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	12/03/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 observation, interview, and record review the facility failed to ensure the resident environment remained free of accident hazards as is possible for 2 of 4 hallways reviewed. The facility failed to ensure 2 of 4 assisted lifting devices were secured properly while being stored in 2 of 4 hallways. This failure had the potential to cause harm to the residents by creating avoidable accident hazards. The findings include: Record Review of an undated facility policy titled Hydraulic Lift reflected there were no instructions on proper storage or caster locking for assisted lifting devices when not in use. Record Review of an undated user manual for Hoyer Advance Patient Lift reflected that the proper storage method for the assisted lifting device is to be fold the mast down towards the legs and then stored in an upright position when the lift is not in use. Record Review of a document titled Inservice Training Attendance Roster for an in-service training titled All beds and hoyers to be locked, dated 1/8/25, reflected 50 staff members were trained on the proper method of locking assisted lifting device when not in use. Observation on 12/3/25 at 8:30 AM showed a hydraulic assisted lifting device stored in the 200 hallway, adjacent to room [ROOM NUMBER], was free rolling with the wheels unsecured. Several residents were also observed in the 200 hallway ambulating past the unsecured assisted lifting device. Observation on 12/3/25 at 11:58 AM showed an assisted lifting device stored in the 400 hallway, adjacent to room [ROOM NUMBER], only had the right rear wheel in the locked position, allowing the assisted lifting device to spin freely around the axis of the secured wheel. Several residents were also observed in the 400 hallway ambulating past the unsecured assisted lifting device. An interview was conducted with RA on 12/3/25 at 8:32 AM. RA stated she had received training that all lockable wheels on the assisted lifting device where to be locked when not in use and stored in the hallway. RA said there was a risk of an accident occurring, with the potential to cause harm if assisted lifting devices are not secured properly. RA's name was located on the document titled Inservice Training Attendance Roster for an in-service training titled All beds and hoyers to be locked. An interview was conducted with the DON on 12/3/25 at 1:31 PM. The DON stated all assisted lifting devices are to be secured by locking the securable wheels and left in the hallways in a ready to use position, when not in use. The DON was advised two of four assisted lifting devices were found to be unsecure while being stored in the hallways of the facility. It was explained to the DON that the two assisted lifting devices were found to be free rolling, with the brakes not applied. The DON further stated an in-service had been conducted around the beginning of 2025 regarding locking the wheels on the assisted lifting devices after a representative for their corporate risk management entity advised them the assisted lifting devices should have their wheels locked when not in use. The DON referred to the document titled Inservice Training Attendance Roster for an in-service training titled All beds and hoyers to be locked, dated 1/8/25, for reference to the time frame when the training occurred. The DON further stated after the request for documents regarding the use and storage of assisted lifting devices, she began an immediate in-service with staff on proper securing procedures for locking assisted lifting devices. The DON was then notified another assisted lifting device was observed to be secured by only the rear right wheel being locked. The DON stated she believed only locking one wheel is sufficient to secure the assisted lifting device. When advised that with only one wheel locked the assisted lifting device can still spin freely around the axis of the locked wheel, she then stated there was a risk for an accident and the potential for harm with only one wheel locked. The DON also stated there is a risk of an accident or harm if an assisted lifting device is left completely unsecured and allowed to move freely when not in use.