STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675817	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ft. Worth Southwest Nursing Center	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record revie, the facility failed to provide a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely for 1 (Resident #1) of 5 residents reviewed for resident rights. The facility failed to provide a space free of severe hoarding of various items that left a narrow walkway of approximately 1 foot wide from Resident #1 door to bed. This failure could place residents at risk of an unsafe, unclean and uncomfortable environmentFindings included:Record review of Resident #1's face sheet, dated 05/20/26, reflected a [AGE] year-old female admitted [DATE] and readmitted on [DATE], diagnoses included unsteadiness of feet (an indicate various underlying issues, often related to balance problems), generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), major depressive disorder, depressive disorder, recurrent, severe with psychotic (psychotic symptoms such as hallucinations or delusions. This condition significantly impairs an individual's ability to function in daily life) and cognitive communication deficient (Symptoms may include difficulty with attention and focus, memory problems, disorganized thoughts, reduced problem-solving abilities, difficulty understanding complex information, and social communication challenges).Record review of Resident #1's care plan, dated 05/16/26 reflected room full of purchases. Items included shelving and bins to store her purchases in. The care plan indicated, [Resident #1] has a hoarding behavior and is not willing to stop purchasing and she is not willing to let staff remove any of her purchases. [Resident #1] is keeping mayonnaise in her room. [Resident #1] has been educated that the mayonnaise needs to be refrigerated, and bacteria can grow in the mayonnaise that could cause serious injury to her. [Resident #1] refuses to let staff remove mayonnaise.[Resident#1] has been asked to clear some items out of her room as she has so much stuff in the room it takes up both sides of the room. [Resident #1] has called the police to facility because she has been asked to clean. Items update, initiated on 02/03/2020 and revised on 06/12/2024. Further record review of Resident #1's care plan indicated intervention/task, initiated on 03/12/26 included, Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by.Record review of Resident #1's quarterly MDS assessment, dated 02/21/26, reflected Resident #1 had a BIMS of 15, indicating cognition was intact.During an observation and interview on 05/20/26 at 10:15 A.M., Resident #1 bathroom was full of items on the floor and stacked up along the walls. Observation indicated both sides of the resident room were full of different items and Resident #1 had a narrow path that led to her bed. Observation further indicated molded bread on top of Resident #1's refrigerator. Resident #1 stated she could not clean her room because her hip hurt and she did not have time to clean her room. Resident#1 stated she does not like all the staff in her room. Resident #1 stated she had problems with ants before, but no ants were observed in Resident #1's room at that time. Resident#1 was observed seated on the side of her bed fully dressed without a roommate.Record review of Resident #1 progress notes dated 03/20/26 to 05/20/26 reflected, no documentation related to the facility's efforts to address the hoarding/shopping behaviors.Record review of psychological progress notes, (continued on next page)

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 - Few	dated 03/30/26, reflected Resident #1's short term therapy goal included reducing the number of items in her room to a level deemed safe by facility staff according to state guidelines within one month. Progress made was 3-Moderate.Record review of QAPI, dated 04/23/26 provided after exit reflected, resident#1 safety plan with department heads and medical director. Record review of Resident #1's fall risk assessment, dated 04/23/26, reflected a score of 5.0 which indicated a moderate risk. Record review of Resident #1's progress notes, dated 05/20/26, reflected no reported falls in the last 90 days. During an interview on 05/20/26 at 3:45 P.M., the DON stated Resident #1 had made improvements on her room. The DON stated Resident #1 used to have items all the way to the ceiling. The DON stated they had a plan of action and were in the process of organizing her room and moving items to an outside storage shed for her. During an interview on 05/20/26 at 4:00 P.M., the Administrator stated they had worked on the room with Resident #1, and she only allowed certain staff to move items around and organize. The Administrator stated Resident #1's room had improved over the last couple of years. Record review of the facility policy, revised 08/2020, titled, Resident Rooms and Environment, reflected, Purpose: To provide residents with a safe, clean, comfortable and homelike environment. Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview, observation and record review, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 1 facility reviewed for storage.The facility failed to secure 10- 1 oz Zinc Oxide Ointment tubes observed on three linen cart pockets and 2- 1oz Zinc Oxide Ointment in a resident open top-drawer.This failure could place residents at risk of unauthorized access to over-the-counter drug or prescription. Findings included:During an observation on 05/20/26 at 8:25 A.M., there were two 1oz tubes of Zinc Oxide ointment in a open top drawer.During an observation on 05/20/26 at 10:10 A.M., of the linen cart side pocket revealed 2-1oz tubes of Zinc Oxide ointment. During an observation on 05/20/26 at 10:15 A.M., of the linen cart side pocket revealed 3-1oz tubes of Zinc Oxide ointment.During an observation on 05/20/26 at 10:20 A.M., of the linen cart side pocket revealed 5- 1oz tubes of Zinc oxide ointment.During an interview on 05/20/26 at 10:30 A.M., CNA A stated Zinc Oxide ointment was in the resident drawers and in the pockets of the linen carts to be used on the residents for skin breakdown.During an interview on 05/10/26 at 10:38 A.M., CNA B stated that when she opened a tube of the Zinc Oxide ointment and she carried the tube with her and used it on each resident until it was gone.During an interview on 05/20/26 at 10:56 A.M., the Restorative Aide stated the Zinc Oxide ointment was found in the resident top drawer and on the linen cart in the side pocket.During an interview on 05/20/26 at 3:24 P.M., the Treatment Nurse stated the Zinc Oxide ointment was not left out in the resident's rooms but in their top drawer and in the side pocket of the linen cart. The Treatment Nurse stated the Zinc Oxide ointment was purchased from the supply vendor and not the pharmacy. The Treatment Nurse stated the Zinc Oxide ointment was used as a preventable measure to prevent resident skin breakdown. During an interview on 05/20/26 at 3:45 P.M., the DON stated the Zinc Oxide ointment was readily available inside the pockets of the linen cart pockets for staff to use on residents. The DON stated there was no risk to residents because the Zinc Oxide ointment was like lotion. Record review of the facility policy, titled Storage of Medication reflected, Medications and biologicals are stored safely, securely and properly.The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication.2 Medication rooms, carts, and medication supplies are locked when not attended by authorized person.