STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Marine Creek Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on observation, interview and record review, the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 2 of 30 (Residents #17 and #114) reviewed for accommodation in needs. The facility failed to ensure Resident #17 and #114's call lights were within reach of the resident. This failure could have affected residents who needed assistance and could have resulted in their needs not being met. Findings included: Record Review of Resident #17's face sheet dated 8-21-2024, revealed a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a primary diagnosis of Covid-19 and Schizoaffective disorder (Bipolar type), and secondary diagnoses dementia, fracture of T11-T12 vertebra, difficulty walking, unsteadiness on feet, abnormalities of gait and mobility, and lack of coordination. Record review of Resident #17's MDS dated [DATE] indicated a BIMS score of 9 which revealed moderate cognitive impairment. Resident #17 needed supervision or touching assistance where a helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activities for lying in bed to sitting on the side of her bed and sitting to a standing position. Record review of Resident #17's care plan dated 3-30-2021 and revised on 6-10-2023, revealed Resident #17 had fallen and was care planned to ensure staff keep her call light within reach while she was in her room. Resident #17's care plan also stated she had an alteration in her musculoskeletal status with fractures of T11-T12 initiated on 6-10-2023 and revised on 8-5-2024 which stated Be sure call light is within reach and respond promptly to all requests for assistance. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #17's nursing notes date 8-21-2024 revealed Resident #17 had a fall on 8-10-2024, in her bedroom, resulting in diagnoses of a non-displaced fracture of the styloid (a break at the end of the ulna bone in the wrist next to the little finger), a closed fracture of the 1st metacarpal bone of the right hand (the bone that connects the wrist to the thumb), osteoarthritis of her left knee (joint disease which breaks down the cartilage), compression fracture of her thoracic spine (a break or crack in one or more vertebrae in the middle section of the spine) and a compression fracture of her lumbar vertebra (a break or crack in one or more vertebrae in the lower back), and lip laceration(a cut or tear of the lip). In an observation and interview on 8-20-2024 at 11:05 AM, Resident #17 was observed to be lying in bed with bruising on the left side of her forehead, left arm, and a brace on her right arm. Resident #17's call light was observed to be tucked underneath Resident #17's fitted sheet between the mattress and fitted sheet out of reach of Resident #17. Resident #17 stated she uses her call light and did not know where it was. Resident #17 stated the bruises on her face and arms were caused by a fall she had about a week ago while trying to go to her restroom. In an interview and observation on 8-20-2024 at 11:10 AM, LVN F revealed she had been working at the facility for about 2 years, worked the 6am-2pm shift, and was the charge nurse for the hall where Resident #17 resided on. LVN F was shown the call light for Resident #17 being hidden underneath the fitted sheet, out of the reach of Resident #17. LVN F was observed removing Resident #17's call light from underneath the fitted sheet, on Resident #17's bed, and attempted to pull the cord of the call light to clip it onto Resident #17's bed. The call light cord was too short to adequately reach Resident #17 and LVN F contacted the maintenance department to get a longer call light cord for Resident #17. LVN F stated the risk to Resident #17 not having a call light within reach, was it could cause Resident #17 to fall as she was a fall risk. LVN F stated she believed the call light was left underneath Resident #17's fitted sheet when CNAs were changing her sheets. LVN F said her expectations were for CNAs to put call lights back in place for residents when they are changing out linens. Record review of Resident #114's face sheet dated 8-21-2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (stroke), and secondary diagnoses of dementia, type 2 diabetes, unsteadiness on feet, and epilepsy. Record review of Resident #114's MDS dated [DATE] conveyed a BIMS score of 9 which indicated Resident #114 was moderately mentally impaired and needed partial/moderate assistance with toileting, showering, and dressing. Record review of Resident #114's care plan dated 6-20-2023 and revised on 10-24-2023 indicated Resident #114 had a fall and was care planned for staff to ensure his call light was within reach so he could use it for needed assistance. In an observation and interview on 8-20-2024 at 10:46 AM, Resident #114's call light was observed to be on the floor close to the wall, by the headboard of his bed, while Resident #114 was lying in bed. Resident #114 stated he did not know where his call light was and that he used his call light. In an interview on 8-20-2024 at 10:50 AM, LVN F said the risk to Resident #114 not having his call light within reach, was that he could fall trying to go to the restroom on his own, and if he was in distress, he would not be able to get help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8-22-2024 at 2:58 PM, CNA B stated she has worked at the facility for a month on the 2:00 PM-10:00 PM shift. CNA B stated she did not know why Resident #17's call light was not in reach. CNA B stated it was a huge risk to the resident not having their call light within reach especially if the resident was a fall risk of getting injured. In an interview on 8-22-2024 at 4:00 PM, the Administrator indicated the CNAs and the nurses, who work on the hallways, were the primary ones responsible to ensure call lights are kept within reach of residents. The Administrator's expectations were for housekeeping or other staff to put call lights within reach before they leave a resident's room. The Administrator said the risk to residents not having call lights within reach was their needs would not be met. The Administrator said the facility does not have a call light policy. In an interview on 8-22-2024 at 4:45 PM, the DON stated anyone in the nursing staff was responsible to ensure call lights to residents are within reach. The DON stated her expectation was for any staff member entering a resident's room to put a call light within reach as this could pose a risk of fall or injury to a resident.

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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 - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to ensure the residents had the right to personal privacy and confidentiality of his or her personal space for one of five residents (Resident #18) reviewed for privacy. The facility failed to ensure that the roommates of residents with AEM had signed consents in the active section of their EHR as evidenced by record review for Resident #18. This failure could place residents at risk of having medical or personal information or conversations recorded or exposed to others, and cause residents to feel a loss of privacy, dignity, and decreased self-worth and self-esteem. Findings included: Observation on 8-20-2024, at 9:54AM of the room shared by Residents #18 and #59 revealed an AEM camera placed on a dresser top aimed to capture motion of most of the room and Resident #59's bed area. Record Review of Resident #18's Admission Record revealed a [AGE] year-old, divorced, Hispanic male whose primary language was Spanish who had initially admitted to the facility on [DATE]. Resident #18 had a Responsible Party, Emergency Contact #1, and Essential Caregiver #1 all listed as sibling who resided in the local area. Resident #18 also had a sibling in California listed as Other Contact. Resident is noted to have been diagnosed with Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (conditions that can occur after a cerebral infarction, or stroke, and are caused by impaired communication between the brain and muscles) as the Primary Admitting diagnosis on 2-03-2017. Other diagnoses included but not limited to Alcohol Dependence with Alcohol-Induced Persisting Dementia (secondary diagnosis, 11-18-2009), Type 2 Diabetes Mellitus Without Complications (formerly known as adult-onset diabetes, is a form of diabetes mellitus that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) 11-8-2009, Urticaria (Hives) 2-26-2013, Anxiety Disorder, Unspecified 3-22-2018, Anorexia (eating disorder causing people to obsess about weight and what they eat) 3-21-2028, Puritis (itchy skin) 6-14-2017, Chronic Embolism and Thrombosis of Other Specified Deep Vein of Lower Extremity, Bilateral (can refer to a number of conditions, including deep vein thrombosis (DVT; chronic condition where blood clots form in the deep veins, usually in the legs), pulmonary embolism (PE; life-threatening condition that occurs when a blood clot from a DVT breaks off and travels to the lungs, blocking blood flow), and chronic thromboembolic pulmonary hypertension (CTEPH; condition that occurs when multiple small pulmonary emboli develop over time) 12-22-2018, Contracture, Right Wrist 6-30-2022, Contracture, Right Foot 12-5-2022, and Contracture, Right Ankle 12-5-2022. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #18's Comprehensive Care Plan, Last Review Completed on 8-05-2024, revealed that resident had a Focus area reporting Resident had impaired cognitive function and impaired thought process r/t Alcohol induced persisting dementia with Date Initiated of 3-29-2021 and Revision on 6-1-2022. The Goal of the impaired cognitive function and impaired thought process Focus Area was to maintain current level of cognitive function through the review date; the Goal was initiated on 3-29-2021 with a Target Date of 9-25-2023 and a Revision on 7-01-2024. The Interventions for the impaired cognitive function and impaired thought process Initiated on 6-29-2021, with no Frequency/Resolved noted were Communicate with the resident/family/caregivers regarding resident capabilities and needs, provide resident with a homelike environment, review medications and record possible causes of cognitive deficit, new medications or dosage increases, anticholinergics, opioids, benzodiazepines, recent discontinuation, omission or decrease in dose of benzodiazepines, drug interactions, errors, or adverse drug reactions, drug toxicity. Resident #18 was also noted to have a Focus Area of Communication Problem that was Initiated on 2-3-2021 and Revision on 12-24-2021; there is no Goal for this Focus Area. The Interventions for the Focus Area of Communication Problem were all Initiated on 2-3-2021 with no Frequency/Resolved status indicated on this document. The Interventions were Provide a program of activities that accommodates the residents communication abilities, Provide information to resident/family about community resources to further adaptive devices; Refer to speech therapy for evaluation and treatment as ordered, Use communication techniques that enhance interaction, allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from resident to ensure understanding, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues . Record Review of Resident #18's Clinical Assessment list printed on 8-20-2024, revealed no assessment for ability to consent or Consent for AEM during timeframe of 2-3-2021, to 8-20-2024. Record Review, of Resident #18's Miscellaneous Notes list printed on 8-22-2024, revealed no Consent for AEM during the timeframe of 2-25-2021, to 8-20-2024, or in any other part of the active section of the resident's EHR. Record Review of Resident #18's Quarterly MDS dated [DATE], revealed that Resident #18 has a BIMS score of 4, indicating that the resident scored in the middle of the severe impairment range of 0-7. The 0-7 severe impairment range indicated that a resident would have significant trouble with cognitive tasks and will likely need extensive help from the staff to navigate daily life. Section GG 0130 Self Care indicated Resident #18 needed supervision or touch assistance with eating and oral hygiene, needed partial or moderate assistance with personal hygiene, shower/bathing, and upper body dressing, and needed substantial or maximum assistance with toileting hygiene, lower body dressing and putting on/taking off footwear. Resident has an active diagnosis of having had a stroke, non-Alzheimer's dementia, type 2 diabetic, hemiplegia, anxiety disorder, and depression. This assessment was completed by SW and LVN and signed by RN assessment coordinator DON, Record Review, of Resident #18's History & Physical Exam, dated 6-27-2024, by CRNP N revealed that Resident #18 was alert and oriented to self only, moderate to severe cognitive deficit. Further review revealed that a Review of Systems was not able to be completed due to cognitive impairment; Physical Exam revealed Psychiatric section completed as Mood and affect appropriate, or at baseline, confused; Advanced Care Planning section indicated the resident's RP was contacted and reviewed goals of care; RP expressed understanding and agreed CRNP N. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review, of Resident #18's Annual Exam dated 9-08-2022, revealed that Resident #18 had a language barrier due to being a native Spanish speaker. Resident was answering questions with a smile and head shake rendering Psychiatric assessment unable to assess. Record Review, of Resident #18's Complete Evaluation by mental health practitioner PMHNP O on 7-28-2021, stated that the resident exhibited symptoms of brain injury, dementia, or delirium. (Resident #18's) memory problems are prominent. (Resident #18) is experiencing time and place disorientation. (Resident #18) loses track of what is happening. (Resident #18) loses things or puts them in inappropriate places . (Resident #18) forgets how to do routine activities. MMSE performed with Resident #18 resulted with a score of 10 out of 30 indicating moderate dementia. Further review revealed Insights into problems appear to be poor. Judgement appears to be poor. There are no signs of hyperactive or attentional difficulties. Record Review, of Resident #59's Admission Record revealed a [AGE] year-old, male, no marital status listed, no primary language listed, who admitted initially on 1-16-2023. Resident #59 had a RP and Emergency Contact #2/Care Conference Person listed. Resident #59 had admission diagnoses of Malignant neoplasm of prostate (prostate cancer), secondary neoplasm of bone (secondary bone cancer), type 2 diabetes, and unspecified dementia among other diagnoses. Record Review of Resident #59's Miscellaneous Notes list revealed a Request for AEM document signed by Resident #59's Emergency Care Contact #2/Care Plan Person. The document was checked that the resident did have a roommate. No accompanying documentation was seen of consent by roommate or their RP. Record Review revealed a hand filled document titled Consent by Roommate for Authorized Electronic Monitoring provided by ADON K. The document has the name of Resident #18 as the requestor to conduct AEM and Resident #59 as the roommate. There is no signature of the resident/RP however the comment of verbal consent given is written on the line and signed as witness by the ADON K and another staff member on 11-2-2023. There is no information on who, or when, this verbal consent was given by or what means of contact were used. Interview on 8-21-2024, at 11:45AM with Resident #18's RP and Emergency Contact #2 revealed that they had placed a covert camera with 2-way audio in the resident room without first notifying the facility due to concerns over resident care. The RP stated that when they spoke with a staff member about a concern and mentioned they had the camera to back up the concern they were at that time informed of the AEM policy and asked to sign the consent form by the facility as Resident #18 did not have the capacity to understand and authorize himself. When asked about obtaining consent from the roommate, the RP was not aware that needed to be done or that the camera should not be pointed to have a broad view of the room. The RP shared she had not brought most concerns to the facility's attention to give them an opportunity to address or explain their policy however would be doing so on a more timely basis going forward. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8-22-2024, at 11:01AM with LVN I revealed that there are a few residents in the facility on each hall with AEM and has not heard of any roommate having an issue with it. LVN I stated if the roommate does not sign a waiver, then the facility will try to move them to another room and switch out to a roommate who is good with the monitoring. LVN I stated that most AEM will have both video and audio. LVN I stated when AEM is ongoing in a resident room care is to be provided with the curtains drawn closed, staff should not be talking about the roommate's medical information in the room due to HIPAA violations, and the camera should not capture the roommate's area at all. Interview on 8-22-2024, at 11:28AM with the DON revealed that when one roommate/RP wanted AEM then the roommate/RP would be contacted and informed. If the roommate/RP was not comfortable with the AEM then the facility will try to move or switch with a roommate that already has AEM or agrees with AEM in room. The DON stated there was also a form that the roommate/RP wanting the AEM would sign and another form for the roommate to sign to show they agreed. When asked if the facility had any guidelines or policy on audio recordings, the DON stated there were none she was aware of, the facility would ask families not to use audio for roommate privacy, and knew of only one resident, who was in a single room, that had AEM with audio. Interview on 8-22-2024 at 11:40 AM with ADON J revealed that knew of at least one room on each hall, and maybe up to three rooms that had AEM. ADON J stated that utilization of audio with AEM would depend on the family and if the roommate/RP consented. When a resident/RP asks for AEM the staff will speak to roommate/RP and inform of the request, review the authorization form, and ask they sign or come into the facility to sign. If the roommate/RP decline to sign the form then the facility would try to find another resident in the facility willing to agree to AEM and swap the rooms. ADON J states the consents for AEM are scanned into the resident's EHR in the miscellaneous tab and also would document the discussions in a nursing Progress Note. Interview with Resident #18's RP on 8-22-2024, at 2:40PM revealed the RP was not aware of the AEM device in the resident's room. The RP did not remember signing or being called about an AEM being placed in the resident's room by roommate or their RP. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADM on 8-22-2024, at 2:45 PM revealed that the facility requests AEM to not be a broad view, camera is not to be rotated. When AEM is requested for a resident the families/RP are notified as they sometimes do not understand when the privacy curtains are pulled closed for care to be provided it is not to hide what is being done but for privacy of the resident. The ADM stated that all rooms with AED have a sign placed outside the door for notification. The residents/RP are given information about AED and the facility policy in the admissions packet, and they have the option to add AED at any time the resident is still in the facility. The ADM stated there was no stipulation or regulation about monitoring audio or having 2-way audio on AEM; the facility will attempt to get the family/RP to understand the issues with recording or listening to conversations and privacy violations that may cause. The ADM stated that the facility cannot make a family/RP not make audio recordings but do ask them not to. The ADM stated that consents are uploaded into the EHR however was unsure where the document would be located. The ADM shared there is no one specific person in the facility who was responsible for AEM consents or uploading them, there is a folder at the nurse's station with the blank forms that can be requested and completed at any time and given to staff. Staff have instructions in the folder to contact roommate/RP for consent as soon as possible. Staff would need to verify with roommate the AEM is consented to and if roommate unable to give consent they would need to contact the RP. The ADM stated that she was not fluent in Spanish and could not speak the language at all but could understand simple words a resident may use to ask for assistance. The ADM stated that Resident #18 was predominately Spanish speaking, understood a little English, and was his own RP making all his own decisions. The ADM shared the potential harm of not having a roommate/RP consent would be that the camera or audio could potentially pick up them saying or doing something that could be viewed as inappropriate and the monitoring party may share it; there could be a discussion of private matters they did not want shared; and the resident being monitored could have a conversation that they do not want others (monitoring party) to know about. Record Review of facility Information Regarding Authorized Electronic Monitoring obtained from the facility provided binder labeled as Survey Ready Binder that included facility policies and procedures documents revealed: Who determines if the resident does not have the capability to request AEM? The resident's physician will make the determination regarding capability to request AEM. When the resident's physician has determined the resident lacks capability to request AEM, a person from the following list, in order of priority, may act as the resident's legal representative for the limited purpose of requesting AEM: 1. A person named in the resident's medical power of attorney or other advanced directive 2. The resident's spouse, an adult child of the resident who has the waiver and consent of all other qualified adult children of the resident to act as sole decision maker 3. A majority of the resident's reasonably available adult children 4. The resident's parents 5. The individual clearly identified to act for the resident by the resident before the resident became incapacitated or the resident's nearest living relative (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Who may consent to AEM? 1. The other resident(s) in the room 2. The guardian of the other resident, of the resident has been judicially declared to lack the required capability 3. The legal representative of the other resident, if the resident does not have capacity to sign the form but has not been judicially declared to lack the required capability. The legal representative is determined by following the procedure for determining a legal representative, as stated above, under Who determines if the resident does not have the capability to request AEM?

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48177

Based on observation, interview, and record review the facility failed to provide residents in need of ADL care the necessary services to maintain good personal hygiene for 1 of 30 residents (Resident #33) reviewed for showers.

The facility failed to ensure Resident #33 received showers/baths on scheduled days.

This failure could affect residents by putting them at risk for diminished quality of life, hygiene, and self-esteem.

Findings include:

Record review of Resident #33's face sheet dated 8-22-2024 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Muscular Dystrophy (a hereditary condition marked by progressive weakening and wasting of the muscles) with secondary diagnoses of quadriplegia (a severe medical condition that causes partial or total loss of function in all four limbs and the torso), heart failure, and contracture of right and left ankles.

Record review of Resident #33's Quarterly MDS dated [DATE], revealed a BIMS Score of 14 indicating being cognitively intact. The functional abilities section of Resident #33's MDS revealed she was totally dependent for shower/tub transfer where Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

Record review of Resident #33's care plan dated 2-2-2024 revealed Resident #33 had an ADL self-care performance deficit requiring 2 staff assistance for bathing.

In an observation and interview on 8-20-2024 at 2:18 PM, Resident #33 was observed lying in bed with a CPAP mask on. Resident #33 spoke extremely soft and was very difficult to hear her when she spoke. Resident #33 indicated she was not getting showered adequately. Resident #33 stated it had been a week since her last shower and she went for 3 weeks earlier not receiving a shower or bath. Resident #33 stated many times she has not been asked by staff, on her shower/bath days, if she wanted a shower or bath. Resident #33 said she has only refused a shower or bath when she has felt weak but would accept a shower the next day when she felt better. Resident #33 said when she does not get showered it makes her feel like she does not matter.

(continued on next page)

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	675779	A. Building B. Wing	08/22/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8-21-2024 at 3:18 PM, CNA A stated she had worked at the facility for 2 weeks, had worked various halls in the facility, and worked 6:00 AM-2:00 PM. CNA A stated the facility kept track of showers/baths in the POC/PCC electronic medical records given to residents. CNA A stated there were no paper shower sheets kept by the facility. CNA A said the CNAs are the staff members who shower and document the showers given in POC/PCC electronic medical records database. CNA A said all the hallways are showered by the same system. The odd numbered rooms were showered on Tuesday, Thursdays, and Saturdays. The even numbered rooms were showered on Mondays, Wednesdays, and Fridays. The A beds got showered or bathed during the morning shift which was 6am-2pm and the B beds got showered on the evening shift which was 2pm-10pm. CNA A said if Resident #33 was not getting showered it is either because Resident #33 was refusing showers or CNAs were not asking her if she wanted a shower. In an interview on 8-21-2024 at 3:51 PM, LVN D stated he had worked at the facility for 1 year, worked the 2:00 PM - 10:00 PM shift, and works the hallway where Resident #33 resides. LVN D confirmed the statements of CNA A stating the facility keeps track of showers/baths in the POC/PCC electronic medical records database, and there were no paper shower sheet logs. LVN D said the odd numbered rooms were showered on Tuesday, Thursdays, and Saturdays. The even numbered rooms were showered on Mondays, Wednesdays, and Fridays. The A beds got showered or bathed during the morning shift which was 6am-2pm and the B beds got showered on the evening shift which was 2pm-10pm. LVN D said the facility expected the CNAs responsible for showering the residents to ask each resident, on his/her shower day if they want a shower. LVN D said he did not know of a CNA not asking a resident for a shower. Record review of Resident #33's PCC/POC shower log dated 8-21-2024, indicated in the last 30 days, Resident #33 had only been showered on 7-31-2024 and 8-5-2024. The log stated Resident #33 had not been showered on: 7-24-2024, 7-25-2024, 7-26-2024, 7-27-2024, 7-28-2024, 7-29-2024, 7-30-2024, 8-1-2024, 8-2-2024, 8-3-2024, 8-4-2024, 8-6-2024, 8-7-2024, 8-8-2024, 8-9-2024, 8-10-2024, 8-11-2024, 8-12-2024, 8-13-2024, 8-14-2024, 8-15-2024, 8-16-2024, 8-17-2024, 8-18-2024, 8-19-2024, 8-20-2024, and 8-21-2024. These dates corroborated the statements Resident #33 made. There was no documentation Resident #33 had refused a shower or bath. In an interview with the Administrator on 8-22-2024 at 4:45 PM it was revealed that CNAs are responsible for showering or bathing residents. The Administrator stated if a resident refused a shower, it should be documented in PCC/POC. The Administrator's expectations were for showers to be offered to all residents. If residents decline a shower, she wants staff to offer the shower a second time. If a resident repeatedly refused a shower, the Administrator wanted that resident to be care planned for refusing showers or baths repeatedly. The Administrator stated the risk to residents who repeatedly refused a shower were possible skin problems and psychosocial issues. Record review of the facility's shower and/or bathing policy dated 2003 stated: ADL HG 03-2.0 Bath, Tub/Shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed. Goals 1. The resident will experience improved comfort and cleanliness by bathing. 2. The resident will maintain intact skin integrity. 3. The resident will be free from soil, odor, dryness, and pruritus following bathing. Nursing Policy & Procedure Manual 2003 ADL HG 03-2.0

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services according to professional standards of maintenance for one (Resident #487) of twelve resident reviewed for enteral feeding. The facility failed to ensure Resident #487's G-tube water and enteral administration set (tubing attached to formula and water bottles for continuous G-tube feeding) were changed when his formula was changed on 08-19-2024 and on 08-21-2024 and failed to ensure the water was dated when it was changed. This failure could place residents at risk of infection due to not following appropriate procedures. Findings included: Review of Resident #487's face sheet dated 08-21-2024 revealed a [AGE] year-old male that was admitted to the facility on [DATE]. His diagnoses included acute respiratory failure with hypoxia (low oxygen), bacterial infection, anemia, cerebral palsy (a congenital disorder of movement, muscle tone and posture), high blood sugar, hypotension (low blood pressure), pneumonia, nutritional problem or potential nutritional problem, tracheostomy status (tracheostomy is a surgical hole made through the front of the neck and into the windpipe (trachea) to keep it open for breathing), enlarged prostate, gastrotomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing) and dependence on respirator ventilation. Review of Resident #487's admission MDS assessment, dated 08-19-2024, reflected Resident #487 had no BIMS (Brief Inventory of Mental Status) score completion. He had no indicators of delirium, depression, or behaviors. Resident #487 had an impaired range of motion, both upper and lower body, on both sides of his body, and was completely dependent on staff for all of his ADLs and movement in bed. Resident #487 had an indwelling catheter for urine and was always incontinent of bowel. The document did not reflect Resident #487 had a feeding tube while in the facility nor did the document reflect Resident #487 received 51% or more of his nutrition through the feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #487's care plans reflected a care plan initiated 08-15-2024, Focus: Resident #487 had a diet order other than regular and was at risk for unplanned weight loss or gain. The care plan did not specify Resident #487's diet. The goal was to maintain ideal weight and receive proper nutrition. Intervention was to determine food preferences, to encourage meal completion and document amount, to serve diet and snacks as ordered. The care plan further reflected Resident #487 required tube feeding; Goals were to remain free of side effects or complications related to tube feeding through review date and to maintain adequate nutritional and hydration status as evidenced by stable wight, no signs/symptoms of malnutrition or dehydration through the review date 11-13-2024. Interventions included Checking for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than (X) cc aspirate. Clean insertion site daily as ordered, monitoring for s/s infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to MD if symptoms arise. Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Monitor/document/report to MD PRN: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubating, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The resident is dependent on tube feeding and water flushes. See MD orders for current feeding orders. Further review of care plan reflected Resident #487 had a potential fluid deficit [no specified cause of dehydration noted]. The goal was for residents to be free of symptoms of dehydration and maintain moist mucous membrane and skin turgor. The interventions were to monitor/document/report to physician PRN signs and symptoms of dehydration such as decreased urine output, concentrated urine, strong urine order, tenting skin, cracked lips, new onset of confusion, dizziness, fever, thirst, weight loss, dry/sunken eyes. Review of Resident #487's order summary, dated 08-21-2024, reflected Enteral feed order every shift for hydration start water flush Q4hour with 25 mls of water to run concurrently with enteral feedings, Active, start date 08-15-2024 . Enteral feed order every shift for keeping tube patent flush tube with 30 ml water before and after medication administration, Active, start date 08-15-2024 .; enteral feed order every shift for nutrition: Isosource [formula]1.5 in lieu of Jevity 1.5 at 50 ml/hr., Active, start 08-15-2024. The order summary did not reflect changing tubing with each enteral feeding set up, it also did not reflect changing enteral feed syringe every 24 hours. An observation on 08-20-2024 at 12:17 PM revealed Resident #487 appeared asleep. Resident #487 had feed running on a pump going at 50 ml/hr with water flush every four hours at 25 ml/hr. The water bag was full, and it was attached to one side of tubing connection to the formula. Water was dated 08-16-2024. The formula was half full attached to other side of same tubbing as the water forming a Y, formula was dated 08-19-2024 with a time stamp of 9:30 pm for formula change. An observation with ADON K on 08-21-2024 at 09:01 AM, revealed Resident #487 awake in his room. He did not answer questions. Resident #487 had the feeding pump was running at 50 ml/hr for formula and 25 ml for water flushes every 4 hours. The water bag was the same water bag observed on 08-20-2024, it was dated 08-16-2024 connected to the Y tubbing with a new formula which was dated 08/21/24. Time stamp for formula change 3:00 AM. ADON K said that she was not sure on the policy on tube feedings and she would get back to me on that. ADON K did not state risk to Resident #487 when asked what the risks to this resident were for not having G-tube tubing and water changed. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN E on 08-21-2024 at 09:05 AM, she stated Residents #487 feeding usually finished during the evening shift. She stated each time she had replaced any residents' feedings, she changed the whole tubing system including the water bag. She stated she was the one that had initially dated the water bag on Resident #487's pump on 08-16-2024 on the day that she had changed the formula. She stated since 08-16-2024 she had been off from the facility and when she came back the water bag was still the same as 08-16-2024 when she hung it. She said it was unacceptable that someone had not changed the tubbing since 08-16-2024. LVN E stated it was the nurse's responsibility to change all the tubing and the water bag when it finished because the tubing and water bag was one system. She stated the water bag was supposed to be changed with the feedings, and both should be dated with the same date. She stated she educated her fell ow nursing staff in the importance of changing the whole tubing set, dating it and flushing the g-tubes after each medication administration. She stated not changing the water and the formula tubing can cause the resident to have an upset stomach, infection and clogging of the G-tube. LVN E stated she would change the feeding and tubing for Resident #487 immediately. In an Interview with LVN F on 08-22-2024 at 02:45 PM, he stated he had added a new formula bag for Resident #487 when it was running low. He stated he had not been paying attention and forgot to change the tubing . LVN stated he was supposed to change the whole tubbing and bag feed set when it runs out and or before adding new feedings. LVN F stated he was not aware of the water bag had not been changed since 08-16-2024. He stated he had not had Inservice on G-tube in a long time. He stated he knew how to take care of G-tubes, how to perform stoma care, program feedings and flushing after medication administration. He stated the tubbing should have been changed with the new formula to reduce the risk for infection control to Resident #487. He stated that the formula becomes very thick in the tubing and can cause G-tube clogging. He stated if he missed something it was the responsibility of the oncoming nurse, ADON, or DON to catch it so that it did not cause harm to the resident. In an interview with DON on 08-22-2024 at 3:19 PM, she stated G-tube feeding pump was a dual tubing system and should be changed with every feeding change. She stated she expected all nursing staff to follow the facility infection control and enteral feed policy by changing feeding tubing when feeds are complete. DON stated staff were trained upon hire via a computer-based training and one on one training with preceptor for enteral feeds and medication administration. DON did not state how stuff are monitored to ensure the policy was followed. DON stated the nurse could ask herself or the ADON for help. She stated the risk to residents was infection. Review of the facility policy titled Enteral Nutrition revision date February 13, 2007, reflected policy did not address replacing the tubing with new tubing, or dating the bags specifically. It did reflect . The nursing services department is responsible for all feeding equipment and administration of tube feedings .problems with the administration of tube feeds are monitored and corrected by nursing . Review of facility policy titled Fundamentals of Infection Control Precautions dated 2019, reflected, read in part . variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions . consistent use by staff of proper hygiene precautions and techniques is critical to preventing the spread of infections .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice for one (Resident #487) of 2 residents reviewed for intravenous fluids. The facility failed to ensure Resident #487 received PICC line orders to manage, access, flush, and perform dressing changes since admission 08-14-2024. A Peripherally Inserted Central Catheter -PICC line is a soft, flexible catheter inserted into a central vein used for prolonged antibiotic therapy, giving fluids, and or getting clinical nutrients. This failure could place residents at risk for infection. Review of Resident #487's face sheet dated 08-21-2024 revealed a [AGE] year-old male that was admitted to the facility on [DATE]. His diagnoses included hypotension (low blood pressure), enlarged prostate (this is a condition when the prostate gland becomes larger than normal making it hard to urinate or empty the bladder), pneumonia, nutritional problem or potential nutritional problem, bacterial infection, anemia, cerebral palsy (a congenital disorder of movement, muscle tone and posture),, high blood sugar, tracheostomy status (tracheostomy is a surgical hole made through the front of the neck and into the windpipe (trachea) to keep it open for breathing), gastrotomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), acute respiratory failure with hypoxia (low oxygen), and dependence on respirator ventilation. Review of Resident #487's admission MDS assessment, dated 08-19-2024, reflection did not reflect intravenous access PICC line. Review of Resident # 487's admission nurse note dated 08-14-2024, reflected Resident #487's BP was 75/57 and he had a PICC line in the left upper extremities. Further admission nurse note reflected Resident #487 had he had a 16 French Indwelling catheter, and he had an enteral tube (G-tube). Review of Resident #487's care plans reflected a care plan initiated 08-15-2024 with no reflection intravenous PICC line. An observation and interview with ADON K on 08-21-2024 at 08:41 AM, revealed Resident #487 was awake in his bed. He could not answer any questions but smiled when you said hello. Resident #487 was observed with a PICC line with three lumens (ports/outlets) on the upper left arm. Resident #487's PICC line was dated 08-11-2024. The lumens had orange caps on them. ADON K stated Resident #487's PICC line dressing should be changed. She said she was not sure on the policy about how long before the dressing is changed. She stated dressing was changed for infection control. She stated nurses were responsible for assessing IV, dressing, and obtaining orders. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN E on 08-21-2024 at 09:05 AM, she stated she was aware Resident #487 had a PICC line. She stated she monitored the PICC line on her shift to make sure dressing was intact, and the lumens were closed, and caps were on the ends of the lumens. She stated being an LVN she could not change the PICC line dressing, and it was the responsibility of an RN, ADON or DON. LVN E stated she did not notify the DON or ADON of Resident #487 PICC line dressing to be changed. She stated she did not pay close attention to the PICC line date on the dressing. LVN E stated it was the nurse's responsibility to obtain orders to manage the PICC line. She stated not having PICC orders and not changing dressing placed residents at risk for infection. In an Interview with LVN F on 08-22-2024 at 02:45 PM, he stated he documented in the admission assessment that Resident #487 had a PICC line. He stated he had used the PICC line one time when Resident #487 was admitted due to low BP of 75/57. LVN F stated he obtained an order from the physician to administer one liter of fluid to help bring the BP up. LVN F stated he notified the DON during the time of the low BP. He stated the PICC line had not been used since admission on 08-14-2024. He stated he could not change the PICC dressing because he was an LVN. He stated only an RN could change PICC line dressing. LVN F stated he should have obtained orders for the PICC line. He stated he forgot. He stated nursing was a twenty-four-hour job therefore whatever he missed someone should have caught it and obtained orders including the DON. He stated the PICC line was somewhat hidden due to location and resident having contractures. LVN F stated he flushed the PICC line with 10 cc on his shift. He stated that flushing the PICC line kept it open and it was nursing practice. He stated PICC dressing should be changed weekly or if it was dirty. He stated he would report to the DON to change the dressing. He stated risk to resident was not making sure PICC was patent, patient was not being taken care of infection wise. In an interview with RN L on 08-22-2024 11:58 AM, she stated she had been employed at the facility for five years. She stated as an RN she could perform PICC line dressing changes. She stated PICC dressing were a sterile process for risk of infection. She stated PICC line dressing should be changed every 7 days and PRN dressing change. She stated she had no in-service on central dressing, but it was part of her nursing skill. She stated it was the nurse's responsibility to obtain orders for dressing changes and PICC management. She stated she was not assigned to Resident #487, and no one had asked her to perform his dressing change. RN F stated any nurse could perform an intravenous dressing change if they had their skill check off. She stated only RNs could remove a PICC line. She stated daily document on skin was required for PICC lines . She sated nurses were required to do daily skin assessment and if any clarifications or orders were missing to notify her. She stated during admission assessment on EMR, there was a column for Intravenous lines charting with standing orders when activated in the EMR by the nurse. She stated the risk for not managing the PICC line and any intravenous lines was infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on 08-22-2024 at 3:19 PM, she stated nurses should have gotten orders. She stated the DON or ADON, does not go through the admission assessment unless nurses asked them to take out the intravenous line or get orders. She stated nurse are good about getting orders. She stated policy does not specify on who could perform PICC line dressing changes if they had the IV Class online through the pharmacy. The DON stated she was not sure why Resident #487 was admitted to the facility with the PICC line because it had not been used. She stated when Resident #487 had a low blood pressure on admission 08-14-2024, a peripheral IV was ordered for fluid resuscitation for the low BP. She stated there no orders to access PICC, orders to flush, make sure there is no redness, flushed are not leaking. She stated she had obtained orders to remove Resident #487 on 08-22-2024. She stated there was no infection noted under the dressing. She stated the policy said to change PICC dressing every week. Interview with ADM on 08-22-2024 at 4:31 pm, she stated orders drive care and she expected nursing staff to obtain orders for care. On 08-22-2024 ADM, DON and ADON were asked for their policy for PICC/IV Dressing Change , no policy was provided prior to exit. Review of the Centers for Disease Control and Prevention guideline titled Prevention of Intravascular Catheter-Related Infections, revision date October 2017, reflected, read in part . 3. Replace catheter site dressing if the dressing becomes damp, loosened, or visibly soiled .6. Replace dressings used on short-term CVC sites every 2 days for gauze dressings.7. Replace dressings used on short-term CVC/PICC sites at least every 7 days for transparent dressings, except in those pediatric patients in which the risk for dislodging the catheter may outweigh the benefit of changing the dressing .14. Monitor the catheter sites visually when changing the dressing or by palpation through an intact dressing on a regular basis, depending on the clinical situation of the individual patient. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or bloodstream infection, the dressing should be removed to allow thorough examination of the site .

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interviews, and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 of 5 residents (Resident #106) reviewed for resident records. Facility failed to ensure physician orders were written for ventilator setting for Resident #106 on admission 06-18-2024 to 08-22-2024. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information records. Findings included: Review of Resident #106 Admission record dated 08-22-2024 revealed a [AGE] year-old female that was admitted to the facility on [DATE]. Her diagnoses included chronic respiratory failure, sepsis (this is a systemic infection), pneumonia, Amyotrophic Lateral Sclerosis (also known as ALS, a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control), mechanical ventilator (a machine that helps your lungs to work by pushing air in and out of lungs so that the body can get oxygen) dependent, tracheostomy status (tracheostomy is a surgical hole made through the front of the neck and into the windpipe (trachea) to keep it open for breathing) , gastrotomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing), dysphagia (difficulty swallowing), muscle weakness and protein calorie malnutrition. Resident was a full code and her own responsible party. Review of Resident #106 quarterly MDS assessment dated [DATE] reflected Resident #106 had a BIMS of 15, indicating resident was cognitively intact. Resident #106 could understand others and others could understand her. The document reflected she had impairment in her upper and lower extremities, was always incontinent, and was completely dependent on staff for all her ADLs. She did not sit up or transfer during the assessment period, due to her clinical condition. Resident #106 received 51% or more of her nutrition through her g-tube. The document reflected Resident #106 was dependent on Invasive mechanical ventilator respiratory ventilator status. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #106 care plan dated 04-02-2024, revealed the resident was ventilator dependent with a goal to be free of complications related to ventilator dependence such as upper respiratory infection, pneumonia (fluid in lungs), atelectasis (fluid collection in the abdominal and chest cavities), decreased cardiac output, pneumothorax (blood in lungs) and subcutaneous emphysema (air bubbles in the skin in the chest areas), increased intra [NAME] pressure and hepatic congestion (a condition in which blood backs up in the liver due to heart failure). Interventions included. Assess for s/sx of hypoxia [low oxygen]: altered level of consciousness, irritability, listlessness, cyanosis. Educate resident/family/caregivers purpose/mode/and all treatments; encourage resident to relax and breath with the ventilator; explain alarms; teach importance of deep breathing. Monitor for changes in respiratory rate or depth. Observe/document for use of accessory muscles. Notify MD of significant changes. Monitor for tube misplacement at least every 2 hours and PRN - document cm markings for placement. [NAME] at lip/teeth/nares after x-ray confirmation. Monitor oxygen saturation while resident is on mechanical ventilatory support and/or during weaning process. Monitor/document and intervene as indicated for psychosocial problems including isolation, withdrawal, and depression. Monitor/document/report to MD PRN any s/sx of upper respiratory infection, pneumonia, atelectasis, decreased cardiac output, pneumothorax, decreased renal perfusion, increased intracranial pressure, hepatic congestion. Review of Resident #106 MAR on 08-20-2024 reflected the following orders: 1. HME T during the daytime or when the resident is out of bed. Add O2 as needed and every shift. Check O2 saturation Q shift and PRN. 2. Every shift check resident Q2h for suctioning need, suction via trach prn. every shift 3. Same size trach and a smaller size at bedside for emergency replacement every shift related to chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (lack of oxygen or accumulation of carbon dioxide) 4. Ambu bag [a silicone shaped device placed on nose and mouth used to manually force air in lungs] with O2 cylinder at bedside (use at 10- 15 lpm) every shift related to dependence on respirator [ventilator] status 5. Bleed in O2 as needed to keep O2 sats > 92% every shift related to chronic respiratory failure, unspecified whether with hypoxia or hypercapnia. 6. MAR did not reflect ventilator setting. Review of Resident# 106 order summary on 08-20-2024 did not reflect ventilator setting orders since 06-18-2024 when Resident#106 was readmitted to the facility. Record Review of Resident #106 hospital discharge for pulmonary dated 06-18-2024 reflected ventilator setting as Ventilator mode: SIMV, Respiratory Rate total 16 bre/min, Tidal Vol Set (ml) 500 mL [this is the amount of air a ventilator delivers to a patient's lungs with each breath], amount of pressure support 10 (helps a patient breath spontaneously by providing pressure during each breath), peep 5 cm H2O, FiO2 30 %. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #106 on 08-20-2024 at 11:26 AM, she stated using a machinal device teleprompter that she was treated with respect and dignity. The reading on her ventilator machine read as follows; SIMV-VC Active PAP, PIP (peak inspirational pressure is the highest pressure applied to lungs during inhalation in mechanical ventilation) 33.2 cm H20, tidal volume 443 mL (this is the amount of air that a mechanical ventilator moves into a patient's lungs during inhalation), RR 16, peep 5 cm H20, PIF 34.4, % spontaneous trigger 0%. FiO2 28%. Her heart rate was 60 and oxygen saturation at 98%. Interview with RT on 08-22-2024 at 3:44pm, she stated when Resident #106 returned from the hospital with the EMT who proved the admitting respiratory therapist with the settings on the ventilator. She stated nurses had a copy of the ventilator setting when residents were readmitted to the facility. RT stated she had worked with Resident #106 for a long time that she knew the resident's ventilator settings by heart. RT stated that the ventilator settings were also documented on Resident#106 flow sheet in the EMR. RT stated there was no risk to Resident #106 not having physician ventilator settings orders because RT had to monitor residents and wean their settings as needed depending on residents' vitals and oxygenation. RT stated the ventilator could not turn off by itself, therefore ventilator settings would not be lost and orders were not required. RT stated that either herself or the DON could enter the order set for the ventilator settings. Interview with DON on 08-22-2024 at 03:50 pm, she stated the facility had two or three respiratory therapists on duty each shift with twenty-four-hour coverage every day. The DON stated no one had updated the ventilator setting when Resident #106 returned after being in the hospital. The DON stated the admitting nurse should have placed the order for ventilator setting. The DON was informed by RT on 08-22-2024 at 03:50 pm and she input the ventilator setting orders. The DON stated there was no risk to Resident #106 for not having physician ventilator setting orders because it was on the EMR flow sheet. Interview with the ADM on 08-22-2024 at 4:31 pm, she stated orders drive care and she expected nursing staff and Respiratory staff to obtain orders for care. The ADM stated she expected Resident #106 to have orders for her ventilator. On 08-22-2024 facility was asked for their policy for Physician Orders, no policy was provided. Record review of policy titled, Medication Orders revised 2014, reflected Supervision by a Physician 1. Each resident must be under the care of a Licensed Physician .2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order .6. Treatment orders - When recording treatment orders, specify the treatment, frequency, and duration of the treatment .

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48520

Based on observation, interview, and record review the facility failed to 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 disease and infections for 4 (Residents #18, #59, #72, and Resident #437) of 12 residents reviewed for infection control.

The facility failed to ensure LVN M disinfected blood sugar monitoring device between use on Resident #18, #59, and Resident #437 and failed to ensure LVN M performed hand hygiene after removing gloves and touching contaminated blood sugar monitoring device between use on Resident #18, #59 and Resident 437.

The facility failed to ensure RN G put on PPE for EBP and perform hand hygiene when administering G-tube medication to Resident #72.

These failures could place residents at risk for the spread of disease and infections.

Findings included:

1. Resident #18

Review of Resident #18's face sheet on 08-21-2024, revealed a [AGE] year-old man, who admitted to the facility on [DATE]. His diagnoses included stroke affecting the right dominant Side, rash and other nonspecific skin eruption (some unknown skin outbreak), Type 2 diabetes mellitus (uncontrolled blood sugar), urticaria with purities (itchy skin and hives), alcohol dependence, alcohol-induced dementia (cognitive decline caused by long term excessive alcohol consumption), depression, anorexia (poor appetite), embolism and thrombosis (blood clots in both legs), Contracture of extremities on the right side (this is a condition of muscle tightening and unable to straighten arms and legs).

Review of Resident #18's care plan initiated on 02-03-2021 reflected, Resident #18 had Diabetes mellitus, revision 06-15-2024. The goal was for Resident #18 to be free from any s/sx of hyperglycemia (high blood sugar) through the review date, revision date 07-01-2024, and that he would have no complications related to diabetes through the review date. Goals Initiated on 02-03-2021, revision on 07-01-2024, target date 10-20-2024. His interventions included Encourage resident to practice good general health practices: lose weight if overweight, stop smoking, compliance with dietary restrictions, compliance with treatment regimen, adequate sleep and exercise, good hygiene, and oral care. Monitor/document/report to MD PRN for s/sx of infection to any open areas: Redness, Pain, Heat, swelling or pus formation and notify the charge nurse for open areas, sores, pressure areas, blisters, edema, or redness to the feet. Initiated on 02-03-2021, revision on 07-01-2024.

2. Resident #59

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's face sheet on 08-21-2024, revealed a [AGE] year-old male, who admitted to the facility on initially on 04-11-2024. His diagnoses included malignant neoplasm of prostate (prostate cancer), secondary neoplasm of bone (secondary bone cancer), muscle weakness, difficulty walking, unspecified dementia (impaired thought process), high blood pressure, and type 2 Diabetes Mellitus (uncontrolled blood sugar). Review of Resident #59's care plan dated 06-20-2024, reflected Resident #59 had rash on his back and upper buttocks, yeast. Initiated date 06-20-2024. The goal was that resident would have no complication through review date, no signs and symptoms of infection of the rash through the review date, and the resident's rash would head. Initiated date 06-20-2024, Revision date 07-10-2024, target date 10-11-2024 for all goals. Resident #59's interventions included avoiding scratching and keeping his hands and body parts from excessive moisture; not to use harsh detergents, soaps, fragrances, or irritating substance; monitoring skin risk for increased spread or signs of infection. 3. Resident #437 Review of Resident #437's face sheet on 08-21-2024, revealed a [AGE] year-old man, who admitted to the facility on [DATE]. His diagnoses included Cerebral infraction (stroke), malignant neoplasm of the colon (colon cancer), stage 4 pressure ulcer (bed sore), chronic ulcer of right foot with fat layer exposed, vitamin D deficiency, anemia, type 2 diabetes mellitus (uncontrolled blood sugar). Review of Resident #437 care plan initiated on 06-25-2024, reflected, Resident #437 was on enhanced barrier precaution (this is an infection control precaution of staff wearing glove, gown, and or a mask during resident care for infections transmission purposes for residents that had any indwelling [inside] medical devices), revision on 08-20-2024. His goal was for Resident #437 not to have any transmission of infection from or to the resident. Date initiated 06-25-2024. Revision date 08-20-2024, Target date 11-18-2024. Interventions included Gloves and gown should be donned if any of the following activities are to occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Date Initiated: 06-25-2024, Revision on: 08-20-2024; Perform hand sanitation before entering the room and prior to leaving the room. Date Initiated: 06-25-2024, Revision on: 08-20-2024; Posting at the resident's room entrance indicating the resident is on enhanced barrier precautions. Date Initiated: 06-25-2024, Revision on: 08-20-2024; Therapy should use gown and gloves, when transfer training, mobility training, or other high-contact activity. Date Initiated: 06-25-2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During medication administration observation and interview with LVN M on 08-21-2024 beginning at 07:03 AM, LVN M stated she would start by checking blood sugars. LVN M gathered her supplies of a one blue glucose monitoring device, 1 alcohol pad, a lancet (small needle for finger pricks), a strip (used to measure the blood) inserted into the glucose monitoring machine, and a pair of gloves. LVN M went into Resident #18's room and told the resident that she was there to do his blood sugar. LVN M went into Resident #18's bathroom and got a paper towel and placed it on his bedside table. She then placed all the supplies on the paper towel. LVN M put on her gloves and took the alcohol pad and with her left hand-held Resident #18's left hand and wiped his finger. She then took the lancet and pricked his finger. She picked up the glucose monitoring machine with strip and took a sample of Resident #18's blood. She let go of resident #18 and placed the glucose monitoring machine back on the bedside table. She took the same alcohol pad used to wipe Resident #18's finger and held slight pressure to stop the bleeding. Blood sugar reading for Resident #18 was 150. LVN M then took all the used supplies and paper towel with her gloved hands and walked to the medication cart. She placed the glucose monitoring machine on top of the medication cart and took the lancet and put it in the sharp's container, then removed the bloody strip out of the glucose monitoring machine and wadded it on the paper towel and removed her gloves and placed them in the trash can on medication cart. No hand hygiene was performed after removing gloves and no sanitation of the glucose monitoring machine. LVN M then stated she would check Resident #59's blood sugar next. She gathered supplies, picked up the soiled glucose monitoring machine without gloves and went into Resident #59's bathroom and got a paper towel. She placed the paper towel on Resident #59's bedside table and placed the soiled glucose monitoring machine on the paper towel on Resident #59 bed side table. LVN M put on her gloves and took the alcohol pad and with her left hand-held Resident #59's right hand and wiped his finger. LVN M then took the lancet and pricked the resident's finger. She picked up the glucose monitoring machine with strip and took a sample of Resident #59's blood. She placed the glucose monitoring machine back on the bedside table and took the same alcohol pad used to wipe Resident #59's finger and held slight pressure. Blood sugar reading for Resident #59 was 143. LVN took all supplies from Resident #59's bedside table and walked to the medication cart. She placed the soiled glucose monitoring machine on top of the medication cart and discarded the used supplies as before. She did not sanitize the glucose monitoring machine after use, and she did not perform hand hygiene. LVN M then stated she would go to Resident #437 to check his blood sugar. Same process as in Resident #18 and Resident #59. Blood sugar reading for Resident #437 was 113. LVN M then stated that Resident #437 was a very sick man that was just reemitted to the facility. She placed the soiled glucose monitoring machine on top of the medication cart and discarded the used supplies as before. She did not sanitize the glucose monitoring machine after use, and she did not perform hand hygiene. LVN M stated that she needed to do another blood sugar, but the process was intervened by a surveyor. LVN M stated she had been at the facility for thirteen years and worked night shift. She stated the facility was short staffed due to med aide being sick and off, so she stayed longer on shift to help the nurses to do blood sugars while they passed their medications. LVN M stated that she sanitized the glucose monitoring machine after she was done with all the blood sugar. LVN M stated that she did not sanitize her hands because she was wearing gloves, and she did not contaminate them. She said she did not need to sanitize the glucose monitoring machine between resident use. She said she had not been in-serviced on blood sugar monitoring or sanitization of the glucose device between resident use. When LVN M was asked if by her touching the soiled glucose monitoring machine that she had placed on the medication cart without gloves on contaminated her hands she stated, oh I guess I did. LVN M did not state the risk to the residents stating that she was unaware of the process to sanitize the equipment used between residents. (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	08/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADON K on 08-21-2024 at 07:18 AM, she walked over to LVN M during interview and ADON K stated that she would in-service her about the policy on sanitizing shared equipment. ADON K stated the correct was to have two blood glucose machines and the person would use one of the glucose machines clean it after use, set it aside on wax paper to cure with the cleaning agent and used the other machine on another resident and vice versa with cleaning in between resident use. ADON K stated she expected all staff to sanitize equipment between residents including glucose machines and BP cuffs. She stated the risk using contaminated equipment and infection. 4. Resident #72 Review of Resident #72's face sheet on 08-21-2024, revealed a [AGE] year-old man, who admitted to the facility on [DATE]. His diagnoses included cerebral palsy (a congenital disorder of movement, muscle tone and posture), server intellectual disability, quadriplegia, urinary tract infection, seizures, dysphagia (difficulty swallowing), Gastrostomy status, and disorder of central nervous system unspecified. Review of Resident #72's care plan dated 03-26-2024 reflected resident was on enhanced barrier precautions, Date Initiated: 03-26-2024, Revision on: 08-20-2024. The goal was there will not be any transmission of infection from or to the resident. Date Initiated: 03-26-2024. Revision on: 08-05-2024, Target Date: 09-10-2024. Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity Date Initiated: 03-26-2024; Perform hand sanitation before entering the room and prior to leaving the room Date Initiated: 03-26-2024; Posting at the residents room entrance indicating the resident is on enhanced barrier precautions. Date Initiated: 03-26-2024; Therapy should use gown and gloves, when transfer training, mobility training, or other high-contact activity. Date Initiated: 03-26-2024. Further review of care plan reflected Resident #72 required tube feeds related to cerebral palsy. Date initiated 11-01-2023. His goals were: The resident will remain free of side effects or complications related to tube feeding through review date. Date Initiated: 11-01-2023, Revision on: 08-05-2024, Target Date: 09-10-2024; The resident's insertion site will be free of signs and symptoms of infection through the review date. Date Initiated: 11-01-2023 Revision on: 08-05-2024, Target Date: 09-10-2024; The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Date Initiated: 11-01-2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of G-tube medication with RN G on 08-20-2024 beginning at 09:05 AM, revealed Resident #72 room entrance had a sign that read Multidrug-resistant Organisms (MDROs) are a threat to our residents. Enhanced Barrier Precautions (EBP) steps, perform hand hygiene, wear gown, wear gloves, dispose of gown & gloves in room. RN G gathered Resident #72s medication in individual medication cups on a tray. He entered the room after locking the medication cart with a pair of gloves in his hands. He closed the door to Resident #72's room. RN G placed the medications on the bedside table and put on his gloves. No hand hygiene before donning gloves. RN G did not wear a gown. Resident #72 was lying in bed. RN G removed residents covers and pillows with his gloved hands, then adjusted the bed remote up. Resident #72 was soiled with a BM. RN G then then stopped Resident #72 feeding pump. No hand hygiene or change of gloves before RN G proceeded to unhook the G-tube tubing from the feeding pump. He then picked up a syringe and attached it to Resident #72 G-tube and took the stethoscope from his neck and listed to Resident #72 G-tube placement. After he was done listening, he checked the residue and returned the G-tube content. RN G then started to administer Resident #72's medications after flushing G-tube and in between medications. Interview with RN G on 08-22-2024 11:42 PM, he stated he washed his hands before starting the procedure. He said that he listened for placement with 10 cc of air. He stated that he had to remove covers to access G-tube. He stated he had already started the process of the g-tube medication administration therefore he asked and at what point can I change my gloves?. He stated that he washes his hands to prevent infection. He said that he had no in-service for Enhanced barrier precaution and was not aware the PPE should be worn for G-tube. He stated not following infection control procedures and policy risked the spread of infection to the resident. In an interview with DON on 08-22-2024 at 3:19 PM, she stated all nursing staff have had competences completed in past two month and blood sugar monitoring were one of the lessons. She stated she just did an in-service on infection control and hand hygiene on Monday when they had some covid positive residents. She stated she expected all nursing staff to follow the infection control policy and procedure. Interview with ADM on 08-22-2024 at 4:31 pm, she stated her expectations were that staff wore PPE in isolation precaution rooms. She stated she expected staff to clean equipment after each resident's use. ADM stated the DON and ADONs were responsible for in-serving staff on infection control, which they had done earlier in the week. ADM stated there was a risk of spreading germs when staff did not follow proper infection control policy and procedure. Review of facility's policy titled, Fundamentals of Infection Control Precautions, dated 2019, reflected the following: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: before and after entering isolation precaution settings .Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); After removing gloves or aprons

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

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program for 3 of 30 residents (Residents #66, 42, and #103) reviewed for effective pest control. The facility failed to maintain an effective pest control program to ensure the facility was free of flies for Resident #66, #42, and #103 in the facilities only dining room. This failure could place the residents at risk for an unsanitary environment. Findings included: Record review of Resident #66's face sheet dated revealed a [AGE] year-old male who had an original admitted [DATE] and a re-admitted [DATE]. Resident #66's primary diagnosis was a cerebral infarction (stroke) affecting the left dominant side and secondary diagnoses of cognitive communication deficit, ulcer of the right heel and midfoot, lack of coordination, and contracture of the right knee. Record review of Resident #66's Quarterly MDS assessment dated [DATE], indicated a BIMS score of 13 revealing being cognitively intact. Record review of Resident #66's care plan dated 6-15-2022 revealed Resident #66 was a hemiplegia (paralysis on one side of the body that can affect the arms, legs, and facial muscles) on the left side requiring ADL assistance. In an observation and interview on 8-20-2024 at 4:12 PM, Resident #66 was observed to be sitting in his wheelchair asleep, in the facilities only dining room, at a table with a coffee cup on it. Resident #66 was observed to have a fly on his neck, one on his right arm, and one on his head. Resident #66 woke-up and stated flies had been bad at the facility for the past week. Resident #66 stated he did not like the flies and did not want them on him. Record review of Resident #42's face sheet dated 8-21-2024, revealed a [AGE] year-old male who had an original admitted [DATE] and a re-admitted [DATE]. Resident #42's primary diagnosis was Dementia with secondary diagnoses of abnormal posture, repeated falls, difficulty in walking, and Parkinson's disease. Record review of Resident 42's Quarterly MDS dated [DATE], indicated a BIMS score of 00 implying being severely cognitively impaired. Record review of Resident 42's care plan dated 6-29-2023 indicated Resident #42 had ADL deficits for hygiene and mobility, was care planned for actual falls, and was on antidepressant medications. (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 8-20-2024 at 4:15 PM, Resident #42 was observed sitting in a wheelchair sitting at a table in the facilities only dining room by Resident #66. Resident #66 said he saw the flies on Resident #66 and on the dining room tables. Resident #42 stated he did not like the flies especially in the dining room. Resident #42 stated dealing with the flies in the dining room made him feel like he was in a trash dumpster. In an observation on 8-20-2024 at 4:20 PM there were 10 flies observed in the facilities only dining room. A fly was observed on 80% of the tables in the dining room. Record review of Resident #103's face sheet dated 8-21-2024, revealed an [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of a fracture of T5-T6 vertebra and secondary diagnoses of morbid obesity, depression, asthma, and generalized muscle weakness. Record review of Resident #103's Quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating Resident #103 had moderate cognitive impairment. Record review of Resident #103's care plan dated 2-6-2024 indicated she had ADL deficient requiring assistance, was on an antidepressant, and was a fall risk. On 8-21-2024 at 12:27 PM, Resident #103 was observed in a wheelchair sitting at a table in the facilities only dining room, eating her lunch. Resident #103 was observed shooing away a fly from her food. Resident #103 said the flies are not too bad today but sometimes they have been worse, and she has scared them away by waving her hand over her food. Resident #103 said she does not like the flies. In an interview on 8-22-2024 at 2:00 PM, the Maintenance Director revealed the facility contracted with a pest control company and he oversaw the responsibilities. The Maintenance Director stated the pest control company came to the facility every Tuesday and treated the facility for spiders, scorpions, rodents, and flies. The Maintenance Director said there was a Pest Control Logbook kept at the nurse's station where anyone could make an entry of a pest control problem. The pest control company comes in and checks the logbook to see where a problem might be to treat that area for that problem. The Maintenance Director said flies were a big challenge for the facility because surrounding the facility was a barn with horses, a creek, a wooded area, and a park. The Maintenance Director said it was a big deal as the facility had trach patients who cannot move to shoo flies off. The Maintenance Director said the risk to residents eating in the dining room was flies could infect residents' food and bring worms in their food. In an interview on 8-22-2024 at 3:00 PM, CNA-B stated she had worked at the facility for a month on the 2:00 PM-10:00 PM shift. CNA-B said when she hired in a month ago flies were really bad in the facility, however, they are not as bad as they were. CNA-B said there were still some flies in the facility, and they were disgusting because they land on feces and are especially not good for residents in the dining room trying to eat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Marine Creek Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8-22-2024 at 4:00 PM, the Administrator said the Maintenance Director was responsible for the pest control of the facility. The Administrator stated her expectations for pest control was for the pest control company to come to the facility every Tuesday to treat for flies inside and outside, to keep having blow curtains at all the entry and exit doors except the fire exits, and to have the smoking patio power washed twice a week. The Administrator said the potential risk to residents having flies in the facility was not having a sanitary environment. Record review of the facilities Pest Control Company's Logs revealed the following: 6-18-2024 - Visit at 12:58 PM - treated for flies, spiders, roaches, ants beetles and crickets. 6-25-2024 - Visit at 12:42 PM - treated for roaches, flies, gnats. 7-02-2024 - Visit at 10:24 AM - treated for roaches, flies, gnats. 7-09-2024 - Visit at 10:47 AM - treated for flies, gnats, ants, roaches, and moths. 7-16-2024 - Visit at 11:00 AM - treated for flies, gnats, and moths. 7-19-2024 - Visit at 09:19 AM - treated for bedbugs - Observed bedbugs in a wheelchair. 7-23-2024 - Visit at 02:35 PM - treated for flies and gnats. 7-30-2024 - Visit at 01:00 PM - treated for flies, gnats, spiders, and moths. 8-06-2024 - Visit at 03:34 PM - treated for flies, gnats, moths. 8-13-2024 - Visit at 09:46 AM - treated for ants, roaches flies, and gnats - Logbook reports roaches in a room. Record review of the facilities Pest Control Policy dated 2012 states: IC 00-12.0 Insect and Rodent Control The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department. Procedure: 1. Arrangements are made with a reputable company for regular spraying for insects which includes rodent control when required. 2. Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Sanitation of facility will be maintained per other stated sanitation policies to prevent food sources, breeding places, etc. for insects or rodents. 4. Deliveries of food and supplies will be monitored for prevention of insect and rodent access. Dietary Services Policy & Procedure Manual 2012 IC 00-12.0