

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 11/26/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (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 0584</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 observation, interview, and record review the facility failed to adhere to the federal requirements regarding residents' rights. The facility failed ensure a safe and decent living environment for two (Resident #2 and Resident #3's rooms) of five rooms reviewed for decent living environment. 1. The facility failed to ensure Resident #2's room was free of dirt, debris, and sticky floors on 10/10/25.2. The facility failed to ensure Resident #3's broken window was repaired. These failures could place residents at risk or diminished quality of life due to the lack of a well-kept environment. Findings included: Record review of Resident #2's face sheet, dated 10/10/25, reflected a [AGE] year-old male, with an admission date of 03/31/25. Resident #2 had a diagnosis of Convulsions (involuntary, uncontrollable muscle contractions), Dysarthria (difficult or unclear articulation of speech), Need for Assistance with Personal Care, Chronic Viral Hepatitis C (long term infection of the liver), and Vascular Dementia (changes in thinking and memory) Record review of Resident #3's face sheet, dated 10/14/25, reflected a [AGE] year-old female, with an admission date of 06/30/25. Resident #3 had a diagnosis of Dementia (changes in thinking and memory), Muscle Weakness, Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Acute Respiratory Failure (lungs cannot adequately exchange oxygen and carbon dioxide), and Emphysema (chronic lung disease that causes irreversible damage to air sacs in the lungs). In an observation and interview on 10/10/25 at 8:30 AM, Resident #2's room had many large brown crumbs on the floor near the television area, cheese balls under the edge of his bed, and had a sticky fall mat with crumbs on it. Resident #2 did not reply back to Surveyor when Surveyor attempted to speak with him. In an observation on 10/10/25 at 10:27 AM, in Resident #2's room, reflected the large crumbs near the television were gone and the floor looked like it was recently swept and mopped, but there were still cheese balls at the edge of his bed. The floor mat still had sticky spots and crumbs on it. In an interview on 10/10/25 at 2:18 PM, the Administrator stated the expectation was for the resident rooms to be cleaned well. She stated the risk of a resident's room not being cleaned was the responsible staff member having to speak with her regarding the violation of resident rights. In an interview on 10/10/25 at 3:05 PM, Housekeeping Supervisor E stated he would check to see who was responsible for cleaning Resident #2's room. Housekeeping Supervisor E stated he was not sure why the room was not cleaned properly, but his staff were trained on how to properly clean a resident's room. He stated Resident #2's room was now fully cleaned. Housekeeping Supervisor E stated the risk of an uncleaned room was infection control and pest issues. In an observation on 10/10/25 at 4:00 PM, from the parking area, outside of the facility, Surveyor noticed a resident room window with large cracks about a foot in diameter, with pink curtains that covered the inside of the window. The specific resident room was not identifiable from the parking area. In an interview on 10/14/25 at 1:15 PM, The Maintenance Director stated he was new at the facility and had a lot of work to complete. He stated he was aware of the broken window and had already purchased some material to repair it. The Maintenance Director stated he started working at the facility on 09/15/25, and the window was broken then. The Maintenance Director stated he would be fixed today. He stated the risk of a broken window in a resident room was the resident could cut themselves on it. In an observation and interview on 10/14/25 at 1:21 PM, reflected Resident #3's room was the room with the broken window. Upon further observation, the broken window had green tape of some of the cracks. There was a broken, open area with no coverage. The window was open. Resident #3 stated she did not realize the window was that bad. Resident #3 stated she was not sure how long the window had been broken. She stated she was not sure who opened the window. Resident #3 stated she hoped maintenance would repair the window soon, and she hoped it would be repaired the same day. In an interview on 10/14/25 at 3:08 PM, the Administrator stated the risk of a broken window in a resident's room was pest control concerns. In an interview on 10/15/25 at 1:21 PM, Resident #2's Family Member stated they had complained to the facility two times in the past regarding his room not being cleaned. The Family Member stated it was mostly on the weekend, and the facility staff told them there were not as many housekeepers who worked on the weekend. The Family Member stated they would like Resident #2's room to be cleaned more consistently. Record review of the facility's policy titled, Resident Rights, dated 08/2020, reflected the following: Purpose To promote and protect the rights of all residents at the facility. Policy All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one of five (Resident #1 Room) resident rooms reviewed for pharmacy services. The facility failed to ensure a tube of Zinc Oxide Ointment and a bottle of Antiseptic Skin Cleanser were not left in Resident #1's room. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversion. Findings included: In an observation and interview on 10/10/25 at 10:11 AM, an uncapped, 1 oz tube of Zinc Oxide ointment was observed on Resident #1's nightstand, and a 4 oz bottle of Antiseptic Skin Cleanser was observed on top of Resident #1's refrigerator, which sat on top of the nightstand. Resident #1 stated staff must have left those items in his room this morning. Resident #1 stated the staff kept all of his medications. In an interview on 10/10/25 at 10:45 AM, RN A stated the aides were responsible for applying creams and ointments. She stated prescription creams and antiseptic would be administered by a nurse. RN A stated the zinc oxide was applied by Aide B this morning, and she stated she was not sure where the antiseptic came from. RN A stated she did not put any antiseptic on him this morning and was not sure if it was from Resident #1's home or the facility. RN A stated those items should not be left in Resident #1's room where a resident could have access to those items. In an interview on 10/10/25 at 11:03 AM, Aide B stated she did use the zinc oxide on Resident #1 this morning while changing him. Aide B stated she was rushing to answer another call light and must have left the ointment in his room. She stated she did not have the antiseptic skin cleanser and was not sure who was responsible for it. Aide B stated she was not supposed to leave ointment in the resident's room, but she was rushing and forgot. Aide B stated the risk was Resident #1 could have got it or touched it. In an interview with the Administrator and the DON on 10/10/25 at 2:18 PM, the DON stated those items should not be left in Resident #1's room. He stated the facility started an in-service to remind staff not to leave medications, ointments, and cleansers in the residents' rooms. The DON stated the risk of leaving those items in Resident #1's room was there was potential for harm, like the resident ingesting something. The Administrator stated the risk of leaving those items in Resident #1's room was possible sickness. Record review of the facility's undated policy, titled, Medication Administration, reflected the following: Purpose To provide practice standards for safe administration of medications for residents in the Facility. VIII. Medications will not be left at the bedside.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and practices and were complete and accurately documented for 1 (Resident #1) of 5 residents records reviewed for treatment documentation. 1. The facility failed to document timely when Resident #1 refused to leave the courtyard area of the facility until 1:00 AM on 10/08/25. This failure could affect the residents' medical record not being an accurate representation of the resident's medical condition or medical needs. Findings included: Record review of Resident #1's face sheet, dated 10/10/25, reflected a [AGE] year-old male, with an initial admission date of 06/17/25, and a readmission date of 10/02/25. Resident #1 had a diagnoses of Parkinson's Disease (progressive disorder that affects movement, balance, and coordination), Type 2 Diabetes (body does not use insulin properly or cannot produce enough insulin), Schizoaffective Disorder (disorder with delusions, hallucinations, disorganized thinking, depressed mood, and manic behavior), Bipolar Disorder (mental health condition with extreme mood swings), Anxiety Disorder (excessive worry, fear, or nervousness), Chronic Pain, Blindness in one eye and low vision in the other eye, Essential Hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (airflow obstruction and breathing difficulties), and Dysphagia (difficulty swallowing). Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 12, which meant Resident #1 had moderate cognitive impairment. Record review on 10/10/25 of the progress notes on Resident #1's electronic record, reflected no note about Resident #1's refusal to leave the courtyard until 1:00 AM. In an interview on 10/10/25 at 12:29 PM, LVN C stated he was the one that repeatedly checked on Resident #1 in the courtyard of the facility on the night of 10/08/25. LVN C stated when his shift started that night around 10:00 PM, the previous shift staff informed him Resident #1 was in the courtyard and was not ready to come back into the facility. LVN C stated he checked on Resident #1 about every 20-30 minutes. LVN C stated Resident #1 kept saying he was enjoying the fresh air and was not ready to leave the courtyard. LVN C stated finally, around 1:00 AM, Resident #1 was ready to leave the courtyard. He stated he was then taken back to his room. LVN C stated the residents have rights, and he could not make Resident #1 leave the courtyard. LVN C stated he felt there was no risk of not documenting when Resident #1 did not want to leave the courtyard, because he went to the courtyard often, but he normally would not be out there as late as he was on 10/08/25. Record review on 10/14/25 of the progress notes on Resident #1's electronic record reflected a late entry note, added on 10/13/25 at 3:16 AM on the incident on 10/08/25, when Resident #1 refused to leave the courtyard at the facility until around 1:00 AM. In an interview with the Administrator and the DON on 10/14/25 at 3:08 PM, the DON stated the risk of late documentation when Resident #1 refused to come inside was important information missing from the resident's electronic record that needs to be shared with the clinical team. The Administrator stated she agreed with the DON about the risk of late documentation on a resident's electronic record. The Administrator stated the staff will be reviewing documentation during the morning review to ensure information is not missed. Record review of the facility's policy titled, Documentation-Nursing, dated, 01/2025, reflected the following: PurposeTo provide documentation of resident status and care given by nursing staff.PolicyNursing documentation will be concise, clear, pertinent, accurate and evidence based.K. Documentation will be completed by the end of the assigned shift.</p>		