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	05/08/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care for 3 of 6 residents (Resident #2, Resident #3, and Resident #76) reviewed for Comprehensive Care Plan.The facility failed to ensure Resident #2, Resident #3, and Resident #76 and/or the resident's representative were invited and given the opportunity to participate in the resident's care plan meeting.This failure could place residents at risk of a loss of independence, loss of opportunity to participate in planning of their care, psychosocial health, and quality of care.In a record review of Resident #2's face sheet, dated 05/08/2026, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and was his own responsible party. His diagnoses included Depression (serious medical illness causing persistent sadness, loss of interest, and decreased energy that interferes with daily life), Generalized Anxiety Disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, lasting for at least 6 months), Post-Traumatic Stress Disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events), and Dysphagia (difficulty swallowing).In a record review of Resident #2's MDS, completed on 04/10/2026, reflected Resident #2's BIMS score was 14/15, and indicated that a person was cognitively intact. Resident #2 required partial to moderate assistance (indicated staff did less than half the effort) with care for toileting, bathing, and lower body dressing and setup or clean-up assistance (staff sets up or cleans up); Resident #2 completed the activity for oral hygiene and upper body dressing.In a record review on 05/08/2026 of Resident #2's assessment tab in the facility's EMR revealed that Resident #2's care conference was 11 days overdue. Further review of the EMR showed no documentation indicating that Resident #2 had been invited to or participated in his care conference. During an interview with Resident #2's on 05/08/2026 at 12:02 p.m., he said he had never received notice of a care conference or care plan meeting with staff and had never been provided with a copy of his care plan. He further stated that he was concerned about not being involved in his care and felt that his care was not being provided according to his preferences.In a record review of Resident #3's face sheet, dated 05/07/2026, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and was his own responsible party. His diagnoses included Acute hematogenous osteomyelitis (a bone infection commonly caused by bacteria via the bloodstream), Asthma (a chronic, long-term disease), Morbid (severe) obesity due to excess calories (excessive fat accumulation), Atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's arteries without causing chest pain), End-stage renal disease (the final stage of kidney failure), and Unspecified atrial fibrillation (an irregular, often rapid heart rate where the upper chambers quiver).In a record review of Resident #3's MDS, completed on 02/23/2026, reflected Resident #3's BIMS score was 15/15, indicated that a person was cognitively intact. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 required substantial to maximal assistance (which meant staff does more than half the effort) with care for toileting, bathing, lower body dressing, and putting on/taking off footwear.In a record review on 05/07/2026 of Resident #3's assessment tab in the facility's EMR revealed that Resident #3's care conference was 42 days overdue. Further review of the EMR showed no documentation indicating that Resident #3 had been invited to or participated in his care conference. During an interview with Resident #3 on 05/08/2026 at 12:18 p.m., he said he had never received notice of a care conference or care plan meeting with staff and had never been provided with a copy of his care plan. He further stated that he would have liked to meet with staff to discuss his care and understand the goals established to help him return home.In a record review of Resident #76's face sheet, dated 05/08/2026, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and was his own responsible party. His diagnoses included Muscle atrophy (loss of muscle mass, strength, and function), Contracture of Muscle (the permanent shortening, stiffening, and tightening of muscles, tendons, or skin, causing reduced mobility and joint deformity), Major Depressive Disorder (a serious, common mental health condition characterized by persistent sadness, loss of interest, and low energy for at least two weeks), Dysphagia (difficulty swallowing), and Cognitive Communication deficit (often caused by brain injury or neurological disease).In a record review of Resident #76's MDS, completed on 02/13/2026, reflected Resident #76's BIMS score was 11/15, indicated moderate impairment in cognitive function. Resident #76 required dependent assistance (which meant staff did all the effort) with care for bathing, upper and lower body dressing, oral hygiene, toileting hygiene, personal hygiene, and putting on/taking off footwear.In a record review on 05/08/2026 of Resident #76's assessment tab in the facility's EMR revealed that Resident #76's care conference was 16 days overdue. Further review of the EMR showed no documentation indicating that Resident #76 had been invited to or participated in his care conference.During an interview with Resident #76 on 05/08/2026 at 12:43 p.m., he said he did not remember the last time he received notice of a care conference or care plan meeting with staff, and he had never been given a copy of his care plan. He also stated that he would have liked to have been involved in his care, as it would have made him feel that the staff cared about him.During an interview on 05/08/26 at 1:15 p.m., the SW revealed she had only been working at the facility for a couple of months. She stated that she noticed care conferences had not been completed and that she had been working to correct the issue. She further stated that she had been providing written notices to residents a couple of days prior to their scheduled care conference date.During an interview on 05/08/26 at 1:32 p.m., the DON stated that care conferences were completed quarterly and that the Social Worker sent letters to the responsible party or to the resident if the resident was their own responsible party. She further stated that when residents were not involved in their care, it could make them feel left out.During an interview on 05/08/26 at 1:43 p.m., the Administrator stated that the facility's care conference process needed improvement and stated that an improvement plan had been implemented. She reported that the plan included sending written notices to residents and/or their responsible party regarding scheduled care conferences. She further stated that when residents were not involved in their care planning process, it could make them feel excluded from decisions regarding their care.Review of the facility policy, Care Planning, revised 06/2020, reflected: Policy.II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.Procedures.II. Once the Baseline Care Plan is completed, the Facility must provide the resident and/or the resident's representative with a written summary of the Baseline Care Plan that includes: A. Initial goals of the residentB. Summary of medications and dietary instructionsC. Services or treatments to be administeredD. Updated information based on completion of the Comprehensive Care Plan, as indicatedE. The Facility may choose to provide a copy of the Baseline Care Plan instead of a summary as long as it includes the required information.XI. The Comprehensive Care Plan must be (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prepared by the IDT team. The IDT team includes the following individuals:A. The Attending Physician;B. The Resident Assessment Coordinator;C. The Licensed Nurse who has responsibility for the resident;D. The Dietary Supervisor and/or registered dietician;E. Social Service staff member responsible for the resident;F. The Activity Director;G. Therapists as applicable;H. Consultants (as appropriate);I. The Director of Nursing (as applicable);J. Certified Nursing Assistants and/or RNAs responsible for the resident's care;K. The resident and/or his/her family or legal representative;i. If the resident and his/her resident representative participation is determined not practicable for the development of the resident's care plan, an explanation should be included in the resident's medical record.L. Other individuals as appropriate or necessary.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food safety. The facility failed to ensure the handwashing sinks #1 and #2 garbage receptacle contained only paper towels.The facility failed to ensure that stored canned goods had uncompromised seals and were free from dents.The facility failed to ensure to discard spoiled items stored in the walk-in refrigerator.These failures could place residents at risk for food-borne illness, cross contamination, and infection.During an observation of the #1 handwashing sink's garbage receptacle on 05/06/2026 at 8:56 a.m., the following was revealed: #1 and #2 handwashing sinks garbage receptacles contained items other than disposable paper towels, including used gloves and plastic wrapping.During an observation of the dry storage room on 05/06/2026 at 9:30 a.m., the following was revealed:1x cream of celery soup 50 oz. (3 lbs. 2 oz.) written date 03/26/2026, best by date 12/09/2027, 2 dents on the bottom seal.1x Diced pears 105 oz. (6 lbs. 9 oz.) written date 04/30/2026, no best by date, dent on the side of the can.1x Tomato juice 46 fl. oz (1 qt. 14 oz.) written date 02/26/2026, best by date 07/14/2027, dent on the bottom seal.1x Refried Beans 112 oz. (7 lbs.) written date 04/02/2026, best by date 10/29/2028, dent on the top seal.During an observation of the walk-in refrigerator on 05/06/2026 at 9:39 a.m., the following was revealed:1x Sliced dill pickles 128 fl. oz (1 gallon), written on the side of the jar was received date 03/19/2026, open date 04/11/2026, and out date 04/31/2026, the manufacturers best by date 07/31/2027.1x Prepared mustard 128 fl. oz (1 gallon), written on the side of the jar was received date 02/26/2026, open date 04/11/2026, and out date 04/31/2026 with no manufacturers best by date.Teriyaki sauce 1 gallon, written on the side of the jar was in date 03/26/2026, open date 04/05/2026, and out date 04/30/2026 with no manufacturers best by date.During an interview on 05/06/2026 at 9:43 a.m., the [NAME] said everyone is responsible for inspecting cans for dents. He said the received date is written on cans that are delivered and refrigerated items should have 3 dates written on them if they are opened, the received date, opened date, and out date. He explained that the out date is the day it is no longer good. He said if residents were to eat expired food they could become very ill or even end up in the hospital.During an interview on 05/06/2026 at 9:55 a.m., the Dietary Manager stated that the individuals responsible for unloading the delivery truck were also responsible for inspecting cans for dents. She explained that the size of the dent did not matter. She said damaged cans were placed on a designated dented-can shelf and returned to the vendor for credit. She said the receive date or the in date was the date the product was delivered, the out date was the date the item needed to be thrown away, and the open date was the date they opened the product. She added that they do not keep products that have been open for more than 15 days. She further stated that the use of dented or damaged cans or expired food could result in residents vomiting or going to the hospital. During an observation of the #2 handwashing sink garbage receptacle on 05/07/2026 at 11:48 a.m., the following was revealed: #2 of #2 handwashing sinks garbage receptacle contained items other than disposable paper towels, including plastic wrap, used gloves, and paper.Observed the Dietary Manager put her dirty gloves in the #2 sinks garbage receptacle.During an interview on 05/07/2026 at 11:48 a.m., the Dietary Manager stated that she had always disposed of her dirty gloves in the #1 and #2 sinks garbage receptacles and reported that she had not been aware that this was inappropriate.In a record review of the facility's Food Storage policy, revised 12/2020, revealed: Procedures.Raw Meat/Poultry/Seafood Guidelines.II. Frozen Meat/ Poultry and Food Guidelines.III. Eggs, Milk, and Cheese Storage Guidelines.IV. Frozen Eggs Storage Guidelines.V. Frozen Cheese Storage Guidelines.VI. Fresh Fruits Storage Guidelines.VII. Frozen Fruit Storage Guidelines.VIII. Canned Fruit Storage Guidelines.Dented or bulging cans should be placed in separate storage area and returned for credit.IX. Fresh Vegetables Storage Guidelines.X. Frozen Vegetable Storage Guidelines.XI. Canned (continued on next page)

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	675817	A. Building B. Wing	05/08/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fruit Storage Guidelines.Dented or bulging cans should be placed in separate storage area and returned for credit.Fresh Milk and Dairy Products Storage Guidelines.Dry Storage Guidelines.There was nothing in the facility policy pertaining to the walk-in refrigerator storage.Review of the U.S. FDA Food Code 2022 reflected: . Section 6-301.20 Disposable Towels, Waste Receptacle. Waste Receptacles at handwashing sinks are required for the collection of disposable towels so that the paper waste will be contained, will not contact food directly or indirectly, and will not become an attractant for insects or rodents.Review of the U.S. FDA Food Code 2022 reflected: Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated.

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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** Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections for catheter care for 3 of 6 residents (Resident #1, Resident #14, and Resident #122) reviewed for infection control.Resident #14's catheter bag was touching his fall mat. Resident #1 and Resident #122's catheter bags hung under their wheelchairs and touched the floor in the physical therapy room. This failure could place residents at risk for infection.Findings included: Resident #14 Record review of Resident #14's face sheet revealed a [AGE] year-old male admitted with a primary diagnosis of atherosclerotic heart disease (arteries become narrow due to build of plaque, reducing blood flow to heart). Other pertinent diagnoses include congestive heart failure (heart cannot pump enough blood), cerebral infarction (stroke), and hypertension (high blood pressure). Resident #14 was on hospice services. Record review of Resident #14's care plan, revised on 05/06/2026, revealed he was care planned for falls and a low bed, a foley catheter and to maintain the drainage bag off the floor, and was on enhanced barrier precautions due to the foley catheter. During an observation on 05/06/2026 at 11:48 a.m., Resident #14's catheter bag was touching the floor mat at his bedside. The resident was sleeping at this time and was unable to be interviewed. Resident #1 Record review of Resident #1's face sheet, dated 05/06/2026, revealed a [AGE] year-old male, admitted with a primary diagnosis of chronic osteomyelitis with draining sinus left ankle and foot (persistent bone infection that requires prompt medical treatment). Other pertinent diagnoses included sepsis (infection resulting in overactive immune response, can lead to damaged organs), proteus (proteus mirabilis and proteus morganii, bacteria that can cause urinary tract infection, wound infections, and sepsis) infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter (infection and inflammation due to catheter and resident receives continued treatment and monitoring for condition), resistance to vancomycin (resistance to antibiotic), methicillin resistant staphylococcus aureus infection (bacterial infection resistant to antibiotics), acute cystitis (infection or inflammation of bladder), metabolic encephalopathy (brain disorder that occurs when a chemical imbalance of the blood affects the brain) and cognitive communication deficit. Record review of Resident #1's care plan, revised 05/04/2026, revealed he was care planned for antibiotic therapy, intravenous antibiotic medication, wounds, and foley catheter with interventions to maintain the drainage bag off the floor. Resident #122 Record review of Resident #122's face sheet, dated 05/13/2026, revealed an [AGE] year-old female, admitted with primary diagnosis of heart failure (heart cannot pump enough blood). Other pertinent diagnoses included stage 4 chronic kidney disease (severe reduction in kidney function) and neuromuscular dysfunction of bladder (impaired bladder control). An observation on 05/07/2026 at 10:46 a.m., revealed Residents #1 and #122 were both sitting in their wheelchairs in physical therapy with their catheter bags hanging from under their wheelchairs and touching the floor. During an interview on 05/08/2026 at 10:43 a.m., LVN B said infection control was ensured with catheter bags by making sure the bag was off the floor. He said even when a resident bed was in the lowest position, it must not touch the floor. LVN B said when residents go to therapy, catheter bags must hang on the wheelchair. He said catheter bags touching the floor could lead to infection by collecting what was on the floor (bacteria, dirt, dust, etc). During an interview on 05/08/2026 at 2:51 p.m., the DON revealed staff should follow the catheter policy and physician orders for catheter care when it comes to infection control. She said the catheter bag should be kept below the bladder and kept off the floor. The DON said the risk of catheter bags touching the floor was floors could be dirty and expose the bag to bacteria. The DON said it was important to prevent infections and watch for any signs and symptoms in residents. The DON said Resident #14 was a fall risk and having a low bed was a recent intervention and she would brainstorm (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ideas on keeping him safe while maintaining infection control. She said when residents were in wheelchairs, catheter bags should not touch the ground. Record review of the facility's Catheter- Care of policy, dated 06/2020, reflected: PurposeTo prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary.Procedure.III. Proper Techniques for Urinary Catheter Maintenance.D. Urinary Flow - an unobstructed flow of urine should be maintained. In order to achieve a free flow of urine:i. Collection bags should always be kept below the level of the bladder, including during transport, avoiding contact with the floor.F. Collection Bags -i. Take care to ensure the collection bag goes not touch the floor at any time.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident and/or resident's representative(s) in writing of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 (Resident #32 and Resident #139) of 6 residents reviewed for discharge planning. The facility failed to notify the residents or the residents' representative or POA of the transfer or discharge with the reasons for the move in writing in a language and manner they understand for Resident #32 and Resident #139.The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #32 and Resident #139.This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. A record review of Resident #32's face sheet, dated 05/07/2026, revealed the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and was her own responsible party. Her diagnoses included Chronic Obstructive Pulmonary Disease (acute flare-up, worsening of symptoms, increased breathlessness, cough, or sputum production beyond normal daily variations), Cognitive Communication deficit (often caused by brain injury or neurological disease), Type 2 Diabetes mellitus without complications (the presence of high blood sugar but without established damage to nerves, eyes, kidneys, or the cardiovascular system), and Atherosclerotic heart disease of native coronary artery without angina pectoris (where plaque builds up in the heart's original arteries without causing chest pain).A record review of Resident #32's MDS, dated [DATE], reflected that Resident ##32's BIMS score was 15/15, indicated that a person was cognitively intact. Resident #32 required dependent assistance (which meant staff did all the effort) to partial to moderate assistance (indicated staff did less than half the effort) with care.A review of Resident #32's progress note dated 03/19/2026 revealed that Resident #32 complained of chest pain and shortness of breath, order was given to send Resident #32 to the hospital. There was no evidence that a transfer or discharge notice had been provided to Resident #32 in writing or to the State LTC Ombudsman.During an interview on 05/06/2026 at 11:28 a.m., Resident #32 revealed she had never received a written letter when she was sent to the emergency room. She also stated she would have liked to have received a letter from the facility so she could review it later.2. A record review of Resident #139's face sheet, dated 05/07/2026, revealed the resident was an [AGE] year-old female initially admitted to the facility on [DATE], she was her own responsible party. Her diagnoses included Metabolic encephalopathy (a brain dysfunction resulting from chemical imbalances or organ failure rather than structural damage), Dysphagia (difficulty swallowing), Cognitive Communication deficit (often caused by brain injury or neurological disease), Obstructive Sleep Apnea (where breathing repeatedly stops and starts because throat muscles relax too much, causing the airway to collapse and block airflow during sleep), and Chronic Obstructive Pulmonary Disease (increased breathlessness, cough, or sputum production beyond normal daily variations).A record review of Resident #139's MDS, dated [DATE], reflected that Resident #139's BIMS score was 11/15, indicated moderate impairment in cognitive function. Resident #139 required dependent assistance (which meant staff did all the effort) to substantial to maximal assistance (which meant staff does more than half the effort) with care. A record review of Resident #139's progress notes dated 03/01/2026 revealed that she had altered mental status and an order was given to send Resident #139 to the hospital. There was no evidence that a transfer or discharge notice had been provided to Resident #139 in writing or to the State LTC Ombudsman. During an interview on 05/06/2026 at 1:33 p.m., Resident #139 revealed she had never received a written letter when she was sent to the emergency room. She also stated she would have liked to have received a letter from the facility so she could (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review it later.During an interview on 05/07/2026 at 12:28 p.m., the Social Worker revealed that she had not provided a written notification to the residents or their representatives regarding the transfer or discharge, including the reason for the transfer or discharge. She also stated that she had not sent a copy of the notice or a list of discharged residents to the State LTC Ombudsman, because she thought someone else at the facility sent them. During an interview on 05/08/2026 at 1:32 p.m., the DON revealed that the nursing staff only provide a transfer sheet to the hospital and the hospital sends clinicals back to the facility when the resident returns to the facility, so if the resident had questions after they returned nursing staff can answer those questions.During an interview on 05/08/2026 at 1:43 p.m., the Administrator revealed that the facility did not provide letters to residents or the resident's representative(s) when they discharged to the hospital. She added that the Social Worker sent a monthly list of residents who had been discharged to the State LTC Ombudsman.A record review of the facility's Transfer and Discharge policy revised 06/2020 states: .IV. Facility staff will provide the resident with reasonable advance notice of the transfer or discharge before it occurs. Unless exigent circumstances exist, the notice should be provided 30 days prior to the proposed date of transfer/discharge. Situations that may prevent 30 days' notice include:.C. The resident is experiencing urgent medical needs;.V. Cases in which 30 days' notice is not possible, notice of transfer or discharge should be provided to the resident of his/her responsible party as soon as practicable.VI. Documentation of written or telephone acknowledgement of the resident's transfer by the resident's personal representative may occur after the transfer in an emergency situation.Procedure .III. Prior to transfer/discharge, Social Services Staff or designee will provide the resident or responsible party with reasonable notice that the resident is going to be transferred or discharged .IV. The Facility may use Notice of Transfer/Discharge or another comparable form to provide the resident of his/her personal representative with advance notice of the transfer or discharge. The notice will include the following information:A. The reason the resident is being transferred/discharged ;B. The effective date of the transfer/discharge;C. The name, complete address and telephone number to which the resident is being transferred;D. A statement that the resident has the right to appeal the action to the state, contact information for the state entity which receives appeal hearing requests, and information for how to request an appeal;E. The name, address, and telephone number of the State Long Term Care Ombudsman;F. For residents with intellectual or developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; andG. For residents with a mental disorder, the mailing address and telephone number of the agency responsible for the protection and advocacy for individuals with mental disorders.V. The Facility will also send a copy of the Notice of Transfer/Discharge to the State Long Term Care Ombudsman for Facility initiated discharges.VI. If the information in the notice changes prior to the transfer or discharge, the Facility will provide updated information to the recipients of the notice as soon as practicable.A. If the changes to the notice are significant, such as a change is discharge destination, a new notice must be given that clearly describes the change(s) and resets the transfer/discharge date in order to provide 30-day advance notification.VII. Bed [NAME]. Before the Facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the Facility will provide written information to the resident or his/her personal representative which specifies:i. The duration of the bed-hold during which the resident is permitted to return and resume residence in the nursing facility; andii. The Facility's policies regarding bed-hold periods permitting a resident to return.B. At the time of transfer, the Facility will provide to the resident and a family member or personal representative written notice which specifies the duration of the bed-hold policy, and will inform the resident of his or her right to exercise a bed hold provision.According to eCFR S483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative (continued on next page)

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	05/08/2026

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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the Office of the State Long-Term Care Ombudsman.(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and(iii) Include in the notice the items described in paragraph (c)(5) of this section.S483.15(c)(4) Timing of the notice.(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged .(ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or(E) A resident has not resided in the facility for 30 days.S483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:(i) The reason for transfer or discharge;(ii) The effective date of transfer or discharge;(iii) The location to which the resident is transferred or discharged ;(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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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 residents were free of accident hazards for 1 of 6 (Resident #72) residents reviewed for accidents hazards and supervision.The facility failed to ensure Resident #72 did not obtain electronic cigarettes in her room.This failure could place residents at risk of being in an unsafe environment and at risk of accidents and injuries.Findings included:Record review of Resident #72's face sheet, dated 05/07/2026, revealed a [AGE] year-old female admitted to the facility with a primary diagnosis of idiopathic epilepsy (seizures that occur without a known cause). Other pertinent diagnoses include abnormalities of gait and mobility (abnormal walking pattern), type 2 diabetes mellitus (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels), mild cognitive impairment (noticeable cognitive decline, normal with aging), dementia (brain disease that alters brain function, causing cognitive decline), schizophrenia (severe mental disorder affecting how a person thinks, feels, and behaves, leading to hallucinations, delusions and disordered thinking), bipolar disorder (serious mental illness that causes mood swings, changes in energy, thinking, behavior, and sleep) and major depressive disorder (persistent feeling of sadness and loss of interest).Record review of Resident #72's MDS (a set of standardized assessments done on admission, quarterly, and with a significant change of condition, on each resident) revealed she had a BIMs (a standardized assessment to measure long and short-term memory) of 15, indicating intact cognitive function. Resident #72 was assessed as an active tobacco user.Record review of Resident #72's care plan, revised 05/01/2026, revealed Resident #72 was care planned for behavior problems, was resistive to care, and was found with a nicotine vape in her possession. Interventions included to intervene as necessary to protect the rights and safety of others, to praise the resident's appropriate behavior, and to educate the resident and family of the possible outcomes of not complying with treatment or care.Record review of Resident #72's progress notes revealed:- 02/03/2026: .Resident found to have a vape in her possession, resident gave to nurse, resident provided extensive education in regard to smoking policy, resident verbalized being very upset with nurse on duty .- 04/27/2026: [sic] Resident seen in courtyard with lit cigarette smoking after hours. Reminded of the smoking times. Resident then requested staff members to buy smoking device (vape) and that she would pay for it. Reminded resident that this was prohibited. Resident then asked staff if one of them could transport her to the [gas station] to pick up a vape device. Informed resident this was prohibited.During an observation on 05/06/2026 at 1:55 p.m., Resident #72 room door completely open, when the state surveyor walked by, Resident #72 was observed to have an object near her mouth. The state surveyor made eye contact with Resident #72, and she placed the object into the seat of her rollator. An interview at this time revealed Resident #72 was a smoker and she used electronic vapes. Resident #72 said she did not keep her electronic cigarettes with her; she said the facility had a box for smoking devices and it was locked. She said during smoking times, she would go outside to use her electronic cigarette. Resident #72 said she charged her electronic cigarettes herself during smoking times because she preferred to be the one to charge it. Resident #72 said she did not have issues with getting her electronic cigarettes during smoking times. She said she loved living at the facility.During an observation and interview on 05/07/2026 at 10:03 a.m., Resident #72 approached and used her rollator to sit next to the state surveyor. While talking to Resident #72, her cellphone rang, she stood up, opened the lid on the seat of her rollator to answer the cellphone call. Resident #72 left the lid open on the seat of her rollator and the state surveyor observed two electronic cigarettes in her rollator seat. During an interview on 05/07/2026 at 4:15 p.m., LVN A said she found electronic cigarettes in Resident #72's room before. She said she would tell the ADM when she found electronic cigarettes in the room, because Resident #72 was violating the smoking policy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and residents were not allowed to smoke or use electric cigarettes in their rooms. LVN A said Resident #72 was cognitive enough to make decisions, indicating Resident #72 knew she was not supposed to use electronic cigarettes in her room.During an interview on 05/08/2026 at 10:43 a.m., LVN B said if he found a resident with an electronic cigarette in their room, he would report it immediately to the ADM and DON. He said the resident would have to fill out a smoking violation form. LVN B said the risk of residents smoking or using electronic cigarettes in their room was the roommate could have a health condition like COPD (chronic obstructive pulmonary disease, progressive lung disease making it difficult to breathe) or the resident could burn down the facility.During an interview on 05/08/2026 at 1:05 p.m., the SW said she was an integral part of the smoking program, by providing the smoking schedule, policy, and reinforcing when there was noncompliance. She said if a resident was noncompliant and had electronic cigarettes in their room, she would ask the resident to turn it in voluntarily for their safety and everyone else's. The SW said on 05/07/2026, she and the ADM had removed electronic cigarettes from Resident #72's room. She said they really had to talk to Resident #72 to get both electronic cigarettes. The SW said if a resident was noncompliant with the smoking policy, there were smoking violation forms that she and the ADM filled out with the residents. She said if a resident continues to be noncompliant with the smoking policy, then the resident would be discharged to a safe environment. The SW said resident safety trumps rights.During an interview on 05/08/2026 at 1:46 p.m., the ADM revealed she had done a room search on Resident #72 the night before on 05/07/2026. The ADM said staff reviewed Resident #72's hospital records from 05/07/2026 and it said she had used her electronic cigarette in the hospital waiting room, so she had to do a room search because of the hazard. The ADM said she and the SW went to Resident #72's room and Resident #72 initially refused to give up the electronic cigarettes but finally did. The ADM said she was unsure of how Resident #72 got the electronic cigarettes, but it could be from a family member that visited often. She said Resident #72 had violated the smoking policy before and had filled out the smoking violation form once. She said the behavior was not consistent but was a hazard and resident safety was paramount (more important than anything else).The ADM said if the family member was providing the electronic cigarettes, the family member's visitation would have to limited and supervised. She said there were consequences for the resident and family member, if they violated the smoking policy.Record review of the facility's Smoking by Residents policy, dated 06/2020, reflected: PurposeTo respect resident choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers.PolicyI. Smoking is not allowed anywhere inside the Facility.II. The Facility permits smoking only in the area(s) designated by the Facility's Safety Committee.III. The Facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely.VI. This policy applies to the use of both cigarettes and e-cigarettes.Procedure.IX. All smoking materials will be stored in a secure area to ensure they are kept safe.X. Smoking sessions will be limited to 15-minute segments.A. The Facility shall determine the times of smoking sessions and post that informationXI. All smoking sessions will be supervised by Facility Staff members.