

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/18/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Number of residents sampled: Number of residents cited: Based on observation, interviews, and record reviews, the facility failed to protect residents' right to a safe, clean, comfortable and homelike environment for 20 of 31 residents in the secured unit reviewed for resident rights. The male side of the secured unit had a strong urine smell on 9/16, 9/17 and 9/18/2025. This failure could result in lack of residents' hygiene and could affect their dignity. Findings included: Observation on 9/16/2025 at 7:45am, the end of hallway 100 which was connected to the secured unit had a strong urine smell. Upon entering the secured unit, there was a strong urine smell that spread through the entire male's side of the secured unit. The male side had 20 male residents. Observation on 9/17/2025 at 6:45am, the male side of the secured unit had a strong urine smell. Observation on 9/18/2025 at 9am, the male side of the secured unit had a strong urine smell. In an interview on 9/18/2025 at 9:15am, CNA A, who was the CNA assigned to male side of the secured unit, stated that there were 4 or 5 residents who would urinate in the hallway, in the dining room and in the TV room. She stated that the staff had tried to direct the residents as much as they could, however, residents still urinated in the common area. She stated that she would redirect the residents to their room and clean the residents and inform housekeeping right away so they could come to disinfect and clean the area. CNA A stated that the smell had always been there, and she was unsure if there were more interventions from the facility to decrease the smell. In an interview on 9/18/2025 at 11:01am, LVN B stated that he and CNA A had been keeping residents who wandered and urinated in common areas in the dining room or TV room for better observation. He stated that some residents would urinate while watching TV. He stated that since the residents were cognitively impaired, his interventions had been redirecting them and cleaning them when they urinated and passing feces in the common area. He also stated that housekeeping got notified right away to come and clean the area. In an interview on 9/18/2025 at 10:55am, Resident #76 stated that he did not remember smelling any urine or bad smell in the facility. Record review of Resident#76's face sheet, dated 9/18/2025, revealed the resident had a BIMS score of 4, indicating cognitive impairment. On 9/18/2025 at 11:00am, an attempt to interview Resident #108 was unsuccessful. Resident was not able to respond to surveyor's questions. Record review of Resident #108's face sheet, dated 9/18/2025, revealed the BIMS was not done because assessment revealed Resident #108's cognitive function was severely impaired to be able to complete the BIMS. In an interview on 9/18/2025 at 11:23am, the administrator stated that the male side of the secured unit did not have good ventilation. She stated she made rounds to the secured unit daily and she was aware of the urine smell. She stated that the wife of Resident #88 came to her about 3 weeks ago to complain about the strong urine smell in the unit, when she first visited her husband in the secured unit. The administrator provided 3 estimates with HVAC companies, with dates of 8/26/2025, 9/5/2025 and 9/16/2025. She stated that one company would be chosen to come out soon, she did not have a scheduled date yet. She stated that had the (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents been cognitively intact, they would not have urinated in the common area, so she could not answer if the smell affected the residents' dignity and rights. Record review of Resident #88 revealed that the resident was moved to the secured unit due to wandering behavior on 8/21/2025. During an interview on 9/18/2025 at 12:49pm, Resident #88's wife stated that when Resident #88 was moved to the secured unit, she went to visit him, and the smell was horrible. She stated that it had gotten a little better since then, but the smell was still strong. She stated she did not remember complaining about the smell to anyone in the facility. Record review of facility's Resident Rights policy, dated 11/28/2016, revealed that the resident has a right to safe, clean, comfortable and homelike environment.		

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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** Based on observation, interview and record review, the facility failed to ensure the residents resided and received services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #136 and Resident #112) of thirty-eight residents reviewed for call lights. Staff failed to ensure Resident # 136's and Resident # 112's call buttons were within reach. This failure could place residents at risk for needs not being met, decreased quality of life, self-worth and dignity. Findings included: Review of Resident #136's face sheet dated 09/18/2025 reflected a [AGE] year-old female admitted to the facility on [DATE], readmitted on [DATE] with diagnoses of Acute and Chronic Respiratory Failure, Unspecified, Whether with Hypoxia or Hypercapnia (a sudden exacerbation and an underlying long-term condition affecting the lungs, where the specific nature of the blood gas issue, low oxygen or high carbon dioxide, has not been determined or documented); Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (a person experiencing symptoms of dementia, but the specific type cannot be determined); Heart Failure, Unspecified (a condition where the heart is unable to pump enough blood to meet the body's needs, without a specific underlying cause being determined); Encounter for Attention to Tracheostomy (a medical visit where a patient receives care related to their tracheostomy, a surgical procedure that creates an opening in the trachea, windpipe, to facilitate breathing). Review of Resident #136's MDS assessment dated [DATE] reflected the resident had a BIMS Score of 13 indicating intact cognition. Resident #136 required extensive assistance to total dependence for ADLs. Review of Resident #136's Comprehensive Care Plan dated 03/07/2023 revised on 09/12/2025 reflected Resident #136 was at risk for falls. Interventions included, to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on 09/16/2025 at 08:40 a.m. revealed Resident #136 lying in bed asleep. The call light was on the floor under the bed lying on the overbed table rail. The call light was not within reach of the resident. In an interview on 09/16/2025 at 12:00 p.m. Resident #136 stated her cord was where she could reach it most of the time. Observed call light still on the floor under the bed. In an interview on 09/16/2025 with CNA D at 12:49 p.m. CNA D stated that all call lights must be within reach of residents. CNA D was not aware that Resident #136's call light was not within reach. CNA D immediately went to Resident #136's room to make sure the call light was in place. CNA D stated residents would not be able to call for assistance if the call light was not within reach. Review of Resident #112's face sheet dated 09/18/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Bipolar Disorder, Current Episode Mixed, Severe, with Psychotic Features (symptoms of delusions and both auditory and visual hallucinations); Essential (Primary) Hypertension (a condition characterized by persistently elevated blood pressure without identifiable underlying cause); Personal History of Traumatic Brain Injury (an injury to the brain caused by an external force, such as a car accident, fall, or sports injury). Review of Resident #112's MDS assessment dated [DATE] reflected the resident had a BIMS Score of 0 indicating severely impaired cognition. Resident # 112 had disorganized or incoherent thinking, rambling or irrelevant conversations, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. Review of Resident #112's Comprehensive Care Plan initiated 03/04/2021, revised 04/14/2023 reflected Resident #112 was at risk for falls related to limited mobility, incontinence, and impaired cognition. Interventions included, Anticipate and meet needs of resident. Personal items need to be kept within easy reach. Call light to be kept within reach was not included in the interventions. Observation on 09/16/2025 at 9:38 a.m. revealed Resident #112 was in her bed resting in her room and her call light was attached to fitted sheet on mattress with cord hanging down to the floor under the bed. The call button was not within of resident. In an interview on 09/16/2025 at 10:30 a.m. Resident #112 stated she did not know what the call button was. Observed call light clipped to (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fitted sheet on mattress within Resident #112's reach. In an interview on 09/18/2025 at 3:45 p.m. with LVN E stated that it was policy of the facility for call lights to be within reach of residents. The call lights were to be answered immediately or at least within 5 to 10 minutes. If a resident was unable to push the button on the call light a push pad was provided for residents. Residents were checked on every 2 hours. In an interview on 09/18/2025 at 3:50 p.m. with LVN F stated that the call lights were to be within reach of the residents. The call lights were answered as soon as possible. Residents were checked on every 2 hours. In an interview on 09/18/2025 at 4:00 p.m. with CNA G stated that call lights must be attached to the resident's bed within reach of the resident. The staff should answer the call lights as soon as possible. Staff try to answer within 5 - 10 minutes. CNA G stated all staff can answer call lights. Residents may only need fresh water or the nurse to give them something for the pain. In an interview on 09/18/2025 at 04:17 p.m. the ADM stated she expected call lights to be within reach of residents. She expected the call lights to be answered. Review of policy revised 11/18/2016 for Resident Rights reflected Safe environment -The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision for one resident (Resident #28) of thirty-eight residents reviewed for supervision and ensured the environment remained free of accident hazards. The facility failed to ensure Resident #28 was not in possession of over-the-counter isopropyl alcohol located in resident's room. These failures could place residents at risk of being in danger and could be fatal if a resident ingested isopropyl alcohol. Findings included: Record review of Resident #28's Face Sheet dated 09/18/2025 revealed a [AGE] year-old male with an admission date of 02/01/2023 with a readmission on [DATE]. Admitting diagnoses included Vascular Dementia, Unspecified, Severity without Behavioral Disturbances, Psychotic Disturbances, Mood Disturbances, and Anxiety (a type of dementia caused by reduced or blocked blood flow to the brain, often stemming from conditions like heart disease, high blood pressure, diabetes, and strokes); Essential (Primary) Hypertension (a condition characterized by persistently elevated blood pressure without an identifiable underlying cause); Primary Osteoarthritis, Unspecified Site (the specific joint or joints affected or unknown). Record review of Resident #28's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 06/15 indicating severe cognitive impairment. Record review of Resident #28's Care Plan dated 09/09/2024 with a revision date of 05/23/2025 revealed resident had impaired cognitive function/dementia or impaired thought processes. Staff were to Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Observation on 09/16/2025 at 9:35 a.m. revealed Resident #28 had an overbed table up against a wall with several personal items on table including a bottle of half-full rubbing alcohol. The bottle was sealed with a lid. In an interview on 09/16/2025 at 10:00 a.m., LVN C stated she did not see the rubbing alcohol in Resident #28's room on the overbed table. LVN C stated that the resident could have ingested the rubbing alcohol, or another dementia resident could have ingested the rubbing alcohol by mistake. LVN C stated that Resident #28's family member must have brought the rubbing alcohol to resident. LVN C removed the bottle of rubbing alcohol while the resident was out of the room because the resident could become easily agitated. LVN C stated that if family members bring in medications or over-the-counter medications from home the facility requests that the family members give them to the nurses. In an interview on 09/16/2025 at 11:40 a.m., DON stated that the alcohol was probably brought in by Resident #28's family member. DON stated she would give resident's family member a call to not bring this type of item into the facility. In an interview on 09/18/2025 at 04:17 p.m., ADM stated it is facility policy that residents are not allowed to have any medications or over-the-counter medications at the bedside. Record review of facility policy for, Items Not Allowed in Resident's Rooms, revised 03/12/2024 reflected in part, Medications includes all Prescription and Over-the-Counter drugs, except emergency items like nitro?glycerin, which must be ordered by the doctor through the Health Care Center.		