resident. He stood while feeding the resident between four to five minutes until another staff member noticed and instructed him to sit while feeding the resident. The staff member gave him her seat and got another seat for herself.Interview on 04/28/2026 at 12:40 p.m. with RN B revealed he normally could get the resident to feed herself by feeding Resident #42 one to two spoonfuls of food, but that day she would not feed herself at all. He stated that the aides typically assist in feeding the residents but he knew he should have been seated while assisting residents with their meals. He stated it may make them feel awkward or even make them upset. Interview on 04/28/2026 at 1:30 p.m. with RA D revealed staff should always be sitting while feeding the residents. She stated that it would help staff keep an eye on the residents, and it would not make them feel like someone was standing over them. She stated she always sat when assisting residents with their meals and even when she assisted in feeding in their rooms. Interview on 04/29/2026 at 2:15 p.m. with LVN B, she stated she didn't always feed the resident during mealtimes, but she had to assist at times. She stated she would always prompt residents to eat and let them know what they were eating. She stated she had to be sitting while she assisted with feeding because no one wanted anyone standing over them while they ate. She stated that could be frustrating and could cause them to lash out. Interview on 04/30/2026 at 3:05 p.m. with the DON, revealed he expected all of his staff to know how to provide proper care for the residents. He stated that he had high expectations for all staff but especially the nurses. He stated that he knew this could affect the dignity of the residents involved.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident's right to formulate an advanced directive for 1 of 3 (Resident #45) residents reviewed for resident rights. The facility failed to ensure Resident #45's code status (a medical directive indicating the type of care a patient wants, specifically regarding CPR or life-sustaining measures if their heart or breathing stops and guides doctors to either provide all available resuscitation or to respect the patient's wish not to be resuscitated) was communicated and correctly indicated in their EHR. This failure could result in residents receiving unwanted treatment or not receiving desired treatment. Findings include: Record review of Resident #45's five day scheduled MDS assessment for a Medicare Part A stay, dated [DATE], reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #45's MDS reflected the resident had hemiplegia (form of paralysis causing total or severe loss of muscle function on one side of the body) following a cerebral infarction (result of disrupted blood flow to the brain due to problems with the blood vessels that supply it causing brain cells to be deprived of oxygen and vital nutrients which can cause parts of the brain to die) affecting the left nondominant side, kidney transplant status (a patient's position and priority on the kidney transplant waitlist), and cancer (any one of a large number of diseases characterized by the development of abnormal cells that divide uncontrollably and have the ability to infiltrate and destroy normal body tissue). The MDS reflected Resident #45 had a BIMS of 15, which indicated the resident was cognitively intact. The MDS indicated that the resident would receive physical and occupational therapy. Record review of Resident #45's admission Record, dated [DATE], reflected no code status. Record review of Resident #45's clinical physician orders, dated [DATE], reflected no code status. Record review of Resident #45's baseline care plan, dated [DATE], reflected no code status. Record review of Resident #45's progress notes, dated [DATE] through [DATE] indicated no code status throughout the notes. Interview on [DATE] at 1:31 PM with LVN A revealed every resident should have a code status in their EHR. LVN A was asked to locate the code status in the EHR. LVN A stated that the code status was not in the EHR where it should be documented. LVN A stated that the code status should reflect if the resident is a full code status or if they have a DNR. LVN revealed the importance of the code status was to alert the nursing staff to perform CPR if the resident stopped breathing or honor the DNR if the resident had a DNR on record. LVN A said that it was the nurse's responsibility who completed admission to ensure there was a code status in the resident's EHR. LVN A stated that any nursing staff could see the resident's missing code status in the EHR and notify administration. LVN A stated she would notify the ADON of the missing code status and ensure it was documented in the EHR. Interview on [DATE] at 2:11 PM with the ADON revealed she had been employed at the facility for about two years. The ADON stated that a resident's code status should be one of the first things entered by the admitting nurse in a resident's EHR because it was one of the most important things in a resident's EHR. The ADON revealed that the code status should be entered upon admission with the resident's orders. The ADON stated it was her and the DON's responsibility to review the admission to ensure the resident's orders, and items such as the code status, were entered correctly. The ADON revealed that if she found that there was no code status in a residents' file, she would make the correction when auditing the chart. The ADON stated that the admission was normally reviewed the following day after the admission was entered into the EHR to ensure all the orders were entered correctly and no items were missed. The ADON stated the code status was usually found on the hospital discharge documentation. The ADON stated that ultimately it was the DON's responsibility to ensure that all residents had a code status in their EHR. The ADON was unsure why the code status was not documented in the EHR. The ADON revealed that if there was no code status in the EHR, there could be a delay in care, and their advance directives' wishes would (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possibly not be followed. The ADON stated that she and the DON should complete chart audits on an as needed basis and when residents received new orders. Interview on [DATE] at 2:26 PM with the DON revealed he had been the DON at the facility for approximately five months. The DON stated that he expected code status to be input by the admission nurse when inputting a resident's orders. The DON revealed he or the ADON reviewed new residents' EHR the day after admissions to ensure that orders were entered correctly. The DON stated the code status should be entered upon admission to ensure the residents' requests such as a DNR would be honored. The DON stated that all nurses should be reviewing their residents' charts to ensure there is a code status in the EHR. The DON revealed that if the nurses could not find the code status, the nurse should notify the DON and/or the resident's physician as well as speak with the resident to find out their code status to ensure that it was input correctly into their EHR. The DON stated he in-serviced his nursing staff about code status, but he could not recall when it was and did not provide the documentation. Record review of the facility's policy titled, Advanced Directives and Advance Care Planning, reviewed [DATE], reflected, ProcedureResidents or their responsible parties receive materials concerning their rights under applicable laws to make decisions regarding their medical care, including the right to accept or refuse medical care, the right to accept or refuse medical/surgical treatment, organ donation requests, and the formation of advance directives upon admission.16.residents receive full resuscitative measures unless a DNR is written in the resident's medical record and is identified in the resident's advance directive.d. Social Services and/or a member of Nursing Administration reviews the DNR status with the resident and /or family and the receiving physician within 72 hours of admission.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to keep drugs and biologicals in locked compartments for 1 (Treatment Cart A) of 5 carts reviewed for medication storage. The facility failed to lock Treatment Cart A on downstairs hall while the cart was unattended on 04/28/2026. This failure could affect residents' safety and privacy. Findings included: In an observation on 4/28/2026 at 9:00am, Treatment Cart A was placed near downstair hall nurse station. The treatment cart was unlocked and unattended. There was one nurse sitting at the nurse station and one resident sitting across from the nurse station. Inside the treatment cart was wound care biologicals and a pair of scissors. In an observation on 4/28/2026 at 9:02am, the Administrator walked by Treatment Cart A and locked the cart. In an interview on 4/28/2026 at 9:05am, the administrator stated she thought Treatment Cart Awas empty. When she was informed that the treatment cart had biologicals and wound care materials, the administrator stated her staff must have forgotten to lock the cart. She stated all carts must stay locked at all times while not in use for safety. In an interview on 4/29/2026 at 8:27am, the Wound Nurse stated all carts should be kept locked when they were unattended. She stated all nurses had keys to access Treatment Cart A, and she also had a key to the treatment cart. She stated the cart did not have to be unlocked for nurses to gain access. She was not sure which nurse had the treatment cart yesterday morning. She stated if the carts were unlocked, unauthorized personnel could have access to it, which could affect residents' privacy. She also stated residents could also get ahold of biologicals there, which could affect their safety. In an interview on 4/30/2026 at 10:14am, the ADON stated she expected her staff to always keep medication and treatment carts locked when they were not using them. She stated the risks included unauthorized access, privacy issues, and safety risk. She stated she often walked the halls to make sure carts were locked, and if she saw an unlocked cart, she would lock it and remind all nurses about cart safety. In an interview on 4/30/2026 at 10:34am, the DON stated he expected his staff to be vigilant and to ensure that carts were locked at all times when not in use. He stated unlocked carts could put residents at risk for injuries. He stated the nurses were responsible for keeping carts locked. He also stated he made rounds around the facility to ensure carts stay locked. Record review of facility's Storage and expiration dating of medications and biologicals policy revised on 6/30/2025, revealed the policy stated, the facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.