

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Marine Creek Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from verbal abuse for 1 of 1 resident reviewed for mistreatment, (Resident #1).</p> <p>The facility did not prevent CNA B from mistreating Resident #1. CNA B yelled at Resident #1 during the early morning of 10/31/2024 trying to force resident to go to bed causing Resident #1 to become angry.</p> <p>This failure could place residents at risk for staff mistreatment.</p> <p>Findings included:</p> <p>Record review of Provider Investigation Report dated 11/06/2024 revealed:</p> <p>On the morning of 10/31/2024 at 12:35 AM, Resident #1 was refusing to go to bed. Resident #1's family had a video camera in resident's room and witnessed a confrontation between resident and CNA B. CNA B was trying to force resident to go to bed by grabbing resident's arm and yelling at resident. Resident was resisting going to bed. LVN A was summoned by CNA B to assisting with resident to get her to go to bed. Resident #1 was placed in bed and covered with blanket.</p> <p>Record review of a face sheet dated 11/19/2024 indicated Resident #1 was an [AGE] year-old female admitted on [DATE] with diagnoses that included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems without behaviors); Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly); Essential (Primary) Hypertension (High blood pressure that is multi-factorial and doesn't have one distinct cause).</p> <p>Record review of an MDS Admission assessment dated [DATE] revealed Resident #1 was unable to complete the interview. A BIMS summary score of 99 indicated memory problems with memory severely impaired. Resident #1 required maximal to moderate (total assistance to minimal assistance) with daily ADL care. Resident #1 requires one person assistance.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a care plan dated 10/10/2024 indicated Resident #1 required the following intervention for has a behavior problem r/t disease process. Resident fights during her showers and refuses assistance with ADLs, refuses meals. Resident refuses to go to her bed at night and sleeps on the couch as she is difficult to be redirected. She scratches, spits, yells, curses, and hits staff when attempting any sort of redirection. Interventions included were the following; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, and intervene as necessary to protect the rights and safety of others. Approach/Speak</p> <p>in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.</p> <p>On 10/31/2024 at 12:00 pm, Family member A met with the DON to report the abuse of Resident #1 by CNA B and LVN A. Family member A showed DON the video camera recording of the incident that occurred between Resident #1, CNA B, and LVN A. The video recording showed the verbal abuse and the forcefulness from the staff against Resident #1. The facility ADM immediately reported the incident to Complaint and Incident Provider on 10/31/2024.</p> <p>In an interview on 11/19/2024 at 12:50 pm, with family member B revealed that her family member A over-heard a confrontation between LVN A, CNA B, and Resident #1 in the early morning of 10/31/2024. Family member B revealed that Resident #1 would not go to bed and was wandering in and out of rooms which was frustrating the CNA B. Family member B stated the staff were very rude to resident. Resident #1 also had a UTI at the time that was being treated. Family member B stated that family member A is the one who saw and heard what happened on the video camera. Family member A would like to be called. Family member B stated she is aware that the CNA B was terminated but thinks some kind of disciplinary action should take place r/t Charge Nurse, LVN A. LVN A is the ultimate person in charge of the unit at night.</p> <p>In an interview on 11/19/2024 at 1:26 pm, with family member A revealed CNA B was trying to get Resident #1 to go to bed. Resident #1 was looking for her purse. Resident #1 always looks for her purse before she will go to bed. This is common. CNA B was upsetting and provoking Resident #1. Resident #1 was calling CNA B a name and CNA B said the name back to her. CNA B was at the point saying she did not care about her job. CNA B told Resident #1 she was [NAME] Trash, and her stuff is crap. CNA B told Resident #1 that she was not allowed to have a purse at the facility. At some point, CNA B called for LVN A for assistance. LVN A took resident by the arm. Both CNA B and LVN A took resident to bed, placed her in the bed and placed a blanket on her. Family member A came to the facility on [DATE] at 12:00 pm to address the problem with the DON and show her the video recording. Family member A is afraid of retaliation due to the video. Family member A was worried about LVN A. Family member A does not believe the situation was handled in the right manner. Family member A believes that the staff need more training in dealing with behaviors. Family member A believes that the Administration is not aware of the issues on the unit. Family member A felt that the family needed to observe and watch the CNA B. Family member A have witnessed this CNA B being impatient with the residents. Family member A is glad she had a video camera in Resident #1's room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/19/2024 at 5:15 pm, with ADON revealed that an assessment was completed on Resident #1 on 10/31/2024 at 2:00 PM. The facility was not aware of the incident until Resident #1's family member came in earlier that day (10/31/24) to report the incident to the DON. LVN A did not report the incident to the DON. After the family member came in and reported the incident with the video is when the assessment was completed by the ADON. No injuries were noted in the assessment completed by the ADON.</p> <p>In an interview on 11/21/2024 at 9:22 am, LVN A revealed that Resident #1 was going in and out of other resident's rooms, trying to pull the fire alarm, trying to get to his computer, yelling, screaming, and hitting out at the CNA B. Resident #1 was complaining she was cold. LVN A revealed that the CNA B was always very good with the residents, but that night Resident #1 was not wanting to go to bed and was more agitated towards CNA B. CNA B called for assistance with resident. Both were able to eventually able to assist resident into her bed and place covers over her. Resident #1 did not resist and stayed in bed the rest of the night. LVN A stated that he did not know that there was a video camera in the resident's room. LVN A did not report the incident to the DON because behaviors like this happen daily on the unit and the resident and staff members were not injured.</p> <p>Documented in-service records indicate that LVN A has been given individual training to address the incident that occurred. There have been other CNAs placed on his shift, but not a permanent one. Other CNAs from other halls have filled in to work on the memory care unit until a permanent CNA is placed.</p> <p>In an interview on 11/21/2024 at 10:01 am, with CNA B revealed that she did not want to talk about the incident. CNA B said, I don't want nothing to do with that place. The surveyor explained that the interview was to discuss what happened that morning of 10/31/2024. CNA B then said, Do you think I will get my job back? CNA B had worked on the unit for 8 months. CNA B revealed that Resident #1 was not wanting to go to bed. She was wandering in and out of other resident's rooms, trying to pull the fire alarms, trying to get in other resident's beds, yelling and screaming at her, not following requests to stop . Called for assistance from LVN A and was able to get Resident #1 to go to bed willingly without resisting. Placed covers over her. Resident #1 slept the rest of the night. CNA B would not discuss specific trainings that she has had on working with residents with dementia on the unit. CNA B stated, I treated them all like family. They should have given me another chance. CNA B said, Had I known that there was a video camera recorder, I would not have said the things I did.</p> <p>In an interview on 11/21/2024 at 11:00 am, with the DON revealed that family member A arrived at her office on 10/31/2024 at 12:00 pm to report the incident that occurred between Resident #1, LVN A, and CNA B. Family member A is calling this incident abuse due to the staff were trying to force resident to go to bed and she did not want to go to bed. Family member A showed the video camera recording and DON was able to view it. CNA B was immediately suspended and then terminated. LVN A was given one-on-one trainings and in-services on reporting incidents. LVN A has not have any issues with this before. CNA B had been employed for 8 months. In-services were provided to all the staff r/t this incident. DON expects charge nurse to report all incidents that occur even if no injury occurs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/21/2024 at 11:30 am, with the ADM revealed LVN A mentioned to the ADM that he did not realize that the incident was anything. LVN A should have reported all issues on Resident #1 before. He should have reported the incident the DON and ADM when it happened. ADM states that there had been no other complaints about CNA B concerning the lack of care with any other residents. There are cameras on the unit that are monitored. ADM revealed that CNA B made the comment to the ADM and DON that if she knew that there had been a video camera that picked up recording, she would not have said anything. ADM's expectations are to report incidents immediately. In relation to falls or altercations the staff are to call ADM in the middle of the night. If they have a skin tear it will trigger and go to DON. ADM thinks that LVN A knows that he should have sent information to DON about incident. All the staff is going to go through trainings in working with residents with dementia.</p> <p>Record review of the facility Abuse policy revised 03/29/2018 revealed in part: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507</p> <p>Based on observation, interviews, and record review, the facility failed to ensure residents' environment remained as free of accident hazards as is possible for 1 of 6 residents (Resident #2) reviewed for environmental hazards.</p> <p>The facility failed to ensure Resident #2's bedframe and mattress were maintained to prevent accidents.</p> <p>This failure could place residents at risk of accidents and injury.</p> <p>Findings included:</p> <p>Record review of Resident #2's admission record dated, 11/19/2024, reflected a [AGE] year-old-male who admitted to the facility on [DATE] with a primary diagnosis of legal blindness.</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated 10/25/2024, reflected a BIMS score of 15, indicating intact cognition.</p> <p>Record review of Resident #2's Care Plan revised on 11/15/2024 revealed Resident #2 required supervision with bed mobility.</p> <p>Observation and interview on 11/19/2024 at 9:48 AM, in Resident #2's room, revealed Resident #2 sitting up on the side of his bed. The bed appeared lopsided; with the lowest side being the side the resident was sitting on. Resident #2 said his bed was uncomfortable and it made him wake up at night. He stated he did not know how long the bed was like that and [staff] had changed the mattress about 2 months ago. Resident #2 said he told the Maintenance Director about the mattress that morning and the Maintenance Director told him he would change it when he got up in his wheelchair.</p> <p>Observation on 11/19/2024 at 3:37 PM, revealed Resident #2 was lying in bed and the bed still appeared lopsided.</p> <p>Observation and interview on 11/19/2024 at 3:41 PM, in Resident #2's room, LVN D stated the bed looked crooked. She stated it had been like that for a while but did not know how long. She said she talked with Resident #2 who said Maintenance was going to take care of it. LVN D stated the risk was that Resident #2 could fall off the bed. She said when something needed repair she was supposed to contact Maintenance.</p> <p>Interview on 11/19/2024 at 3:48 PM, the Maintenance Director stated Resident #2's bed worked perfectly, and he changed the mattress 4 months ago. He said they flip the mattress every now and then, and Resident #2 goes through 3-4 mattress per year. He stated he reinforced the headboard because Resident #2 pulled on it and that the frame was not crooked. He said the mattress appeared crooked because the way the resident sat, he was heavy on one side. The Maintenance Director stated the resident could fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/21/2024 at 10:38 AM, the DON stated she was aware the Maintenance Director offered to change Resident #2's mattress frequently. She said there was no risk in the headboard or mattress being uneven. The DON stated they did not have a policy on accidents or hazards.</p> <p>Interview on 11/21/2024 at 11:29 AM, the Administrator stated Resident #2's mattress fit on the bed. She said there was no risk to the resident with the headboard or mattress being uneven.</p> <p>No policy on accident prevention was provided.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 1 facility reviewed for effective pest control.</p> <ol style="list-style-type: none"> 1. The facility failed to effectively treat for flies. 2. The facility failed to effectively treat for roaches. <p>These failures could place all residents at risk for the potential of a decreased quality of life.</p> <p>Findings included:</p> <p>Interview on 11/19/2024 at 9:48 AM, Resident #3 stated he had seen roaches and killed one yesterday on his dresser during the 10-6 night shift.</p> <p>Observation on 11/19/2024 at 11:46 AM in Resident #4's room revealed resident was not in room. Resident #4's mattress had no sheets, and a yellowish-brown stain was in the center of the mattress. Four live flies were observed on the mattress near the stain.</p> <p>Interview on 11/19/2024 at 11:50 AM, Resident #5 stated a roach had crawled on her, and on top of her bed. She stated that happened about 2 Sundays ago (November 3rd) and the roach was about in inch in size. Resident #5 stated she had seen one near the dining room about 2-3 months ago.</p> <p>Interview on 11/19/2024 at 3:48 PM, the Maintenance Director stated staff will come and tell him if any pests were found, and he will log it in the book. He stated if he was not around, the staff were to write the sighting in the logbook themselves. He stated a couple months ago there were complaints from CNAs moving something in the rooms on 200 hall and seeing live roaches. He said staff cannot bring chemicals in the rooms and they had to be treated by pest control. He stated if it was urgent, they call them the next day to treat. He said the pest control company was out every week and treated for flies .</p> <p>Observation and interview on 11/19/2024 at 4:05 PM, in Resident #4's room, revealed resident sitting up in her wheelchair. At least 2 flies were observed flying in the room. Resident #4 stated her room was fumigated, but 1 or 2 roaches still come back. She stated last night she saw 2 crawling out under the bed. She said her room was deep cleaned last Wednesday (11/13/2024) and there were a lot of dead roaches, and they were swept up. Resident #4 said because the roaches were crawling around it made her feel uncomfortable. A fly was then observed and landed on Resident #4's left arm. Resident #4 stated the flies bothered her in the dining room, but not much in her room.</p> <p>Interview on 11/21/2024 at 10:38 AM, the DON stated she had not received any complaints about roaches. She stated she had never seen a roach in the building and her expectation was for staff to let her know if they did see any pests. She stated she would let the Maintenance Director know so that pest control can get there off cycle.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/21/2024 at 11:29 AM, the Administrator stated if staff or a resident complained of pests her expectation was for it to be logged in the book. She said pest control comes out every Tuesday unless they had to call for something else.</p> <p>Record review of pest sightings revealed:</p> <ul style="list-style-type: none"> -08/01/24 - 208 - roaches -09/06/24 - 208, 213 roaches -09/27/24 - 207 bathroom - roaches were seen, small/big -09/28/24 - 200 hall - roaches in hallway -09/30/24 - 208 cockroaches under bed in curtains, etc. lots of baby ones -10/09/24 - 208A/B family complaint of roaches in dresser/bed -10/16/24 - 200 shower room - roach <p>Record review of pest control visits revealed in part:</p> <ul style="list-style-type: none"> -10/08/24 - .the log book showed one entry for 208. Inspected room [ROOM NUMBER] and did find live roaches behind both nightstands, the small black fridge and the larger cabinet. Resident was in the room, so gel baiting and dry flowable baiting were the only treatment options. -10/15/24 - Observed issues: German roach in 211 .Spoke to [Administrator] and [Maintenance Director] while in sight. They didn't have any reports, but a staff member reported rooms [ROOM NUMBERS] for roach sightings . -11/12/24 - This is just a routine inspection to make sure they're [sic] not any issue with roaches or other pests. <p>Record review of facility policy titled, Insect and Rodent Control dated 2012, reflected in part: The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department .</p> <p>No other pest control policy was provided by the facility.</p>		