STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER: Life Care Center of Haltom		STREET ADDRESS, CITY, STATE, ZIP CODE: 2936 Markum Dr, Fort Worth, TX 76117	

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 3 residents (Resident #2) reviewed for abuse. The facility failed to implement the abuse and neglect policy and procedure regarding reporting an injury of unknown origin for Resident #1 to the Administrator or HHSC. These failures could place the residents at an increased risk for abuse and neglect. Findings included: Record review of the facility policy for Abuse, Neglect, and Exploitation, dated 06/17/24, indicated the following: The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes. For those allegations that meet the definition of a crime, the facility should refer to the Abuse - Reporting and Response - Suspicion of a Crime Policy. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Record review of Resident #2's Admission Record, dated 03/11/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's quarterly MDS Assessment, dated 02/20/25, reflected diagnoses included muscle weakness, dysphagia (difficulty swallowing), unilateral primary osteoarthritis (degenerative joint disease), vascular dementia, hemiplegia and hemiparesis (muscle weakness/partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident #1's BIMS score of 3 indicating his cognition was severely impaired. The MDS further revealed Section GG - Functional Abilities for Mobility Resident #1 needed partial/moderate assistance for chair/bed-to-chair transfer. Record review of Resident #2's care plan, revised 02/17/25, reflected: Focus: Patient with left side weakness following a CVA. Goal: The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. Interventions/Tasks: Reposition/Ambulate as tolerated and at least every 2 hours. Record review of Resident #2's EHR revealed no progress notes or assessments completed on 01/24/25. Record review of Resident #2's X-Ray dated 01/25/25 reflected the following: LEFT Elbow X-Ray 2 Views: BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen. JOINTS: No dislocation. Osteoarthritis is identified. SOFT TISSUES: The soft tissues are unremarkable. IMPRESSION: No acute osseous process. LEFT FOREARM X-RAY 2V: BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen. JOINTS: No dislocation. Osteoarthritis is identified. SOFT TISSUES: The soft tissues are unremarkable. IMPRESSION: No acute osseous process. Interview on 03/11/25 at 8:43 AM with Resident #2's Family Member B revealed on 01/24/25 a bruise was noticed on Resident #2's left forearm. Family Member B stated Resident #2 was unable to state how it happened and resident unable to move his left arm due to paralysis. Family Member B stated the bruise was reported to the DON and RN D on 01/24/25 and she followed-up with an email to the DON on 01/25/25 with no response. Family Member B stated it was unknown how the resident sustained the bruise. Family Member B stated x-rays were completed with no findings of fractures or dislocations. Family Member B stated a picture was taken on 01/25/25 a day after it was noticed. Family Member B stated visits were completed prior to 01/24/25 and no bruising was noticed on his left forearm. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a picture of Resident #2's left forearm provided by Family Member B on 03/11/25 reflected a significant dark red/purple bruising on resident left forearm. Bruise started from left mid forearm to elbow. Observation on 03/11/25 at 9:08 AM of Resident #2 awake and in bed. Resident #2 was not a good historian and was unable to answer questions. Observed Resident #2 skin color to be light skinned with light brown spots. No visible marks or bruises observed on Resident #2 left arm. Interview on 03/11/25 at 11:29 AM with LVN A revealed she was the nurse assigned to Resident #2 during the morning shift. She stated she could not recall the exact date, but Resident #2 family member had notified her about a bruise on Resident #2's left forearm. She stated she could not recall much of what happened; however, an x-ray was completed, and no fractures noted. LVN A stated prior to Resident #2 family member notifying her of the bruise, no one else had mentioned anything to her or any incidents. She stated Resident #2 was known to be combative but was unsure how the resident sustained the bruise. Interview on 03/11/25 at 2:45 PM with RN D revealed he was the nurse assigned to Resident #2. RN D stated about a month ago on 01/24/25, he was notified Resident #2 had a bruise on his left forearm. He stated he could not recall if it was a family member or DON who informed him about the bruise. RN D stated prior to 01/24/25 he was never informed of the bruises and none of his staff had reported to him of the bruise. RN D stated it was a significant bruise to the mid left forearm, approximately measuring 2x2 cm maybe a little bigger. RN D stated after he was notified, he obtained orders to complete an x-ray. He stated results were negative for any acute fractures. RN D stated he could not recall being told Resident #2 was being combative during showers. Interview on 03/11/25 at 4:44 PM with the DON revealed she was notified of Resident #2's bruise by Resident #2's family member. She stated after she interviewed the staff that had worked with Resident #2 it was informed Resident #2 had been combative during showers and resident was swinging his arms. She stated it appeared that was how the resident sustained the bruises. The DON stated Resident #2's left arm was not completely paralyzed and resident could still move it. She stated anyone was responsible for reporting to the state any alleged abuse, neglect concerns. The DON stated Resident #2's bruise was not suspicious of any abuse because Resident #1 was being combative during showers. She stated she could not recall but she believed it was reported to the Administrator. The DON stated Resident #2's bruise should have not been reported to the state. Interview on 03/11/25 at 5:33 PM with the Administrator revealed any concerns of abuse or neglect he was expected to be notified. He stated he was notified of Resident #2's bruise today (03/11/25). He stated the DON was made aware of Resident #2's bruise on January 24th. He stated he went back and looked at his emails and noticed he had an email on 01/27/25 regarding the bruise but was not sure if he read it. He stated based on the DON's investigation Resident #2's bruise did not meet the criteria for it to be reported. He stated an x-ray was completed and results were negative. He stated the bruises on Resident #2 arm could had been from Resident #2 being combative or different things of nature. The Administrator stated Resident #2's bruises was not considered an injury of unknown origin due to Resident #2 being known to be combative.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse to the Administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 3 residents (Resident #2) reviewed for abuse and neglect. The facility failed to report to HHSC when Resident #2 was found to have a significant bruise of unknown origin on his left forearm on 01/24/25. This failure to report could place the residents at risk for abuse. Findings included: Record review of Resident #2's Admission Record, dated 03/11/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's quarterly MDS Assessment, dated 02/20/25, reflected his diagnoses included muscle weakness, dysphagia (difficulty swallowing), unilateral primary osteoarthritis (degenerative joint disease), vascular dementia, hemiplegia and hemiparesis (muscle weakness/partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident #1's BIMS score of 3 indicating his cognition was severely impaired. The MDS further revealed Section GG - Functional Abilities for Mobility Resident #1 needed partial/moderate assistance for chair/bed-to-chair transfer. Record review of Resident #2's care plan, revised 02/17/25, reflected: Focus: Patient with left side weakness following a CVA. Goal: The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. Interventions/Tasks: Reposition/Ambulate as tolerated and at least every 2 hours. Record review of Resident #2's EHR revealed no progress notes or assessments completed on 01/24/25. Record review of Resident #2's X-Ray dated 01/25/25 reflected the following: LEFT Elbow X-Ray 2 Views: BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen. JOINTS: No dislocation. Osteoarthritis is identified. SOFT TISSUES: The soft tissues are unremarkable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IMPRESSION: No acute osseous process. LEFT FOREARM X-RAY 2V: BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen. JOINTS: No dislocation. Osteoarthritis is identified. SOFT TISSUES: The soft tissues are unremarkable. IMPRESSION: No acute osseous process. Interview on 03/11/25 at 8:43 AM with Resident #2's Family Member B revealed on 01/24/25 a bruise was noticed on Resident #2's left forearm. Family Member B stated Resident #2 was unable to state how it happened and resident unable to move his left arm due to paralysis. Family Member B stated the bruise was reported to the DON and RN D on 01/24/25 and she followed-up with an email to the DON on 01/25/25 with no response. Family Member B stated it was unknown how the resident sustained the bruise. Family Member B stated x-rays were completed with no findings of fractures or dislocations. Family Member B stated a picture was taken on 01/25/25 a day after it was noticed. Family Member B stated visits were completed prior to 01/24/25 and no bruising was noticed on his left forearm. Record review of a picture of Resident #2's left forearm provided by Family Member B on 03/11/25 reflected a significant dark red/purple bruising on resident left forearm. Bruise started from left mid forearm to elbow. Observation on 03/11/25 at 9:08 AM of Resident #2 awake and in bed. Resident #2 was not a good historian and was unable to answer questions. Observed Resident #2 skin color to be light skinned with light brown spots. No visible marks or bruises observed on Resident #2 left arm. Interview on 03/11/25 at 11:29 AM with LVN A revealed she was the nurse assigned to Resident #2 during the morning shift. She stated she could not recall the exact date, but Resident #2 family member had notified her about a bruise on Resident #2's left forearm. She stated she could not recall much of what happened; however, an x-ray was completed, and no fractures noted. LVN A stated prior to Resident #2 family member notifying her of the bruise, no one else had mentioned anything to her or any incidents. She stated Resident #2 was known to be combative but was unsure how the resident sustained the bruise. Interview on 03/11/25 at 2:45 PM with RN D revealed he was the nurse assigned to Resident #2. RN D stated about a month ago on 01/24/25, he was notified Resident #2 had a bruise on his left forearm. He stated he could not recall if it was a family member or DON who informed him about the bruise. RN D stated prior to 01/24/25 he was never informed of the bruises and none of his staff had reported to him of the bruise. RN D stated it was a significant bruise to the mid left forearm, approximately measuring 2x2 cm maybe a little bigger. RN D after he was notified, he obtained orders to complete an x-ray. He stated results were negative for any acute fractures. RN D stated he could not recall being told Resident #2 was being combative during showers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 4:44 PM with the DON revealed she was notified of Resident #2's bruise by Resident #2's family member. She stated after she interviewed the staff that had worked with Resident #2 it was informed Resident #2 had been combative during showers and resident was swinging his arms. She stated it appeared that was how the resident sustained the bruises. The DON stated Resident #2's left arm was not completely paralyzed and resident could still move it. She stated anyone was responsible for reporting to the state any alleged abuse, neglect concerns. The DON stated Resident #2's bruise was not suspicious of any abuse because Resident #1 was being combative during showers. She stated she could not recall but she believed it was reported to the Administrator. The DON stated Resident #2's bruise should have not been reported to the state. Interview on 03/11/25 at 5:33PM with the Administrator revealed any concerns of abuse or neglect he was expected to be notified. He stated he was notified of Resident #2's bruise today (03/11/25). He stated the DON was made aware of Resident #2's bruise on January 24th. He stated he went back and looked at his emails and noticed he had an email on 01/27/25 regarding the bruise but was not sure if he read it. He stated based on the DON's investigation Resident #2's bruise did not meet the criteria for it to be reported. He stated an x-ray was completed and results were negative. He stated the bruises on Resident #2 arm could had been from Resident #2 being combative or different things of nature. The Administrator stated Resident #2's bruises was not considered an injury of unknown origin due to Resident #2 being known to be combative. Record review of the facility's Abuse, Neglect, and Exploitation, dated 06/17/24, reflected: The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes. For those allegations that meet the definition of a crime, the facility should refer to the Abuse - Reporting and Response - Suspicion of a Crime Policy. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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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** 44140 Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for 2 of 5 residents (Resident #1 and Resident #2) reviewed for accidents. 1. The facility failed to ensure Resident #1 was provided with adequate supervision to prevent falls when Resident #1 fell when attempting to self-transfer, due to staff not returning to assist her. 2. CNA E failed to obtain assistance from another staff member when using a mechanical lift to transfer Resident #2 from his geri chair to his bed on 01/21/25. Agency CNA failed to obtain assistance from another staff member when using a mechanical lift to transfer Resident #2 from the shower chair to his bed on 1/23/25. This failure could place residents at risk for accidents and injuries. Findings included: 1. Record review of Resident #1's Admission Record, dated 03/11/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's quarterly MDS Assessment, dated 02/24/25, reflected her diagnoses included unspecified dementia, history of falling, difficulty in walking, muscle weakness, essential hypertension (high blood pressure) and chronic kidney disease. Resident #1's BIMS score of 7 indicating her cognition was severely impaired. The MDS further revealed Section GG - Functional Abilities for Mobility Resident #1 needed partial/moderate assistance for chair/bed-to-chair transfer. Record review of Resident #1's care plan, revised date 01/16/25, reflected the following: Focus: ADL Assistance and Therapy Services needed to maintain or attain highest level of function. Goal: Resident has a goal to be independent with ambulation by completion of skilled services. Resident wishes to attain prior level of function. Interventions/Tasks: Assist with mobility and ADLs as needed. Use [mechanical] lift for transfers. Focus: Resident is at risk for falls r/t impaired mobility/balance, cognitive deficits, history of falls, malnutrition, arthritis, DMII , and receiving antidepressant medication. 2/24/25 Unwitnessed fall attempting to transfer self without calling for assistance. Goal: Resident's risk for falls will be minimal with fall interventions through review date. Interventions/Tasks Staff will monitor resident when up in w/c for tiredness and assist her to bed in a timely manner. Call light within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Incident Report dated 02/24/25 05:15 PM reflected: Un-witnessed Fall. Incident Description: CNA notified this nurse that resident is on the floor. upon entry resident room noted she is lying on the floor on her left side close to her bed. resident wheelchair was behind her and was on locked. Skin assessment done, noted hematoma to left side of her head with 2 small laceration. range of motion done, neuro checks done. resident [mechanical] lift from the floor to bed. resident stated she try to go to bed and fall. Immediate Action Taken: skin assessment, range of motion and neuro checks done. resident [mechanical] lift by staff to bed. ice pack applied. Injuries Observed at Time of Incident: No injuries observed at time of incident. Mental Status: Oriented to Person/Oriented to Place. Notes: 2 small laceration to left side of her head. Record review of Resident #1's progress notes dated 02/24/25 21:13 [9:13PM] by LVN A reflected: CNA notified this nurse that resident is on the floor. upon entry resident room noted she is lying on the floor on her left side close to her bed. resident wheelchair was behind her and was on locked. Skin assessment done, noted hematoma to left side of her head with 2 small laceration. range of motion done; neuro checks done. resident [mechanical] lift from the floor to bed. Notified DON and family member while this nurse was in resident room taking care of her. Her [family] request for her mother to transfer to hospital. Notified NP about resident and her [family] requested. Order to transfer resident to hospital. resident transfer to [hospital name] by [ambulance] around 6:40pm. Record review of Resident #1's hospital discharge summary, dated 2/28/25, reflected the following: Patient is a 87 y.o. female with past medical history significant for T2DM (type 2 diabetes mellitus), HTN (high blood pressure), CKD stage IV (Chronic Kidney Disease), gout, dementia, CVA (cerebrovascular accident), and HLD (hyperlipidemia) who was brought to [hospital name] ED [emergency department] after a mechanical GLF (Ground Level Fall) while she was trying to transfer from her wheelchair to the bed. Patient hit her had but no LOC (Level of Consciousness). Denies prodromal symptoms. Since falling she has been experiencing headache and right thigh pain. She has felt overall weak for the last several weeks. CT head and cervical spine and XR pelvis/hips neg (negative) for acute injury - Discharge to long term care facility Record review of video footages reflected the following: Dated 02/24/25 at 20:59 [8:59 PM] Resident #1 was observed sitting in her wheelchair watching television. CNA C entered the room to ask resident if she was doing okay and if she needed anything. Resident #1 is heard saying she wanted to go to bed, CNA C stated okay and told Resident #1 she would return. Dated 02/24/25 at 22:44 [10:44 PM] Resident #1 was observed sitting in her wheelchair, leaning forward against her bed and then falling to the floor. -Video does not show Resident #1 hitting her head, it only showed resident's bottom hitting the floor and then her upper body landed underneath her bed. Dated 02/24/25 at 23:08 [11:08 PM] LVN A observed to enter the room asking Resident #1 how she ended up on the floor and then LVN A exited the room. Dated 02/24/25 at 23:11[11:11 PM] LVN A, CNA B and CNA C were observed in the room checking resident and with a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 02/24/25 at 23:13 [11:13 PM] LVN A, CNA B and CNA C were observed transferring Resident #1 back in bed via mechanical lift. Interview on 03/05/25 at 10:12 AM with Resident #1 Family Member A revealed there was video footage of Resident #1 asking a staff she wanting to go to bed, staff took too long to return, so resident attempted to transfer by herself and ended up falling. Family Member A stated the video footage time stamps were incorrect, she stated it happened in the afternoon. She stated on 02/24/25 at 2:39PM Resident #1 asked the staff that she wanted to be put to bed and then at 4:44 PM Resident #1 had the fall. Family Member A stated Resident #1 laid on the floor for about 23 minutes before someone came to the room to assist her. Family Member A stated resident was transported to the hospital for further evaluation. Family Member A stated there was no fractures. Observation and interview on 03/05/25 at 10:33 AM revealed Resident #1 in bed, she stated she was doing well. Resident #1 stated she had a fall a couple of weeks ago, could not recall the exact date or time. She stated she was in her wheelchair, and she had told someone she wanted to go to bed. Resident #1 could not recall the name of staff she asked. She stated it took about 23 minutes for some to come in the room, she stated she tried to get in bed by herself and she fell to the floor. She stated she hit her head but does not recall having any injuries. Interview on 03/11/25 at 11:29 AM with LVN A revealed Resident #1 had an unwitnessed fall in her room while resident was trying to self-transfer from her wheelchair to bed. She stated upon entry of Resident #1's room she observed Resident #1 on the floor, wheelchair was behind the resident and locked. She stated she asked Resident #1 what happened, and Resident #1 stated she wanted to go to bed. She stated Resident #1 had a small hematoma, and two tiny superficial laceration on the head. She stated Resident #1 refused to go to the hospital, but family requested resident to go. Interview on 03/11/25 at 12:47 PM with CNA B revealed she was working the day Resident #1 had a fall from her wheelchair. She stated she could not recall the exact date; however, she came in for her 2PM-10PM shift. She stated she was not assigned to Resident #1, but she still went over to check on resident to see how she was doing. She stated she checked on Resident #1 around 2:45 PM, and resident was sitting in her wheelchair. CNA B stated Resident #1 did not mentioned anything about wanting to go to bed. She stated she asked Resident #1 who she wanted to work with that day, and CNA C was standing at the door and CNA C stated she was assigned to Resident #1. CNA B stated around dinner time before 5PM, she was called to the nurses' station by LVN A to assist with Resident #1. She stated herself, LVN A and CNA C went to Resident #1 and Resident #1 was observed to be on the floor. She stated Resident #1 stated she was trying to transfer herself to the bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Haltom		STREET ADDRESS, CITY, STATE, ZIP CODE 2936 Markum Dr Fort Worth, TX 76117	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 1:19 PM with CNA C revealed about 2 weeks ago, unknown of the exact date, Resident #1 had a fall. CNA C stated she came in for her 2-10PM shift, she was the CNA assigned to Resident #1. She stated she was doing her arounds and she got to Resident #1's room between 2:00PM-2:30PM. She stated Resident #1 told her she wanted to go to bed, she stated Resident #1 was a mechanical lift transfer. CNA C stated she went out to get the mechanical lift and to request assistance to transfer Resident #1. She stated when in route she was stopped by LVN A, LVN A told her Resident #1 had been reassigned to CNA B. She stated after she was told Resident #1 was no longer assigned to her, she went to go check on her other residents. CNA C stated she observed CNA B in Resident #1's room and assumed Resident #1 might had told her to put her to bed. CNA C stated she did not follow up to ensure if Resident #1 was transferred to bed and she did not notify anyone Resident #1 had requested to be put to bed because she was reassigned. CNA C stated between 3:45 PM- 4PM, she was gathering the residents to transfer them to the dining area for dinner, she went to the room across from Resident #1 room. She stated she looked over to Resident #1's room and noticed Resident #1 was not in the room. She stated she did not enter the room, she looked inside the room from the hallway. She stated she walked to the nurse's station and asked LVN A where was Resident #1. She stated LVN A went to Resident #1's room and noticed resident was on the floor. She stated she assisted LVN A, CNA B with picking up Resident #1 via mechanical lift. She stated CNA B thought Resident #1 was assigned to her; however, she thought Resident #1 was assigned to CNA B. CNA C stated it was a miscommunication between LVN A, CNA B, and herself on who was assigned to Resident #1. Follow-up interview on 03/11/25 at 2:02 PM with LVN A revealed when Resident #1 had the unwitnessed fall, Resident #1 was initially assigned to CNA C but then CNA B told her that Resident #1 requested CNA B to be her CNA. LVN A stated CNA B stated the DON was made aware of the change and for her to notify CNA C. She stated she notified CNA C of the reassignment at around 2:30PM-3PM. She stated CNA C never mentioned anything about Resident #1 wanting to go to bed. She stated there was a miscommunication between the CNAs on who was assigned to Resident #1. She stated CNA B thought Resident #1 remained assigned to CNA C and CNA C thought Resident #1 was reassigned to CNA B. However, if Resident #1 asked CNA C to put her to bed, it was the responsibility for CNA C to complete the task or notify someone about it and then continue with her work. She stated it was Resident #1 right to be put to bed when requested. LVN A stated CNA C failed to obey request. She stated the potential risk would be resident falling. Interview on 03/11/25 at 4:44 PM with the DON revealed she was not present at the time of Resident #1's fall; however, it was reported Resident #1 had asked an aide to put her to bed. She stated the aide had left the room to go get help. She stated she was not sure of about the details; however, there was a miscommunication on who was assigned to Resident #1. She stated Resident #1 was first assigned to CNA C but then was reassigned to CNA B. She stated she notified LVN A of the change and the LVN A notified the CNAs of the reassignments. The DON stated Resident #1 had told CNA C to put her to bed but did not. She stated Resident #1 did not get transfer back to bed in which Resident #1 attempted to self-transfer and fell . The DON stated her expected time for when a resident request to be put to bed should not be more than 15 minutes, depending on how busy they are. The DON stated CNA C failed to communicate Resident #1 request to be put to bed, she stated it should had been reported to the nurse or task should had been completed. She stated the potential risk on this incident would have been resident not receiving care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Haltom	2936 Markum Dr Fort Worth, TX 76117

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 5:33 PM with the Administrator revealed he was made aware of Resident #1's fall by the resident's family. He stated Resident #1's family observed resident on the floor via video footage and did not notify anyone about it until when they arrived at the facility. The Administrator stated when he asked the family why they did not report the fall to the facility, the family response was We just wanted to see how long it would take for the staff to enter the room. He stated Resident #1 had asked CNA C to put her in bed but did not. He stated there was some miscommunication on who was assigned to Resident #1. He stated the expectation was for CNA C to complete the task and put Resident #1 to bed. He stated everything was a risk if not completing a task. 2. Record review of Resident #2's Admission Record, dated 03/11/25, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's quarterly MDS Assessment, dated 02/20/25, reflected his diagnoses included muscle weakness, dysphagia (difficulty swallowing), unilateral primary osteoarthritis (degenerative joint disease), vascular dementia, hemiplegia and hemiparesis (muscle weakness/partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident #1's BIMS score of 3 indicating severe. The MDS further revealed Section GG - Functional Abilities for Mobility Resident #1 needed partial/moderate assistance for chair/bed-to-chair transfer. Record review of Resident #2's care plan, revised date 02/17/25, reflected: Focus: Patient with left side weakness following a CVA. Goal: The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. Interventions/Tasks: Reposition/Ambulate as tolerated and at least every 2 hours. Focus: Patient with impaired mobility/balance, poor safety awareness requiring total assist with ADLs. Goal: The resident maintain his current level of function as possible. Interventions/Tasks: Transfers - total assist X 2 with use of [mechanical] lift. Record review of video footage dated 01/21/25 at 15:44 [3:44 PM] it was observed Resident #2 being transferred via mechanical lift by CNA E. Resident #2 was observed to be on the sling and being lowered to the bed. Record review of video footage dated 01/23/25 at 12:37 PM it was observed Resident #2 to be on the shower chair. Resident #2 was transferred via mechanical lift from shower chair to bed by Agency CNA. Interview on 03/11/25 at 8:43 AM with Resident #2's Family Member B revealed there was video footage of facility staff completing a mechanical lift transfer by one person. Family Member B stated it had been brought up to the facility attention but was unknown if it was addressed. Family Member B stated there had been on incident from the one person transfers. Observation on 03/11/25 at 9:08 AM of Resident #2 awake and in bed. Resident #2 was not a good historian and was unable to answer questions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Haltom		STREET ADDRESS, CITY, STATE, ZIP CODE 2936 Markum Dr Fort Worth, TX 76117	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 3:55 PM with CNA E revealed she had been employed for about 2 months. She stated she had assisted with Resident #2 mechanical lift transfers. She stated Resident #2 required a mechanical lift for transfers and was a two person assist. CNA E stated she had not completed Resident #2 transfer by herself. CNA E reviewed video footage and stated she was the one completing the transfer but could not recall why she did it by herself. She stated she had always done two-person transfer. She stated she was in-serviced on mechanical lift transfer but could not recall the exact date of when it was completed. She stated the potential risk of transferring a resident via mechanical lift by one-person could lead to resident falling. Interview on 03/11/25 at 4:16 PM with ADON revealed when a resident transfers via mechanical lift there should be two staff completing the transfer. She stated her expectation was for two staff to complete the transfer from beginning to end. She stated the risk would be a safety risk of resident falling. Interview on 03/11/25 at 4:44 PM with the DON revealed the facility expectation was for two staff to complete a transfer via mechanical lift. The DON reviewed both video footage, she stated one of the CNAs was CNA E and the other CNA was an Agency CNA. She stated the Agency CNA no longer worked at the facility. She stated she was unaware of the video footage and was never informed Resident #2 had been transferred via mechanical lift by one person. She stated her staff should know better and should never complete a transfer by themselves when using a mechanical lift. She stated it was not safe to do a one person transfer via mechanical lift and it was not the facility policy. Follow-up interview on 03/11/25 at 5:40 PM the DON revealed she was unable to obtained Agency CNA's contact information. Record review of CNA E Total Mechanical Lift Competency Checklist was completed on 01/04/25. Record review of the facility's Fall Management policy, revised 11/25/2024, reflected the following: To promote patient safety and reduce patient falls by proactively identifying, care planning and monitoring of patients' fall indicators . Each resident receives adequate supervision and assistance devices to prevent accidents. Record review of the facility's Transfer with a mechanical lift, long-term care policy, revised 05/20/2024, reflected the following: The facility will ensure that two associates should be present during the transfer of residents who require a mechanical lift .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #2) reviewed for accuracy of medical records. The facility failed to ensure a bruise found on Resident #2's left forearm was documented accurately and completely in the resident's EHR when it was noticed on 01/24/25. This failure could place the residents at risk for incomplete and inaccurate clinical records which could lead to miscommunication or a delay in services. Findings included: Record review of Resident #2's Admission Record, dated 03/11/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's quarterly MDS Assessment, dated 02/20/25, reflected his diagnoses included muscle weakness, dysphagia (difficulty swallowing), unilateral primary osteoarthritis (degenerative joint disease), vascular dementia, hemiplegia and hemiparesis (muscle weakness/partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. Resident #1's BIMS score of 3 indicating his cognition was severely impaired. The MDS further revealed Section GG - Functional Abilities for Mobility Resident #1 needed partial/moderate assistance for chair/bed-to-chair transfer. Record review of Resident #2's care plan, revised date 02/17/25, reflected: Focus: Patient with left side weakness following a CVA. Goal: The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date. Interventions/Tasks: Reposition/Ambulate as tolerated and at least every 2 hours. Record review of Resident #2's EHR revealed no progress notes or assessments completed on 01/24/25 of resident bruise. Record review of Resident #2's X-Ray dated 01/25/25 reflected the following: LEFT Elbow X-Ray 2 Views: BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen. JOINTS: No dislocation. Osteoarthritis is identified. SOFT TISSUES: The soft tissues are unremarkable. IMPRESSION: No acute osseous process. (continued on next page)

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

LEFT FOREARM X-RAY 2V:

BONES: No acute fracture or focal osseous lesion. Diffuse osteopenia is seen.

JOINTS: No dislocation. Osteoarthritis is identified.

SOFT TISSUES: The soft tissues are unremarkable.

IMPRESSION: No acute osseous process.

Interview on 03/11/25 at 8:43 AM with Resident #2's Family Member B revealed on 01/24/25 a bruise was noticed on Resident #2's left forearm. Family Member B stated Resident #2 was unable to state how it happened and resident unable to move his left arm due to paralysis. Family Member B stated the bruise was reported to the DON and RN D on 01/24/25 and she followed-up with an email to the DON on 01/25/25 with no response. Family Member B stated it was unknown how the resident sustained the bruise. Family Member B stated x-rays were completed with no findings of fractures or dislocations. Family Member B stated a picture was taken on 01/25/25 a day after it was noticed. Family Member B stated visits were completed prior to 01/24/25 and no bruising was noticed on his left forearm.

Record review on 03/11/25 of a picture of Resident #2's left forearm reflected a significant dark red/purple bruising on resident left forearm. Bruise started from left mid forearm to elbow.

Observation on 03/11/25 at 9:08 AM of Resident #2 awake and in bed. Resident #2 was not a good historian and was unable to answer questions. Observed Resident #2 skin color to be light skinned with light brown spots. No visible marks or bruises observed on Resident #2 left arm.

Interview on 03/11/25 at 2:45 PM with RN D revealed he was the nurse assigned to Resident #2. RN D stated about a month ago on 01/24/25, he was notified Resident #2 had a bruise on his left forearm. He stated he could not recall if it was a family member or DON who informed him about the bruise. RN D stated prior to 01/24/25 he was never informed of the bruises and none of his staff had reported to him of the bruise. RN D stated it was a significant bruise to the mid left forearm, approximately measuring 2x2 cm maybe a little bigger. RN D after he was notified, he obtained orders to complete an x-ray. He stated results were negative for any acute fractures.

Interview on 03/11/25 at 4:44 PM with the DON revealed when an incident occurs, a skin injury was noted or a change of condition happens her expectations was for her staff to document in the progress notes, complete an incident report, document that all parties had been notified and assessments to be completed. She stated she was aware RN D had not documented in the Resident #2's chart regarding the bruise. She stated she had been clear with her staff regarding her expectations regarding documentation. She stated the potential of not documenting could lead to not knowing if things were being done.

Follow-up interview on 03/11/25 at 5:28 PM with RN D revealed he could not recall being told Resident #2 was being combative during showers. RN D stated he failed to document the bruise on Resident #2's clinical records. He stated he should had completed an incident report, assessments, document that the family and doctor were made aware. He stated the potential risk of not documenting can lead to something coming back and not knowing what happened.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 5:33 PM with the Administrator revealed he was notified of Resident #2's bruise today (03/11/25). He stated there was no documentation regarding Resident #2's bruise. He stated it was the responsibility of the charge nurses to document in the resident's progress notes, complete an incident report and to complete assessments. Record review of the facility's Nursing Documentation policy, revised 09/05/2024, reflected the following: This facility will ensure nursing documentation is consistent with professional standards of practice, the state nurse practice act, and any state laws governing the scope of nursing practice. Medical Records: The medical record shall reflect a resident's progress toward achieving their person-centered plan of care objectives and goals and the improvement and maintenance of their clinical, functional, mental and psychosocial status. Staff must document a resident's medical and non- medical status when any positive or negative condition change occurs, at a periodic reassessment and during the annual comprehensive assessment. The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions.