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	09/03/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure the resident's right to be free from abuse for 2 (Resident #45 and Resident #23) of 2 residents reviewed for abuse, in that: On 08/29/2025, the facility failed to ensure that Resident #45 was not punched in the face by Resident #23, resulting in injury to the face.This failure resulted in injuries to Resident #45.Resident #45Record review of a face sheet dated 09/03/2025 revealed Resident #45 was [AGE] years old and was admitted on [DATE] with a primary diagnosis of hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, and other pertinent diagnoses including cognitive communication deficit and mood disorder due to known physiological condition with major depressive-like episode.Record review of Resident #45's MDS dated [DATE] reflected a BIMs score of 15. The residents mood interview revealed he had felt down, depressed or hopeless for several days (2-6 days) over the last 2 weeks.Record review of Resident #45's care plan, last reviewed on 05/29/2025, revealed the following care areas: Potential for psychosocial well-being problem with interventions including consult with psych services, when conflict arises- remove residents to a calm safe environment and allow to vent/share feelings.Potential to demonstrate verbally abusive behaviors and becomes very loud and verbally aggressive if he does not get his way. Various interventions included analyze and document triggers and what de-escalates behavior, assess resident's understanding of the situation and allow resident to express self and feelings towards the situation, notify the charge nurse of any abusive behaviors, psychiatric/psychogeriatric consults, and when the resident becomes agitated- intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, ensure all residents involved are safe and staff to walk calmly away, and approach later.Record review of Resident #45's progress note dated 08/28/2025 at 18:34 (6:34PM) reflected: Resident was complaining about having verbal disagreement with his roommate about the noise both of them were making disturbing each other, upon asking both the resident about the situation, both were blaming each other about the noise statement. Advised them to be calm and issue resolved for now.Record review of Resident #45 skin assessment following the incident dated 08/29/2025 revealed the resident had skin tear on the right side of upper chest bone and right wrist.Record review of Resident #45 psychological services progress note dated 08/29/2025 reflected: (Resident #45) and therapist met. (Resident #45) apparently had a physical altercation with his roommate. (Resident #45) was still upset and reported that he did not hit his roommate but that he was struck by the roommate. It was reported the (Resident #45) through a board . Overall, he is not a danger to others but is upset that his roommate attacked him. Record review of a written interview summary from the provider investigation report, dated 08/29/2025, of Resident #45's statement reflected: Resident #45 reported that he was in bed and attempting to get up to use the bathroom when Resident #23 began yelling at him for being too noisy. Resident #45 stated that he informed Resident #23 he was simply getting up to go to the bathroom. He alleged that Resident #23 then picked up his wheelchair and threw it at him, followed by hitting him in the mouth. Resident #45 further stated Resident #23 also threw water at him. According to Resident #45, both residents were yelling when a nurse entered the room and witnessed Resident #23 strike him in the stomach. Resident #45 added that the nurse was also aware water had been thrown on him, as he had to change his shirt due to it being wet.An interview on 09/03/2025 at 5:04PM with Resident #45 revealed anytime he was moving around the room, Resident #23 would go crazy when he made a noise. He said Resident #23 had only been his roommate for a few days and had not really discussed Resident #23 prior to the altercation. Resident #45 explained he got hit in the mouth by Resident #23's fist and hit in the chest; he further stated he was only injured on the mouth had a few scratches on his chest. Resident #45 stated Resident #23 hit him because he was making too much noise in the room when he was moving his wheelchair around the room. He further explained Resident #23 told him to quit making noise, and anytime Resident #45 made a noise, Resident #23 would bang on the wall. He said Resident #23 then rolled his wheelchair at Resident #45 really hard and it hit his leg. Resident #45 said he picked up his sliding board and raised it up (to intimidate), but never threw it at Resident #23. He said Resident #23 threw water at him and he [NAME] it back at Resident #23. Resident #45 said Resident #23 followed him out of the room and punched him one time on the mouth. Resident #45 said he had not had any issues since the altercation and stays away from Resident #23. He said felt safe at the facility and lets staff know if he had issues. Resident