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	07/14/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed ensure the resident's right to personal privacy and confidentiality of his or her personal and medical records for fourteen (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) of thirty residents reviewed for privacy and confidentiality. 1. The facility failed to ensure LVN C pulled the privacy curtain while suctioning (mechanical aspiration of pulmonary secretions to clear the airway) Resident #1 on 07/12/2025. 2. The facility failed to ensure LVN C closed the door while suctioning Resident #2 on 07/12/2025. 3. The facility failed to ensure LVN D did not leave Residents #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13's medical information on top of his cart on 07/12/2025. 4. The facility failed to ensure RN E closed, locked, or minimized his laptop's monitor, thus, showing Resident #14's medical information on 07/13/2025. These failures could place the residents at risk of not having their personal privacy maintained during medical treatment and their medical information exposed to unauthorized individuals. Findings included: 1. Record review of Resident #1's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy (is an opening surgically created through the neck to allow air to fill the lungs). Record review of Resident #1's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 05/07/2025, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS (screening tool used to assess cognitive status) score of 00. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care while a resident of the facility. Record review of Resident #1's Comprehensive Care Plan, dated 05/21/2025, reflected the resident had tracheostomy and one of the interventions was to suction as necessary. Record review of Resident #1's Physician Order, dated 07/01/2025, reflected Check resident Q2H for suctioning need, suction via trach PRN every shift. Observation on 07/25/2025 at 9:10 AM revealed LVN C entered Resident #1's room to check on the resident. The resident signaled LVN C that she wanted to be suctioned. LVN C sanitized her hands, put on a pair of gloves, and put on a gown. She proceeded to suction the resident without pulling the privacy curtain. Resident #1 could not be seen from the hallway but could be seen by Resident #2, resident's roommate, who was sitting at the side of her bed and facing towards Resident #1's bed. Observation and attempted interview on 07/12/2025 at 10:54 AM, revealed Resident #1 did not reply when asked if it was okay for her that her roommate could see what the nurse was doing to her. 2. Record review of Resident #2's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy. Record review of Resident #2's Comprehensive MDS Assessment, dated 06/06/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care while a resident of the facility. Record review of Resident #2's Comprehensive Care Plan, dated 06/08/2025, reflected the resident had tracheostomy and one of the interventions was to suction as necessary. Record review of Resident #2's Physician Order, dated 01/16/2025, reflected Check resident Q2H for suctioning need, suction via trach PRN every shift. Observation on 07/25/2025 at 9:25 AM revealed after LVN C was done suctioning Resident #1, Resident #2 requested to be suctioned, as well. LVN C proceeded to suction Resident #2 without closing the door or pulling the privacy curtain. Resident #2 could be seen from the hallway and the treatment being done could be seen from the hallway and her roommate. In an interview on 07/12/2025 at 10:34 AM, LVN C stated she guessed she needed to close the door and pull the privacy curtain every time care or treatment was being done for the residents, not just for Resident #1 and Resident #2, to provide privacy. She said somebody from the hallway might see that they were being suctioned and the residents might be embarrassed. In an interview on 07/12/2025 on 10:54 AM, Resident #2 stated the nurses, not only LVN C, would not close the door or pull the privacy curtain when they were treating them. She said she already got used to it, but a change would be nice so that others would not see that a tube was being inserted in her throat. 3. Record review of Resident #3's Face Sheet, dated 07/12/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy. Record review of Resident #3's Physician Order, dated 07/12/2025, reflected Assess before & after a treatment - O2 Sat, Resp Rate, Pulse . four times a day. Record review of Resident #3's Vital Signs, dated 07/12/2025, reflected BP: 98/60 mmHg, Temp: 97.6, Pulse: 86, Respiration: 20, O2 sats: 99.0%

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #12) of five residents reviewed for feeding tube (a process of providing nutrition directly to the stomach). The facility failed to ensure LVN C checked Resident #12's g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) placement and residual before administering the resident's medications and failed to administer the resident's medication one by one on 07/12/2025. These failures could place residents with g-tubes at risk for aspiration and drug-to-drug interaction. Findings included: Record review of Resident #12's Face Sheet, dated 07/12/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #12's Comprehensive MDS Assessment, dated 05/15/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #12's Quarterly Care Plan, dated 05/12/2025, reflected the resident required tube feeding and one of the interventions was to check for tube placement and gastric contents/residual volume. Record review of Resident #12's Physician Order, dated 06/11/2025, reflected every shift start continuous enteral feeding. Formula: Diabetasource; Rate: 65ml/hr, flush 200 ml H2O q 4 hrs. Record review of Resident #12's Physician Order, dated 04/04/2025, reflected every shift check placement prior to feeding and medication administration. Record review of Resident #12's Physician Order, dated 04/04/2025, reflected every shift check residual before medications and feedings; return contents after each check. Record review of Resident #12's Physician Order, dated 06/25/2025, reflected Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug* Give 1 tablet via PEG-Tube (a flexible feeding tube inserted directly to the stomach) every 6 hours for pain, hold for sedation. Record review of Resident #12's Physician Order, dated 06/25/2025, reflected Docusate Sodium Oral Tablet 100 MG (Docusate Sodium) Give 1 tablet via PEG-Tube every 24 hours as needed for constipation. Record review of Resident #12's Physician Order on 07/12/2025 reflected no order that her medications could be cocktailed (could be given altogether at the same time). Observation and interview on 07/12/2025 at 10:38 AM revealed LVN D was preparing Resident #12's medication on his cart. LVN D said he wound administer the resident's 11:00 AM medication. He went inside the room with one small plastic cup with crushed medications in it and a big plastic cup with some water in it and placed them on the resident's overbed table. When inside the room, he incorporated some water on the small cup to dissolve the crushed medications. LVN D sanitized his hands and put on a pair of gloves. He took a 60 ml piston syringe from the resident's side table and placed it also on the overbed table. He raised the bed, lifted the resident's gown to expose the g-tube site. He pulled the plunger of the syringe, attached the syringe to the g-tube, and flushed the g-tube. After flushing the g-tube, he poured the dissolved medication. He did not check for the placement of the g-tube and the gastric content before flushing and administering the medication. After pouring the medications, he flushed the g-tube, and detached the syringe. He cleaned the syringe, took off his gloves, and sanitized his hands. In an interview on 07/12/2025 at 10:51 AM, LVN D stated he forgot to check for the g-tube placement and to check the residual of both residents. He said the right procedure was to check the placement and the residual every medication administration. He said g-tube placement was checked to ensure the tube was correctly positioned. He said the residual was also checked before administering medications to check if the stomach could accommodate the medications and fluid to be given and to prevent aspiration. He said he knew he needed to check for the placement and residual but failed to do so because he was nervous. He said he administered Resident #12's midday medications, which were oxycodone and docusate. He said he crushed the medications and put them both in a single cup. He said he was not sure if the resident had an order that would say her medications could be cocktailed. He said if there was no order to cocktail, then the medications should have been administered one by one. He said the reason for giving one by one was to prevent drug-to-drug interaction or drug-to-formula interaction that could impede the medication's effectiveness. In an interview on 07/12/2025 at 3:33 PM, ADON A stated both the gastric residual and the g-tube placement should be checked before administering the medications. She said g-tube placement should be checked to ensure the g-tube was in the right place. She said even though the residents were on continuous feeding, the placement should still be checked. She said the gastric residual was also checked to prevent aspiration and also to

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four (Resident #1, Resident #2, Resident #12 and Resident #15) of twenty residents reviewed for infection control. 1. The facility failed to ensure LVN C did not re-use a gown to provide treatment for some residents at hall 400 on 07/12/2025. 2. The facility failed to ensure LVN C changed her gown in between Resident #1 and Resident #2 who were with tracheostomy on 07/12/2025. 3. The facility failed to ensure LVN C changed her gloves and performed hand hygiene when changing Resident #2's tracheostomy dressing on 07/12/2025. 4. The facility failed to ensure LVN D wore a gown while administering Resident #12's medication via g-tube on 07/12/2025 5. The facility failed to ensure CNA F changed her gloves and performed hand hygiene while providing incontinent care to Resident #15 on 07/12/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #1's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy (is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) and gastrostomy (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). The Face Sheet indicated that the resident was on enhanced barrier precaution as a special instruction due to tracheostomy and gastrostomy. Record review of Resident #1's Comprehensive MDS Assessment, dated 05/07/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care and had a feeding tube. Record review of Resident #1's Comprehensive Care Plan, dated 05/21/2025, reflected the resident was on enhanced barrier protection and one of the interventions was to put on gloves and gowns. Record review of Resident #1's Physician Order, dated 06/11/2025, reflected Trach care every shift and PRN. Record review of Resident #1's Physician Order, dated 07/01/2025, reflected Bolus Isosource 1.5 250 ml via g-tube if PO intake < 50 % after meals. Record review of Resident #2's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy. The Face Sheet indicated that the resident was on enhanced barrier precaution as a special instruction due to tracheostomy. Record review of Resident #2's Comprehensive MDS Assessment, dated 06/06/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care while a resident of the facility. Record review of Resident #2's Comprehensive Care Plan, dated 06/08/2025, reflected the resident was on enhanced barrier protection and one of the interventions was to put on gloves and gowns. Record review of Resident #2's Physician Order, dated 01/16/2025, reflected Trach care every shift and prn. Observation and interview on 07/12/2025 starting at 9:05 AM revealed gowns were hanging on some of the rooms in hall 400. One of the rooms with a gown hanging on the door was for Resident #1 and Resident #2. LVN C went inside the residents' room, took the gown hanging on the door, and proceeded to do a medical procedure. She said she would hang her gown after use and would just discard the gowns at the end of her shift. She said the other gowns hanging on the doors of the other residents were also hers. 2. Record review of Resident #1's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy and gastrostomy. The Face Sheet indicated that the resident was on enhanced barrier precaution as a special instruction due to tracheostomy and gastrostomy. Record review of Resident #1's Comprehensive MDS Assessment, dated 05/07/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was receiving tracheostomy care and had a feeding tube. Record review of Resident #1's Comprehensive Care Plan, dated 05/21/2025, reflected the resident had tracheostomy and required tube feeding. Record review of Resident #1's Physician Order, dated 06/11/2025, reflected Trach care every shift and PRN. Record review of Resident #1's Physician Order, dated 07/01/2025, reflected Bolus Isosource 1.5 250 ml via g-tube if PO intake < 50 % after meals. Record review of Resident #2's Face Sheet, dated 07/12/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy. The Face Sheet indicated that the resident was on enhanced barrier precaution as a special