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	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marine Creek Nursing & 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for one (Resident #1) of six residents reviewed for the storage of drugs and biologicals. This facility failed to ensure MA A did not leave Resident #1's medications unattended on the Medication Cart located on the 400 hall, while she was in another resident's room. This deficient practice had the potential risk of affecting all residents who received medications on the 400 hall, which could cause residents to miss getting their medications or cause other residents to ingest the medications, which could result in adverse reactions in residents. Findings included:Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted to the facility 02/06/26. She had a BIMS score of 13 (cognitively intact) and used a wheelchair and walker for mobility. She was frequently incontinent with bladder and continent with bowels and had a debility with cardiorespiratory conditions (diseases of the heart, blood vessels and respiratory system). She had diagnoses of heart failure (weak heart not pumping blood efficiently), hypertension (high blood pressure), acute respiratory failure (lungs not deliver enough oxygen to blood), with hypoxia (not getting enough oxygen to tissues) or hypercapnia (high level carbon dioxide in blood stream), obesity (excessive body fat), and obstructive sleep apnea (chronic sleep disorder with upper airway blockage). Record review of Resident #1's June 2026 MARs dated 06/10/26 revealed, for the morning medications, MA A gave Resident #1 Furosemide 20 mg one tablet one time per day for heart failure, Lactulose 10 gm/15 ml solution one time per day for high ammonia levels, Multivitamin tablet one time per day for supplement, prednisone 10 mg 1 tablet one time per day for respiratory failure, Senna-plus 8.6 - 50 mg 2 tablets by mouth one time per day for constipation, Apixaban tablet 5 mg 1 tablet two times per day for DVT prevention, and Diltiazem tablet 30 mg 1 tablet two times per day for hypertension. Record review of Resident #1 Care Plan dated 02/09/26 revealed, she had a communication problem related to tracheostomy, ADL (Activity of Daily Living) self-care performance deficit, bladder incontinence, congestive heart failure, hypertension, oxygen therapy, GERD (Gastroesophageal Reflux Disease), constipation related to decreased mobility, medication side effect. She had bowel incontinence, altered cardiovascular status related to hypertension and a regular diet, mechanical soft texture, regular drinks. Observation on 06/10/26 at 10:14 am, along the middle of the 400 hall, on top of a locked medication cart, there were seven pills in various colors in a small medicine cup and there was a yellowish liquid in a medicine cup. There was a 6 oz cup of water next to these medications. A minute later there was one female staff in black scrubs and ADON B walked south down the 400 hall. (There no residents were seen passing by). Observation and interview on 06/10/26 at 10:16 am, MA A walked up to grab the medications, she said she answered a call light as quickly as she could and did not want it to ring for too long. She stated she was not sure where the aides were. (Then she went to give the Resident #1 her medications). Observation and interview on 06/10/26 at 10:18 am, MA A returned to the medication (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cart. She stated the resident in another room needed help and she was looking for the CNAs but could not find one. She stated the resident in room [ROOM NUMBER] had vomited and she asked him if he was okay and got him cleaned up. She stated she was moving too fast but normally she made sure the residents' medications were secured before walking away from the med cart. She stated the ADONs told the staff they needed to answer the call lights and felt the CNAs were busy with other residents. She stated one CNA went to lunch and she was not sure where the other CNA was. She stated that for unattended medications, anything could happen to them and said if she did not answer the call light anything could happen. She said she did not mind accepting the fact she left the medications on the med cart and should have taken the time and gave Resident #1 her medications and documented giving them then answered the call light. She stated she knew better and should not have left the medications like that because somebody could have come along and picked the medications up. She stated another Resident or family member; anybody could have picked the medication up and ingested them. She stated ingesting medications could cause a person to get sick. Interview on 06/10/26 at 12:05 pm, Resident #1 was sitting up in bed watching TV. She stated she had no concerns about medications she received from the staff. Interview on 06/10/26 at 1:42 pm, LVN C stated she never left medications on the med cart because anyone could come along and take them or throw them away. She stated leaving medications unattended was not the right thing to do, because the residents could get sick and have a need for medical attention.Interview on 06/10/26 at 2:53 pm, MA D stated she never left the residents' medications on the med cart because somebody else not needing the medications could take and swallow them. Interview on 06/10/26 at 4:06 pm, ADON B stated sometimes she gave medications to the residents and never left medications unattended on top of the med cart. She stated leaving medications on the med cart was not a good practice to do because it was an accident waiting to happen. She stated anyone could come up to get the resident's medications; another resident or visitor could grab the resident's medications. She stated this morning (06/10/26) she saw unattended medications on the med cart on the 400 hall. She stated when she walked by the med cart, she looked at the cart and immediately realized what MA A left the medications unattended to. She stated MA A told her she was sorry and she already knew she had messed up, she said she pulled MA A aside and reinforced medication administering education. She stated she spoke to MA A on how to properly handle medication and gave her opportunity to respond. She stated MA A said she was trying to rush around and this should not have happened.Interview on 06/10/26 at 4:28 pm, the Administrator stated ADON B told her MA A left a resident's medication unattended on the med cart today. She stated MA A should not have left the medications on the med cart, she should have given the resident her medication first and checked to see if someone else could answer the call light. She stated if the call light was still on after that MA A should have assisted the other resident, then. She stated ADON B had a 1:1 meeting with MA A today and wrote her up for this issue. She stated her expectation was for the residents to get their medications without them being left unattended on the med carts. Record review of MA A's Coaching Form dated 06/10/26 revealed, Situation - Leaving medicine unattended on med cart in hallway.Specific coaching/Education given to the employee - medication administration Inservice verbal coaching. Employee response: Blank.Record review of the facility's Medication Administration Policy dated 2003 revealed, Medication Administration Procedures 3.Open the unit dose package only when you are administering medication directly to the resident. Removing the medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increases the chance of drug administration errors and contamination. 4. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered. 8. After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured.