STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675779	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marine Creek Nursing and Rehabilitation	3600 Angle Ave Fort Worth, TX 76106

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review the facility failed to ensure residents had a right to personal privacy for 1 of 5 residents (Resident #1) reviewed for personal privacy. LVN P failed to ensure Resident #1's dignity and privacy was provided when he failed to use the privacy curtain as she laid naked and exposed. This failure placed the residents at risk of not having their privacy respected. The findings included: Record review of Resident #1's face sheet dated 10/09/24 reflected a female age [AGE] year-old that was admitted on [DATE] with the current DX: Dementia with other behavioral disturbances (disease causing cognitive decline), Cognitive communication deficit (difficulty with language), Basal Cell Carcinoma of skin of other part of trunk (a type of skin cancer that causes bumps, lumps or lesions). Record review of Resident #1's admission MDS dated , 09/10/24, revealed a BIMS score of 02, indicating the resident was severely cognitively impaired. Resident #1's required maximal assistance for with ADLs of bed mobility, transfers, supervision and touching for personal hygiene, eating, dressing, eating, toilet use and personal hygiene. Record review of Resident # 1's care plan dated 09/03/24 reflected the resident has impaired cognitive function/dementia or impaired thought process r/t dementia. Record review of Resident # 1's Hospice order dated 09/23/24 reflected Lorazepam 1mg ml topical gel. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 10/17/24 at 11:10 AM of a Ring Camera that was installed in Resident #1's room reflected a date and time of 09/30/24 at [6:13 PM and 06 seconds to 6:13 PM and 42 seconds] The video revealed LVN P and a male entering Resident #1's room. Both passed the resident's bed, where she laid asleep naked (nothing covering the top of her body, left buttocks, and feet). The privacy curtain was not closed. The male was observed turning his head and looking back at the Resident #1. Resident #1's pelvic and right thigh to shin bone was covered in a white flat sheet, revealing her chest, right hip, and right buttocks'. LVN P said he did not realize the resident was exposed when he welcomed the contractor in the room. The video was silent and could not confirm conversation and sounds prior to entering (announcing or knocking on the door) the room. The contractor was later identified by LVN P, DON, and the family member. An interview on 10/17/24 at 2:05 PM with LVN P revealed that he was not familiar with Resident #1's treatment, behaviors, and care at the time he entered the room to search for the oxygen concentrator. He stated that he was focused on locating the oxygen concentrator for the contractor. LVN P said once he confirmed the serial number of the concentrator, he invited the contractor inside the room. LVN P said he should have called for assistance, closed the privacy curtain, or covered the resident. LVN P said the risk to the resident exposed her naked body to the contractor entering the room, and violated her privacy and could have caused embarrassment. An interview on 10/17/24 at 2:17 PM with the DON revealed the resident and family did not want Resident #1 clothed. She did not respond to the interview questions regarding Resident #1's privacy, bringing in the contractor while she was naked, or the risk to the resident. The DON said Resident #1's care plan stated that the family preferred that the resident not be covered or dressed in any garments due to her agitation. However review of the care plan stated The resident has impaired cognitive functions/dementia or impaired thought processes r/t Dementia. Intervention communicates with the residents family/caregivers regarding resident capabilities and needs. Review of the facility policy, Resident Rights, not dated, reflected: The resident has a right to a dignified existence and self-determination. A facility must treat each resident with respect and dignity and care for each resident in a manner recognizing each resident's individuality. The facility must protect and promote the rights of the of the resident. Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Self-determination - The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided care, consistent with professional standards of practices for 2 of 7 residents reviewed for respiratory care (Residents #5 and #16). 1. RN K staff failed to ensure Resident #5's and Resident #16's nasal cannula was bagged for sanitation when not in use per the facility's policy on 10/09/24. 2. RN K failed to ensure Resident #5's oxygen concentrator and filter were free of food crumbs, debris (dust gray fuzzy participles) and spilled brown liquid on 10/09/24. 3. RN K failed to ensure Resident #16's nasal cannula was bagged for sanitation when not in use per the facility's policy on 10/09/24. 4. LVN J failed to ensure Resident #16's oxygen concentrator and filter were free of food crumbs, debris (dust gray fuzzy participles) spilled brown liquid on 10/09/24 and 10/15/24. These failures could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress. Findings: Resident #5 Record review of Resident #5's face sheet dated 10/15/24 revealed she was a [AGE] year-old female admitted on [DATE] with the following DX: Cerebral Infarction (stroke), Communication Deficit (difficulty talking), Dementia (cognitive loss), Dysphasia (difficulty swallowing), and anxiety disorder (fear of the unknown or worrying). Record review of Resident #5's quarterly MDS dated [DATE], reflected a BIMS score of 14 indicating the resident was intact cognitively. Oxygen was not addressed in MDS Section O, although Resident #5 was ordered oxygen to maintain saturations greater than 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan dated 09/20/24 reflected the resident requires PRN oxygen. She can put on and remove cannular on her own. She does not replace cannular in bag when removing and it is sometimes found on the floor. The resident will have no s/sx of poor oxygen absorption through the review date. Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry (method of monitoring blood oxygen), Increased heart rate (Tachycardia), Restlessness, Diaphoresis (excessive sweating), Headaches, Lethargy(tiredness or sleepiness), Confusion (lack of understanding), Atelectasis (lung collapse of close), Hemoptysis (discharge of blood or blood stained mucous), Cough, Pleuritic pain (inflammation of the membranes surrounding the lungs), Accessory muscle usage, Skin color . Following Facility Protocol for COVID-19 (an acute disease in humans caused by the coronavirus, which is characterized by fever and cough affecting respiratory function in older people with underlying health conditions and may cause death) . screening/Precautions .Observe for psychosocial and mental status changes-document and report as indicated. Record review of Resident #5's MD orders dated 07/08/24 reflected, the resident may have oxygen at 1-5 l/m as needed to maintain O2 sats (oxygen saturation how much oxygen is in your blood) greater than 92% as needed. Record review of Resident #5's September 2024 TAR reflected no oxygen use documentation for the resident from [DATE], to [DATE]. Record review of Resident #5's October 2024 TAR reflected no oxygen use documentation from [DATE], to [DATE]. In an observation of Resident #5's oxygen concentrator and NC on 10/09/24 at 10:10 AM revealed the resident's NC tubing was lying on top of the oxygen concentrator unbagged exposed to the environment. The tubing was a cloudy and smudged in appearance. The concentrator was observed with food crumbs, fuzz, particles that were gray, white, and brown dried liquid. The concentrator filter was full of gray fuzz and hairy texture on the power knob, gauge, handle, and back of the machine. The resident was not in her room at the time of the observations on 10/09/24. In an interview on 10/09/24 at 11:55 AM with RN K revealed that she changed Resident #5's NC this morning. She said she would change the tubing again since she observed the tubing unbagged. RN K said she would clean the oxygen concentrator. She did not respond to questions about the date and bagging of tubing when not in use nor who was responsible for cleaning the oxygen concentrator filter and exterior. She said it was important for the nursing staff to bag tubing when not in use and clean the concentrator and filter. The risk to the residents was respiratory illnesses. In an interview on 10/15/24 at 2:18 PM with LVN J revealed the policy for the oxygen was to change the NC out every Sunday night. LVN J said he observed Resident #5's NC being worn recently. He could not recall the date. LVN J said that nursing was responsible for checking the NC and water every shift for cleanliness, airflow, bagged when not in use, and change as needed. He stated that the central supplies staff CS M was responsible for contacting an outside service to clean and service the oxygen concentrators when needed. He said Resident #5 had dementia and removed her own oxygen. The risk to the residents was respiratory illnesses. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/17/24 at 2:30 PM with Resident #5 revealed that she had no concerns with her care and that the staff changed her tubing regularly. She did not remember the last time her tubing was changed. Resident #5 stated she used her tubing every day. Resident #16 Record review of Resident #16's face sheet dated 10/15/24 revealed he was a [AGE] year-old male admitted on [DATE] DX included COPD (progressive lung disease with chronic respiratory symptoms and limited airflow.), Asthma (a long-term inflammatory disease of the airways of the lungs.), Anxiety (disorder causing fear and worrying.), Schizophrenia disorder (mental disorder characterized by hallucinations and delusions). Record review of Resident #16's quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating the resident was intact cognitively. His oxygen treatment was addressed. In a Record review of Resident #16's care plan dated 08/05/24 reflected The Resident's Non-compliant with oxygen therapy educate and encourage resident to place oxygen tubing in bag when removing when transferring .Notify MD of non-compliance, staff continue to monitor. Resist care and yell at staff. Record review of Resident #16's MD orders dated 04/05/22 reflected May use oxygen @ 2_l/m via nasal cannula every shift related to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation. Record review of Resident #16's September 2024 TAR reflected May use oxygen @ 2_l/m via nasal cannula every shift related to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation (J44.1) sats were check every shift. Resident #16's TAR reflected from September 1, 2024, to September 30 24. (h) on hold by physician on 09/10/24 and 9/15/24. Record review of Resident #16's October 24 TAR reflected May use oxygen @ 2_l/m via nasal cannula every shift related to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation (J44.1) sats were checked every shift and oxygen administered. In an observation with Resident #16 on 10/09/24 at 10:36 PM revealed his NC lying on the floor with the prongs touching the floor. There was a white draw string bag attached to the concentrator. The concentrator water bottle was not dated. Observation of the concentrator revealed food crumbs on top of the concentrator in the creases that had built up, and grey fuzzy and white particles. In an interview with Resident #16 on 10/09/24 at 10:40 AM the resident stated that the staff did not bag the NC. He said he could not reach the NC on the floor. Resident #16 said he did not remember when his oxygen tubing was last changed. Resident #16 said he used his oxygen that morning. Resident #16 said the tubing fell on the floor recently and could not give a time. He denied putting the tubing on the floor. In an observation with Resident #16 on 10/15/24 at 12:38 PM revealed his NC tubing lying on top of the oxygen concentrator unbagged. In an observation of the oxygen concentrator revealed food crumbs on top of the concentrator that had built up grey fuzzy and white particles. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 10/15/24 at 11:44 AM a request for the most recent oxygen in-service completed was requested. In an interview on 10/15/24 2:36 PM with CS M, central supplies, stated the nursing staff were responsible for cleaning the concentrators and filters of all residents receiving treatment by oxygen concentrators. In an interview on 10/15/24 at 2:41 PM with the DON revealed the nurses are responsible for cleaning the oxygen concentrators and filters as needed. She stated that was a task for nursing that included them documenting in the TAR. The policy does not require staff to date tubing. The policy requires NC to be bagged. The ADON's are responsible for checking and ensuring the concentrators are cleaned. As needed if not functioning properly. The facility in-service for respiratory care was requested. In an interview on 10/15/24 at 02:46 PM with the ADON, she stated that she expected nursing staff to change the resident's NCs as needed, when visibly soiled, or on the floor and contaminated. She stated that dating and changing the oxygen tubing weekly was no longer the requirement in nursing. She stated that it would be in the O2 policy. She stated it was the ADON's and DON's responsibility to monitor nursing tasks. The ADON said the risk of not dating resident tubing can result in respiratory infections and illnesses. The ADM was called for an interview and exit on 10/15/24 at 3:10 PM, and the DON reported that she was unavailable. The oxygen in-service that was requested from the ADM nor DON were not provided at the time of exit on 10/15/24 at 3:28 PM. In a record review of the facility policy titled Oxygen Administration. Dated March 21, 2023, reflected Oxygen therapy includes the administration of oxygen (02) in liters/minute (min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. 02 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse Goals:1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen .2. The resident will maintain an effective breathing pattern with administration of oxygen. 3. The resident will be free from infection. Procedure: Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated . Document care . Remove mask at least every 8 hours .Oxygen concentrators should be cleaned according to manufacturer recommendations . Change or clean oxygen concentrator filters according to manufacturer recommendations. The facility policy and procedure did not address storing the tubing when not in use.