

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER FT Worth Southwest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Alta Mesa Blvd Fort Worth, TX 76133	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 Resident (Resident #1) of 3 residents reviewed for accident hazards/devices. The facility failed to ensure CNA A and CNA B used the required assistive device (gait belt) to transfer Resident# 1 to prevent accidents. This failure could place residents at risk of avoidable falls, injuries, and reduced safety during transfers. Findings included: Record review of Resident #1's MDS Assessment, dated 08/01/25, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE]. He had a BIMS score of 09, indicating moderate cognitive impairment. His diagnoses included Anemia (A condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), hypertension (a condition where the blood pressure is lower than normal), Renal Insufficiency (a condition where the kidneys do not function properly and cannot filter waste products from the blood), Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) levels that occur when the body does not produce enough insulin or does not use insulin effectively), Parkinson Diseases (a progressive neurodegenerative disorder that affects movement, balance, and coordination), Anxiety, and schizophrenia (Schizophrenia is a serious mental health condition that affects how people think, feel and behave). Record review of Resident #1's care plan, initiated 08/28/2025, reflected the following: Focus: The resident has an ADL Self Care Performance Deficit r/t blind. Interventions/Tasks transfer: The resident requires 2 staff total participation with transfers. In an observation on 09.24.2025 at 11:49AM revealed CNA A and CNA B entered Resident#1's room. CNA A and CNA B introduced themselves and notified Resident# 1 that they were going to transfer him from the wheelchair to the bed. CNA A was on the right side and CNA B was on the left side. CNA A and CNA B placed their arms under the resident's arm and pulled the resident to a standing position, then pivoted the resident toward the bed. No gait belt was used in the transfer. In an interview on 09/24/2025 at 11:55AM with CNA A revealed that Residents# 1 required two people for transfers. She stated that she should have used a gait belt. She stated that the risk to the residents when a gait belt was not used was fall and injuries to the resident's shoulder. CNA A stated she had been in serviced on how to transfer with a gait belt. In an interview on 09/24/2025 at 11:57 AM with CNA B revealed that she did not work with Resident#1 and was assisting CNA A with the transfer. She stated that she knew she should have used a gait belt to transfer Resident#1 and there was no reason why they did not use one. She stated that the risk to the resident when a gait belt was not used was injury to the resident and the resident could fall. CNA B stated she had been in serviced on how to transfer with a gait belt. In an interview with 09/24/2025 at 12:00PM with LVN C revealed that Resident#1 required two people for transfers. She stated that every resident should be transferred using a gait belt. She stated that the risk to the resident when a gait belt was not used with transfers was injuries such as broken bones due to falls. In an interview on 09/24/2025 at 12:49PM with the DON revealed that his expectation was that staff used a gait belt with all transfers. He stated that the risk to the resident was fall, injury to the resident and the staff and skin issues. He stated that staff had been in-serviced on safe transfers and the use of gait belts with all transfers unless contraindicated. He stated that Resident#1 had no restrictions for gait belt use. Record review of the facility's policy, revised 06/2020, and Titled Transfer of Residents Reflected: To provide the form of transfer best suited to the residents' needs and to maintain resident safety during the procedure. i. A Licensed Nurse and/or the Director of Rehabilitation Services assess and determine lifting and transfer requirements, and the procedure used for each resident. the procedure is recorded in the residents 's care plan. ii. Residents must be lifted or transferred according to the determined procedure. iii. Residents who require assistance in transferring will be transferred using a gait/transfer belt or with a lift. iv. Member of the Nursing Staff are trained to use good body mechanics, knowing the proper procedures and properly operating assistive devices. v. Mechanical lift procedures are used on any resident unable to independently pivot or transfer. B. Two-Person Assisted Transfer i. Place the chair on the convenient side of the bed with the back of the chair parallel to the foot of the bed and facing the head of the bed. ii. If using a wheelchair, make sure footrests are not in the way and wheels are locked. iii. Place appropriate pressure-reducing devices into chairs. iv. Turn residents onto their side and pivot the residents to sitting positions, with legs dangling over the side of bed. v. Assist residents in daily attire as requested. vi. May apply gait belt (unless contraindicate) around residents'</p>		