| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675779 | A. Building<br>B. Wing | 11/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marine Creek Nursing and Rehabilitation | 3600 Angle Ave<br>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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791<br><br>Based on interview and record review, the facility failed to ensure residents had the right to retain and use personal possessions for one (Resident #1) of five residents reviewed for personal property.<br><br>The Administrator took Resident #1's cell phone away from her because she had called 911 several times.<br><br>This failure could place residents at risk of not being able to retain and use personal property.<br><br>Findings included:<br><br>Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and expired on [DATE]. Resident #1 had diagnoses which included congestive heart failure, respiratory failure requiring the use of a tracheostomy, and ventilator dependence. (The resident's heart was failing, she developed breathing issues, was intubated and placed on a ventilator. The resident could not breathe without the ventilator, so a breathing tube was placed in her neck and she continued to rely on the ventilator to breathe.)<br><br>Record review of Resident #1's baseline care plan, dated [DATE], reflected she was dependent on a ventilator, she was on oxygen, and she had a pacemaker.<br><br>Interview on [DATE] at 10:28 AM with Resident #1's family member revealed the resident had called 911 several times on [DATE] because she felt she could not breathe. The resident could not speak to the 911 operator and would hang up. The family was advised by the Administrator the resident's phone was taken away because she kept calling 911. The family member stated the phone was her only way of communicating with family via text messages. The resident would also text staff members when she needed something.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on [DATE] at 11:50 AM with the Administrator revealed she had been contacted by the local police department regarding someone in the facility calling 911 seven times and then hanging up. The Administrator stated they investigated and discovered it was Resident #1 who had been making the calls. The Administrator stated she was contacted by a sergeant from the police department, who stated if the resident continued to call 911, she would be written a citation for abuse of the 911 system. The Administrator stated she took Resident #1's phone from her to prevent her from calling 911 and being issued a ticket. She explained the situation to the family, and they stated he would text the resident to stop calling 911. The Administrator stated the ADON returned the phone to the resident within about 10 minutes.<br><br>The resident's death was not the result of her phone being taken away.<br><br>Record review of the facility's policy Resident Rights dated [DATE], reflected:<br><br>.Respect and dignity<br><br>.2. The right to retain and use personal possessions unless to do so would infringe on the rights or health and safety of other residents . |