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	04/23/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 2 of 3 (Emergency cart 1, Emergency cart 2) emergency crush carts reviewed for emergency preparedness. 1. Facility failed to have an ambu bag [is a portable, handheld device used to provide ventilation to a resident struggling to breathe or has stopped breathing] on Emergency cart 1. 2. Facility failed to check inventory daily on Emergency cart 2 from [DATE] to [DATE] and from ,d+[DATE] to [DATE]. These failures could place residents at risk for delayed emergency care. The findings included: Review of emergency crash cart 2's daily inventory check off on [DATE] at 3:30 AM, revealed no check off was completed on [DATE], [DATE] to [DATE] and from ,d+[DATE] to [DATE]. RN B completed check off on , d+[DATE], ,d+[DATE], and [DATE]. Review of emergency crash cart 3's daily inventory check off on [DATE] at 3:59 AM, revealed check off was completed from [DATE] to [DATE]. RN A had completed the daily check off on [DATE]. Observation and interview with RT F [DATE] at 3:23 AM, revealed an Ambu bag was missing on Emergency Cart 1. RT F said it was not necessary to have an Ambu bag on Emergency Cart 1 because all the residents on 300 hallways (location of emergency cart #1) had two Ambu bags in their rooms. He said there was no risk to the residents. He said if someone needed an Ambu bag they could just go in another resident's room and get one or they could get one from the central supply closet which was in the same 300 hallway. (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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN M on [DATE] at 3:30 AM revealed Emergency cart 2 for was not checked from [DATE] to [DATE] and from ,d+[DATE] to [DATE], VN M stated the night shift nurses were responsible for checking the emergency carts daily. He said whoever was assigned to the hallway with the emergency cart was responsible for checking and making sure all the necessary emergency supplies were accounted for and if anything was missing to replace it. He said the person responsible for Emergency cart #2 was LVN G which was on the 100 hallways. LVN M said all staff were in-serviced on suction and having a good working suction, so he always makes sure that he checks the suction on the emergency carts. He stated if you have an emergency and you are missing supplies cause a delay in care . In an interview with LVN G on [DATE] at 3:43 AM, revealed she had been employed by the facility for one year. She stated she had worked on [DATE] and she did not check Emergency cart #2 because it was not her responsibility alone. She said all nurses were responsible for checking all the crash carts not just her. She said she was aware that the book had to be signed and each item checked to make sure emergency items were on the cart and unexpired. She said the risk of not checking the cart was they would run out of an item needed for an emergency. In an interview with LVN B on [DATE] at 3:59 AM, he said the night shift nurses 10 PM-6 AM were responsible for checking the crash carts nightly. He said he did his already for [DATE]. He said it was important to check emergency cart so that you have everything in case of an emergency in the facility. In an interview with ADON on [DATE] at 11:57 AM, revealed the expectation was that the 10pm - 6 AM nursing staff checked the emergency carts daily. She said if an item was used, it needed be replaced to make sure that they always have all the necessary emergency equipment in an emergency. She said if a nurse did not know how to do something the expectation was that they would ask. In an interview with the DON on [DATE] at 12:08 PM, She said the emergency crash carts was the responsibility of central supply to make sure that nothing was expired monthly. DON said she did not expect the nurses to check the emergency carts each day. She said if the crash cart was used it got replaced by central supply. She said at her old job they had a lock on the crash cart after being stocked and the lock was only broken when the cart was used. she said she did not know the policy on emergency crash carts therefore, she could not say the risk. She said the expectation was the emergency crash carts should be ready to go when needed. Interview with CNA I on [DATE] at 1:43PM, she said she checked the emergency crash carts once a month for expired supplies. She said if something were expired, she would replace it and if she did not have it in stock she would order it. CNA I said the log of items on the cart are sent to corporate. She said the nurses at night have a check off list and they are responsible to check that off. She said it was important to have everything on the cart in case there was an emergency and want to make sure all the supplies are there for a code. She said if crash cart was used, it was the responsibility of either day shift or night shift if happened on night to replace it. She said the risk of not having emergency cart readily available was Something bad, they could maybe pass. In an interview with ADM on [DATE] at 6:45 PM, she said the expectation was the nurses maintained the crash cart and it should be ready when they have a code, and afterwards it was cleaned and restocked. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility in-service titled suction machine was completed on [DATE] lead by ADON and DON. Twenty-two nurses attended the in-service including RT, LVN's and RN's. Review of facility policy Cardiopulmonary Resuscitation, revised [DATE], reflected 20. The facility will maintain an emergency cart with at least the following supplies: a. Backboard b. Ambu bag c. O2 and administration set d. Disposable Gloves e. Crash cart (ER cart/AED) is checked daily, PRN and restocked immediately after a code is completed .

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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** 48520 Based on interviews and record reviews, the facility failed to ensurethat a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to obtain physician orders with specific non-rebreather (this is a mask that delivers high concentration oxygen with a minimum of 10 to 15 Liters/minute of Oxygen flow via a mask and has a valve that ensures air only comes in or out one way) amount on resident #1 from 11/11/24 to 11/14/24. This failure could place the resident at risk for receiving inaccurate oxygen therapy and retention of too much carbon dioxide in residents with COPD. Findings Included: Record review of Resident #1's admission record dated 04/23/25 revealed a [AGE] year-old female with an admitted [DATE]. Her primary diagnosis was unspecified dementia (a brain disease that alters brain function and causes a cognitive decline), and her secondary diagnoses were Myxedma coma (this is a rare life threatening endocrine emergency that occurs when the thyroid hormone regulation is disrupted), heart failure, Atrial fibrillation (this is a heart condition that causes an irregular, often rapid heart rate that can cause poor blood flow), acute respiratory failure with hypoxia, COPD (a lung disease that blocks airflow and makes it difficult to breathe). Resident #1 was on hospice and Resident #1 RP was family. Record review of Resident #1's quarterly MDS Assessment, dated 09/25/24, revealed the resident's BIMS score was 10 out of 15, indicating she had moderate cognitive impairment. The MDS Assessment reflected Resident #1 was able to make self-understood and understood others. Further review revealed Resident #1 was dependent on staff for all ADLs and required respiratory treatments oxygen therapy. Review of Resident #1's care plan initiated on 01/17/24 revealed the following care areas: *Resident #1 had emphysema (a chronic lung diseases that progressively damages the tiny air sacs in the lungs)/COPD. The goal was for Resident #1 to display optimal breathing pattern daily through the review date. The interventions were to give oxygen therapy as ordered by the physician. *Resident #1 had oxygen therapy. The goal was for Resident #1 not to have any signs and symptoms of poor Oxygen. The interventions were to change residents position every 2 hours to facilitate lung secretion movement and drainage, If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal, Oxygen at 2-4 lpm per nasal canula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's care plan initiated on 04/20/24 revealed Resident #1 had a terminal prognosis and was receiving hospice services. Resident #1 was admitted to hospice on 02/13/24 for Alzheimer's disease with late onset (this is a brain condition that progressively destroys memory and other important mental functions). Interventions were to review residents living will and ensure it was followed and to involve family in the discussion. Care plan did not reflect use of non-rebreather high flow supplement oxygen therapy for Resident #1. Review of Resident#1's physician orders reflected: -DNR- Do not Resuscitate ordered on 08/12/24 -Admission to hospice with diagnoses of Alzheimers diseases (with late onset (this is a brain condition that progressively destroys memory and other important mental functions) level of care on 02/13/24. - May use oxygen at 2-3 liters/minute via nasal canula every shift (nasal cannula is a thin flexible tube that gives additional oxygen up to 5 L through the nose). Ordered 02/13/24. - Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) Microgram/Activation (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for Shortness of Breath [breathing treatment]. Ordered 01/16/24. - Acetaminophen Rectal Suppository 650 MG (Acetaminophen) Insert 1 suppository rectally every 4 hours as needed for Pain and /or fever Not to exceed 4 doses in 24-hour period. Ordered 02/12/24. - Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 1 ml by mouth every 2 hours as needed for Very excruciating pain and /or very severe SOB. Ordered 02/12/24. -Further review of the physician orders did not reflect orders for non-rebreather high flow supplement oxygen therapy Review of Resident #1's MAR for November 2024 did not reflect administration orders for non-rebreather high flow supplement oxygen therapy. Record review of Resident #1's progress notes for November 2024 reflected as follows: Effective Date: 11/12/2024 13:42 [1:42 PM] Type: Nursing Progress Note, Author: RN A: Hospice RN in pt room, pt having SOB with 02 at 87% per 3L nasal cannula, Temp 101.2, Resp 24, BP 187/86, pulse 96. Nonrebreather mask placed on pt with 02 turned up to 5L, O2 level at 95% at this time. Hospice RN given orders by provider to start Levaquin 500 mg [antibiotic], Prednisone 20mg [steroid], and Duonebs q 6 hours [breathing treatment]. First doses given along with first Duoneb per nebulizer. Pt ia [is] alert and oriented x 2, with some confusion, with moderate SOB observed. Pt has no c/o pain at this time. Tylenol supp [suppository] given for elevated temperature. Pt head of bed elevated with instructions given to CNAs to keep it elevated due to pt SOB. Effective Date: 11/13/2024 07:04 [7:04 AM]- Author: RN A (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note Text: Pt resting quietly with 02 at 96% per nonrebreather at 4L. B/P 128/79, pulse 74, resp 26, temp 98. 9 with rhonchi [lung sound characterized by low pitch rumbling sound] and wheezing heard in bilateral [both] lobes. Duoneb given per order, along with Morphine 1ml sublingually [under the tongue]. Pt alert and responsive to verbal stimuli [awakening] with nodding or shaking her head. Call light within reach and no distress noted at this time. Effective Date: 11/13/2024 21:45 [9:45 PM] Type: Nursing Note- Author: LVN B Note Text: This resident is being treated for URI . BP-110/72. P-86. R-18. T-97.3. O2-97. Oxygen at LPM: 5 via mask continuously. Negative Findings: Hoarseness, Respirations: Labored Breathing, Abnormal breath sounds: Rhonchi, to Right Lower Lobe, to Right Upper Lobe, to Left Lower Lobe, to Left Upper Lobe. Interventions: Breathing treatment: DUONEBS TID head of bed up, No Pain. Effective Date: 11/14/2024 02:24 [AM] Type: Nursing Note Author: RN C This resident is being treated for URI. BP-127/64. P-90. R-18. T-97.5. O2-97. Oxygen at LPM: 5 via mask continuously. Negative Findings: None Respirations: Labored Breathing, Breath sounds clear. Interventions: Breathing treatments: ALBUTEROL TID. -11/14/2024 at 14:01 [2:01 PM] change in condition entered by RN D Effective Date: 11/14/2024 14:23 [2.23 PM] Type: Nursing Progress Note- Author: RN D Note Text: Resident transitioning to end of life. VS T97.3 P93 R12 shallow with apnea, SATS 91-97% on 10L via non-rebreather mask. Scheduled morphine and PRN Ativan given throughout shift as needed for pain/SOB. Repositioned Q2hrs for comfort, oral care provided. Family at bed side all shift. Effective Date: 11/14/2024 15:38 [3:38 PM] Type: Nursing Progress Note Effective Date: 11/14/2024 14:23 Type: Nursing Progress Note- RN B Note Text: Noted change in VS they are dropping BP 86/49, P 74, T 95.6, R20, O2 93% 10L mask, cannot verbalize pain morphine given 1 ML. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with Resident #1's RP on 03/26/25 at 1:26 PM revealed Resident #1 passed away on 11/14/24 at 6 pm. She said Resident #1 sounded like she was suffocating due to the non-rebreather not set correctly. She said Resident #1's non-rebreather was set to administer only five liters of oxygen instead of the ten liters that were required to support non-rebreather oxygen therapy. She stated, no one noticed the wrong non-rebreather setting of oxygen until the next business day (11/14/24), when RN D corrected it and placed Resident#1 on the recommended 10 Liters to support non-rebreather treatment. She said the non-rebreather was later removed before Resident #1 passed away on 11/14/24. Review of Resident #1's respiratory vitals from 11/11/24 to 11/14/24 revealed the following: - 11/11/24 - 18 breaths per minute - 11/13/24 - 26 breaths per minute - out of range for breaths per minute - 11/17/24 - 17 breaths per minute - 11/14/24 - 19 breaths per minute Review of Resident #1's oxygen saturation levels from 11/11/24 to 11/14/24 revealed the following: - 11/14/24 - between 93-94 % (day of Resident's passing) - 11/13/24 - between 95-96% - normal range for oxygen - 11/12/24 - between 95-96% - normal range for oxygen - 11/11/24 - 97% - normal range for oxygen (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 RN A on 04/23/25 at 7:15AM, revealed she had been employed at the facility for eight months. She stated one of the CNA's (CNA J) informed her that Resident #1 was not doing well, she immediately went to Resident #1's room and assessed her [11/12/24]. She said while she was assessing her the hospice nurse RN K walked into the room. She said Resident #1 was on a nasal cannula at 3 L. RN K told her to increase Resident #1's oxygen to 5 L, therefore RN A placed Resident #1 on a non-rebreather because her oxygen level was not going up. She said RN K them got on the phone with hospice physician and obtained other orders immediately . She said she could not remember the orders as it had been a long time ago. RN A stated she had never used a non-rebreather before and she would not have done so without someone telling her to do so. She said, I believe RN K told her to use the non-rebreather for Resident #1 but She did not remember 100 percent. She stated she was not familiar on range of the oxygen on non-rebreather mask. She said she would google and ask someone for the range. She said the process of receiving orders was verbal or written and that she would put the orders in the computer after the hospice nurse gave them to her . She said some hospice nurses put their own orders in, so she was not sure if the order for the non-rebreather was added. RN A said she did not take off the non-rebreather from Resident #1 until she was stable . She said the hospice nurse left after Resident #1 stabilized and she did not tell her to remove the non-rebreather. She said because the hospice nurse was in there, she assumed it was ok to the leave the non-rebreather on because she did not say to remove it and put Resident #1 back on her nasal cannula. RN A said the hospice nurse (RN K) notified the physician and she did not have to because Resident #1 was on hospice and the hospice nurse was in the room. Said it was important to get physician orders for the safety of the patient so they can know how what to do. RN A said she was aware of RT in the facility, but it all happened so fast, and they moved as fast to stabilize Resident #1 that she forgot to ask RT to check Resident #1 who had been placed on the nonrebreather. In a phone interview with RN K on 03/26/25 at 2:41 PM, she stated she was Resident #1's hospice nurse. She said she went to see Resident #1 on 11/11/24 the non-rebreather was used on her. She said when she got to Resident#1's room, Resident #1 was having difficulty breathing and had shortness of breath. She said the facility nurse RN A had already placed Resident #1 on the non-rebreather. She said she could not remember the liters of the non-rebreather because she herself and RN A were trying to stabilize Resident #1. RN K said she was knowledgeable that non-rebreathers should be set at minimum ten liters otherwise the patient is not getting the needed oxygen fast. RN K said that she did not get orders for the non-rebreather. She said that she called the hospice physician while she was in Resident #1's room and reported Resident #1's condition and he gave her orders but the hospice physician did not give order to keep Resident #1 on a non-rebreather for supplemental oxygen. RN K said the order process was that she wound send the doctor a text on the phone to get orders then she wrote them down on paper and give the order to the facility nurse to imputed in her computer. She said the written orders are placed in the resident's hospice book afterwards. RN K said a non-rebreather was used in emergency cases to help patients get large amounts of oxygen fast to help them recover. She said non-rebreathers were not for long term use. She said when she left, Resident #1 was still on the non-rebreather, but she was stable. She said she was not aware the facility left Resident #1 on the non-rebreather until 11/14/24. She said she did not give them any verbal orders to keep Resident #1 on the non-rebreather oxygen therapy. She said she was also not aware that the facility had Respiratory Therapists on site 24 hours because no one told her. She said the risk to the resident for not getting orders for non-rebreather was retention of carbon dioxide especially in a resident with COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a phone interview with CNA J on 03/26/25 at 2:10 PM, she said that she worked for the hospice company that Resident #1 was admitted to while in the facility. She said she proved ADL care, to Resident #1 three times a week and then the week before she passed away, ADL care was changed to five days a week. She said that she had found Resident #1 without oxygen or still connected to an empty oxygen tank on her wheelchair on multiple occasions. She said she would connect Resident #1 to the oxygen compressor in her room then go out and tell facility nursing staff to let them know what she saw and to get Resident #1 a full oxygen tank to use in the shower room for Resident #1.CNA J said she could not remember the names of the facility staff she reported to. CNA J said the last week before Resident #1 passed away she was assigned to provide daily ADLs care as usual, she said she told the facility that Resident #1 did not need a lot of oxygen and asked them to remove the non-rebreather off Resident #1.CNA J said she could not remember the exact date. She said Resident #1 looked more comfortable with just the nasal canula after the non-rebreather was removed. She said she could not remember the exact date when they removed the non-rebreather, but she had to tell the facility to remove it and put her on the nasal cannula. In an interview with LVN B on 04/23/25 at 3:59 AM, he stated he had been employed by the facility for a year and a half. He said he had gotten training on Ventilators, non-rebreathers, tracheostomy, and other supplemental oxygen therapy when he first started working at the facility. He said he knew that non-rebreathers were only used to short term use and when he took care of Resident #1, he used a regular simple oxygen mask on her. He said he did not see any orders for a non-rebreather. He said it was important to make sure residents had physician orders for consistency and to follow orders so that you do not make the patients worse by doing the wrong thing. He stated if he needed clarification on orders, he could reach out to the facility physician or the hospice physician or hospice nurse. In a phone interview on 04/23/25 at 11:18 AM, revealed RN C had worked with Resident #1 before she passed away [11/14/24] but he could not remember if Resident #1 was on a non-rebreather. He said he knew that a non-rebreather was used only in an emergency when a residents oxygen level drops to help bring back [NAME] quickly. He said after a resident was stabilized, they should be placed on a nasal cannula or if they do not stabilize 911 would be called. RN C said he did not obtain new orders for Resident #1 because the physicians were already aware of the residents' current conditions. He said he believed the oxygen orders were in the computer and he just continued with what was given to him in report. RN C stated it was always good to look at the residents' orders and verify them so that you did not do something wrong. (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 RN D on 04/23/25 at 7:40 AM, revealed she had been employed at the facility for four years. She said Resident #1 had been moved to her hallway [100 hall] and was assigned to her on 11/14/24 at 2PM. She said she noticed that Resident #1 was on a non-rebreather connected the hospice compressor however the compressor could only deliver a maximum of 5 Liters of oxygen so she asked the transferring nurse to get an Oxygen compressor that could deliver 10 L of oxygen. She said she then increased the non-rebreather to 10 L of oxygen which was the minimum required setting for non-rebreather mask. RN D said she completed a change of condition. RN D stated at this time, after getting the compressor and non-rebreather set to correct parameters, Resident #1 appeared stable she informed Resident #1's family that the non-rebreather was only to be used for short term use. RN D stated family refused to remove the non-rebreather even after she educated them. RN D said she did not call RT to access Resident #1 because she was already at end of life and both herself and the hospice nurse educated family on no-rebreather. RN D said eventually the family decide to allow her to remove the non-rebreather and Resident #1 was placed on a nasal cannula. RN D said physician orders are required to drive care. She said all nurses were trained on how to use a non-rebreather and for what it was used. RN D sated she forgot to document that Resident #1's RP was refusing to have the non-rebreather removed from Resident #1. In an interview with RT E and RT F on 04/23/25 at 3:23 AM, revealed they were not responsible for all the residents on supplemental oxygen therapy in the facility except for the ones on mechanical ventilation. They said in an event nursing needed assistance or had a respiratory question they would help. RT E said if a resident is needing to be on a non-rebreather, and they are a full code they would not be in the facility long, We would be calling 911. He said no-rebreathers are good for short term use to deliver fast 100% oxygen to help bring low oxygen up quickly. Both RT E and RT F said the non-rebreather should be set at 15 L or 10-12 Liters for it to be effective. RT E said a non-rebreather should not be used for 3 days as it affects PH which can cause the lungs to fail to remove enough carbon dioxide from the body. He said non-breathers can only be used for the shortest time possible. Both RT E and RT F said orders are required for all residents on oxygen therapy. In an interview with the DON on 04/23/25 at 12:08 PM, revealed she did not expect the nurses to obtain new orders for supplemental oxygen because Resident #1 already had orders to used supplement oxygen. She said even though the method of delivery was different, Resident #1 still had orders to use oxygen. DON said a non-rebreather was used for emergency when Resident #1 was having difficulty breathing and because it was an emergency to stabilize the resident, no physician orders are needed. DON said RN D educated the family that Resident #1 could not be on the no-rebreather for an extended time, but the family would not allow them to take off the non-rebreather. DON stated because Resident #1 was a DNR and was on hospice actively passing away, they did not need to call 911 for the resident needing to be on a nonrebreather oxygen delivery form. DON stated the expectation for a non-rebreather was 10-15 L of oxygen to be effective, she said she would not expect someone to put a non-rebreather at 4-5 L, however the hospice nurse (RN K) who was in the room with Resident #1 and RN A notified the physician, and the physician was aware of the condition of the resident. DON did not state the risk because Resident #1 already had supplemental oxygen orders. In a phone interview with the physician on 04/23/25 at 12:53 PM, he said he deferred supplemental Oxygen, or anything related to oxygen to the pulmonologist. He said in the event the nurses cannot reach the pulmonologist then he would put in the orders. He said he could not remember Resident #1 without looking at her records, but the nurses were good about notifying him when there was a change of condition and he expected nurses to reach out to him for oxygen order when they could not reach the pulmonologist first and he would give them the orders. He said physician orders drives care. (continued on next page)

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	04/23/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADM on 04/23/25 at 6:45 PM, she said the expectations was that all residents on supplemental oxygen obtain orders. She said she expected all staff to obtain physician orders and to follow the physician orders. In an interview with ADM on 04/23/25 at 4:44 AM, she stated all records for residents on hospice were uploaded to the EMR of each resident after they discharge. Record review of Resident #1 EMR on 04/23/25 at 4:44 AM did not reflect orders for non-rebreather use. Record review of Resident #1's discharge MDS assessmet, dated 11/14/24, did not indicate cause of death. Cause of death report requested from hospice company, but surveyor has not yet obtained. Review of the facility policy titled Physician Orders dated 2015 reflected the purpose of policy was. To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. 1. Nurse will review the order and if needed contact the prescriber for any clarifications. 2. The nurse will enter the order into PCC for the resident and select either verbal or telephone, depending on how the nurse received the order. 3. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed . Review of facility policy titled Oxygen Administration: revised March 21, 2023, reflected . The Resident will maintain oxygenation with safe and effective delivery of prescribed Oxygen

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interviews and record reviews the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to ensure RN A was trained on using a non-rebreather on Resident #1 and what parameters are required and when to discontinue use of the non-rebreather. This failure could place the resident at risk for receiving inaccurate oxygen therapy and retention of too much carbon dioxide in residents with COPD. Findings Included: Record review of Resident #1 ' s admission record dated 04/23/25 revealed a [AGE] year-old female with an admitted [DATE]. Her primary diagnosis was unspecified dementia (a brain disease that alters brain function and causes a cognitive decline), and her secondary diagnoses were Myxedma coma (this is a rare life threatening endocrine emergency that occurs when the thyroid hormone regulation is disrupted), heart failure, Atrial fibrillation (this is a heart condition that causes an irregular, often rapid heart rate that can cause poor blood flow), acute respiratory failure with hypoxia, COPD (a lung disease that blocks airflow and makes it difficult to breathe). Resident #1 was on hospice and Resident #1 RP was family. Record review of Resident #1's quarterly MDS Assessment, dated 09/25/24, revealed the resident's BIMS score was 10 out of 15, indicating she had moderate cognitive impairment. The MDS Assessment reflected Resident #1 was able to make self-understood and understood others. Further review revealed Resident #1 was dependent on staff for all ADLs and required respiratory treatments oxygen therapy. Review of Resident #1 ' s care plan initiated on 01/17/24 revealed the following care areas: *Resident #1 had emphysema (a chronic lung diseases that progressively damages the tiny air sacs in the lungs)/COPD. The goal was for Resident #1 to display optimal breathing pattern daily through the review date. The interventions were to give oxygen therapy as ordered by the physician. *Resident #1 had oxygen therapy. The goal was for Resident #1 not to have any signs and symptoms of poor Oxygen. The interventions were to change residents position every 2 hours to facilitate lung secretion movement and drainage, If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal, Oxygen at 2-4 lpm per nasal canula. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1 ' s care plan initiated on 04/20/24 revealed Resident #1 had a terminal prognosis and was receiving hospice services. Resident #1 was admitted to hospice on 02/13/24 for Alzheimer ' s disease with late onset (this is a brain condition that progressively destroys memory and other important mental functions). Interventions were to review residents living will and ensure it was followed and to involve family in the discussion. Care plan did not reflect use of non-rebreather high flow supplement oxygen therapy for Resident #1. During a phone interview with Resident #1 ' s RP on 03/26/25 at 1:26 PM revealed Resident #1 passed away on 11/14/24 at 6 pm. She said Resident #1 sounded like she was suffocating due to the non-rebreather not set correctly. She said Resident #1 ' s non-rebreather was set to administer only five liters of oxygen instead of the ten liters that were required to support non-rebreather oxygen therapy. She stated, no one noticed the wrong non-rebreather setting of oxygen until the next business day (11/14/24), when RN D corrected it and placed Resident#1 on the recommended 10 Liters to support non-rebreather treatment. She said the non-rebreather was later removed before Resident #1 passed away. In an interview with RN A on 04/23/25 at 7:15AM, revealed she had been employed at the facility for eight months. She stated one of the CNA's (CNA J) informed her that Resident #1 was not doing well, she immediately went to Resident #1's room and assessed her [11/12/24]. She said while she was assessing her the hospice nurse RN K walked into the room. She said Resident #1 was on a nasal cannula at 3 L. RN K told her to increase Resident #1's oxygen to 5 L, therefore RN A placed Resident #1 on a non-rebreather because her oxygen level was not going up. She said RN K them got on the phone with hospice physician and obtained other orders immediately . She said she could not remember the orders as it had been a long time ago. RN A stated she had never used a non-rebreather before and she would not have done so without someone telling her to do so. She said, I believe RN K told her to use the non-rebreather for Resident #1 but She did not remember 100 percent. She stated she was not familiar on range of the oxygen on non-rebreather mask. She said she would google and ask someone for the range. She said the process of receiving orders was verbal or written and that she would put the orders in the computer after the hospice nurse gave them to her . She said some hospice nurses put their own orders in, so she was not sure if the order for the non-rebreather was added. RN A said she did not take off the non-rebreather from Resident #1 until she was stable . She said the hospice nurse left after Resident #1 stabilized and she did not tell her to remove the non-rebreather. She said because the hospice nurse was in there, she assumed it was ok to the leave the non-rebreather on because she did not say to remove it and put Resident #1 back on her nasal cannula. RN A said the hospice nurse (RN K) notified the physician and she did not have to because Resident #1 was on hospice and the hospice nurse was in the room. Said it was important to get physician orders for the safety of the patient so they can know how what to do. RN A said she was aware of RT in the facility, but it all happened so fast, and they moved as fast to stabilize Resident #1 that she forgot to ask RT to check Resident #1 who had been placed on the nonrebreather. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with RN K on 03/26/25 at 2:41 PM, she stated she was Resident #1 ' s hospice nurse. She said she went to see Resident #1 on 11/11/24 the non-rebreather was used on her. She said when she got to Resident#1 ' s room, Resident #1 was having difficulty breathing and had shortness of breath. She said the facility nurse RN A had already placed Resident #1 on the non-rebreather. She said she could not remember the liters of the non-rebreather because she herself and RN A were trying to stabilize Resident #1. RN K said she was knowledgeable that non-rebreathers should be set at minimum ten liters otherwise the patient is not getting the needed oxygen fast. RN K said a non-rebreather was used in emergency cases to help patients get large amounts of oxygen fast to help them recover. She said non-rebreathers were not for long term use. She said when she left, Resident #1 was still on the non-rebreather, but she was stable. She said she was not aware the facility left Resident #1 on the non-rebreather until 11/14/24. She said she did not give them any verbal orders to keep Resident #1 on the non-rebreather oxygen therapy. She said the risk to the resident for not getting orders for non-rebreather was retention of carbon dioxide especially in a resident with COPD. In a phone interview with CNA J on 03/26/25 at 2:10 PM, she said that she worked for the hospice company that Resident #1 was admitted to while in the facility. She said she proved ADL care, to Resident #1 three times a week and then the week before she passed away, ADL care was changed to five days a week. She said that she had found Resident #1 without oxygen or still connected to an empty oxygen tank on her wheelchair on multiple occasions. She said she would connect Resident #1 to the oxygen compressor in her room then go out and tell facility nursing staff to let them know what she saw and to get Resident #1 a full oxygen tank to use in the shower room for Resident #1.CNA J said she could not remember the names of the facility staff she reported to. CNA J said the last week before Resident #1 passed away she was assigned to provide daily ADLs care as usual, she said she told the facility that Resident #1 did not need a lot of oxygen and asked them to remove the non-rebreather off Resident #1. She said Resident #1 looked more comfortable with just the nasal canula after the non-rebreather was removed. She said she could not remember the exact date when they removed the non-rebreather, but she had to tell the facility to remove it and put her on the nasal cannula. In an interview with the DON on 04/23/25 at 12:08 PM, revealed the expectation for a non-rebreather was 10-15 L of oxygen to be effective, she said she would not expect someone to put a non-rebreather at 4-5 L DON did not state the risk because Resident #1 already had supplemental oxygen orders. Review of facility policy titled Oxygen Administration: revised March 21, 2023, reflected . The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen .become familiar with the type of oxygen administration, medical diagnosis and reason for oxygen, intermittent or continuous use of oxygen, amount to be delivered .