STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675935	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Haltom	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, the facility ensured a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable; and a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 6 residents (Resident #1 and Resident#2) reviewed for pressure ulcers/injuries. The facility failed to provide pressure relieving devices to support the residents being repositioned on their side. This failure could place residents at risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings include: 1. Record review of Resident #1's face sheet, dated 05/06/25, reflected the resident was admitted to the facility on [DATE]. Resident #2 was diagnosed with cellulitis of left lower limb (bacteria infection of the skin and the tissue beneath the skin.) contusion (bruise, occurs when blood vessels are damaged due to trauma) of left lower leg and Crohn's disease (inflammatory bowel disease (IBD) that causes chronic inflammation of the gastrointestinal (GI) tract, which can affect any part from the mouth to the anus). Record review of Resident #1's admission MDS Assessment, dated 03/03/25, reflected she had a BIMS score of 8, which indicated moderate cognitive impairment. Resident#1 did not have a wound infection (other than the foot). Resident#1 was at risk of pressure ulcers/injuries, Resident #1 had one or more unhealed pressure ulcers. Resident #1 had 1 stage 2 pressure ulcer at entry, Stage 2 pressure ulcers meant Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Resident #1's skin and ulcer/injury treatments included: pressure ulcer/injury care, application of nonsurgical dressings and applications of ointments/medications. (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident#1 care plan, initiated on 02/27/2025, reflected: Resident#2's focus reflected, the Resident was admitted with a stage II pressure ulcer, and continued to have a potential for pressure ulcer development r/t cognitive deficits, impaired mobility, incontinence, history of ulcer, dislocation or fright shoulder, arthritis (swelling and tenderness of one or more joints), and osteoporosis (a condition that weakens bones and increases the risk of fractures.). Initiated on 02/27/2025. Resident #1's goal reflected, the resident would have intact skin, free of redness, blisters or discoloration by/through review, initiated on 02/27/2025. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Assist resident to turn and reposition self at least every 2 hours. Record review of Resident#1 progress note dated 04/30/25 by WCN reflected, Patient seen by [NAME] physician this morning and daughter notified of the status and progression of wound and exacerbated due to generalized decline of patient. Patient is non-compliant with offloading wounds as well as turning and repositioning. patient education provided to patient with the help of staff translating the importance of offloading wounds, patient verbalized understanding. Record review of Resident#1 wound report dated 05/06/05 reflected assessment date of 04/30/25 with an acquired onset date of 4/16/25, sacrum pressure that was unstageable. Sacrum ulcer had a length of 19, width of 11 and depth of 0.1. Resident#1 wound status for sacrum was classified as deterioration. Observation on 05/06/25 at 9:07 AM revealed Resident #1 was laying on her back with no support. There was a wedge on the dresser. Attempted to interview resident#2 on 05/06/25 at 9:10 AM and resident#2 did not answer surveyor. 2. Record review Resident #2's face sheet, dated 05/06/25, reflected the resident was admitted to the facility on [DATE]. Resident #2 was diagnosed with Urinary tract infection,)(a very common type of infection in your urinary system) site not specified, unspecified protein-calorie malnutrition,(reduced availability of nutrients leads to changes in body composition and function) adult failure to thrive(Older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), Dementia (General decline in cognitive abilities that affects a person's ability to perform everyday activities), unspecified convulsions (rapid involuntary muscle contractions), type 2 diabetes mellitus without complications (chronic condition characterized by insulin resistance and elevated blood sugar levels), contracture of muscle (Condition where muscle fibers permanently shorten, leading to stiffness and reduced flexibility) in the right and left upper arm, (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's admission MDS Assessment, dated 04/02/25, reflected she had a BIMS score of 0, which indicated severe cognitive impairment. Resident #2 did not have a wound infection (other than the foot). Resident#2 was at risk of pressure ulcers/injuries, Resident #2 had one or more unhealed pressure ulcers. Resident #2 had 7 stage 2 pressure ulcers at entry, Stage 2 pressure ulcers meant Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Resident #2 had 1 stage 4 pressure ulcer at entry which meant stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Resident #2 MDS had 1 unstageable pressure injury presented as deep tissue on entry. Resident #2's skin and ulcer/injury treatments included: pressure reducing device for bed and pressure ulcer/injury care. Record review of Resident #2 care plan goals, initiated on 04/02/25, reflected: Minimize risk for symptoms of infection through next review. Resident #2's interventions revised on 05/02/25 reflected enhanced barrier precautions .weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Record review of Resident #2 care plan, initiated on 04/23/25 and revised on 05/02/25, reflected: Resident #2 had pressure ulcers: DTI to left, proximal, lateral heel DTI to left, distal, lateral foot DTI to left, lateral, fifth toe, Stage IV to left, medial foot (3-28-25) Placing her at risk for complications and developing new pressure ulcers r/t immobility, hx of ulcers, contractures Record review of Resident #2's progress notes reflected, on 04/29/25 by LVN D .reposition every 2 hours and PRN. With bilateral boots on. With multiple wounds. Wound treatment done by the treatment nurse. With diagnosis of end stage skin failure. Resident[sic] is aware of his mother condition but refused all the other alternatives. Record review of Resident #2's MAR, dated 05/06/25, reflected active order date of 04/11/25 which indicated enhanced barrier precautions for skin opening requiring a dressing every shift. Record review of Resident #2's wound report, dated 05/06/05, reflected assessment date of 04/30/25 with admitted on set on 03/28/25, sacrum pressure that was a stage 4. The Sacrum ulcer had a length of 9, width of 6.2 and depth of 0.1. Resident #2's wound status for sacrum was classified as other-not at goal. Observation on 05/06/25 at 9:44 AM revealed Resident #2 was laying on her back with no support. Observed wedge on top of her dresser. Attempted to interview Resident#2 and was not able to make out her words. Interview on 05/06/25 at 10:00 AM, the WCN stated residents were supposed to be on their side not laying on their back and applying pressure to the sacrum wounds. The WCN stated sometimes Resident #1 would refuse to be repositioned if she had pain. The WCN stated the resident was monitored for pain and given pain medications as needed and scheduled. The WCN stated she did training about repositioning residents, using pressure relieving devices. The WCN stated she was one person, and it took the whole nursing team to help residents wounds heal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/06/25 at 2:53 PM, CNA B stated she repositioned residents every 2 hours to prevent pressure sores, bed sores and to keep the blood flowing. CNA B stated she had just finish Resident #2's bath and did not want to keep moving her because she knew the WCN was coming to do wound care. CNA B stated she did not place wedge since she would be moved again. CNA B stated staff wear PPE to prevent the spread of bacteria. Interview on 05/06/25 at 3:06 PM, LVN C stated she usually worked over night and would reposition residents every 2 hours with the wedge to put them on their side. Interview on 05/06/25 at 3:12 PM, the DON stated Resident # 1 and Resident #2 could be repositioned on one side, then back and to the opposite side every 2 hours. The DON stated Pressure relieving devices are used to help promote healing. DON stated, Blood vessels are like hoses and when you are seating on the skin the blood vessel is closed, and oxygen cannot come through and cannot prevent cell and tissue death. Record review of the facility's policy titled skin integrity and pressure ulcer/injury prevention and management, revised, 07/09/24, reflected Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care:a. reposition at least every 2-4 hours (per NPIAP standards) as consistent with overall patient goal and medical condition. b. utilizes positioning devices to keep bony prominences from direct contact. c. ensure proper body alignment when side-lying;

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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 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 two of six residents (Resident #2 and #3) residents reviewed for infection control. 1. The facility failed to provide Enhanced barrier precaution signage and PPE outside of Resident#2 door. 2. The facility failed to provide PPE inside and/or outside of Resident# 3 room. These failures could place residents at risk for infection. Findings include: 1. Record review Resident #2's face sheet, dated 05/06/25, reflected the resident was admitted to the facility on [DATE]. Resident #2 was diagnosed with Urinary tract infection,)(a very common type of infection in your urinary system) site not specified, unspecified protein-calorie malnutrition,(reduced availability of nutrients leads to changes in body composition and function) adult failure to thrive (Older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), Dementia (General decline in cognitive abilities that affects a person's ability to perform everyday activities), unspecified convulsions (rapid involuntary muscle contractions), type 2 diabetes mellitus without complications (chronic condition characterized by insulin resistance and elevated blood sugar levels), contracture of muscle (Condition where muscle fibers permanently shorten, leading to stiffness and reduced flexibility), right and left upper arm, Record review of Resident #2's admission MDS Assessment, dated 04/02/25, reflected she had a BIMS score of 0, which indicated severe cognitive impairment. Resident #2 did not have a wound infection (other than the foot). Resident#2 was at risk of pressure ulcers/injuries, Resident #2 had one or more unhealed pressure ulcers. Resident #2 had 7 stage 2 pressure ulcers at entry, Stage 2 pressure ulcers meant Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Resident #2 had 1 stage 4 pressure ulcer at entry which meant stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Resident #2 MDS had 1 unstageable pressure injury presented as deep tissue on entry. Resident #2's skin and ulcer/injury treatments included: pressure reducing device for bed and pressure ulcer/injury care. Record review of Resident #2 care plan goals, initiated on 04/02/25, reflected: Minimize risk for symptoms of infection through next review. Resident #2's interventions revised on 05/02/25 reflected enhanced barrier precautions .weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2 care plan, initiated on 04/23/25 and revised on 05/02/25, reflected: Resident #2 had pressure ulcers: DTI to left, proximal, lateral heel DTI to left, distal, lateral foot DTI to left, lateral, fifth toe, Stage IV to left, medial foot (3-28-25) Placing her at risk for complications and developing new pressure ulcers r/t immobility, hx of ulcers, contractures Record review of Resident #2's MAR, dated 05/06/25, reflected an active order, dated 04/11/25, which indicated enhanced barrier precautions for skin opening requiring a dressing every shift. Record review of Resident #2's census reflected she transferred rooms on 04/15/25. 2. Record review of Resident #3's face sheet reflected the resident was admitted to the facility on [DATE]. Resident #3 was diagnosed with diabetes mellitus (insulin deficiency or resistance) due to underlying condition with diabetic neuropathy (nerve damage) unspecified, acquired absence of other right toe's, acquired absence of left leg below knee and end stage renal disease (Kidney failure). Record review of Resident #3's admission MDS Assessment, dated 04/10/25, revealed she had a BIMS score of 15, which indicated no cognitive impairment. Resident #3 was at risk for developing pressure ulcers. Record review of Resident #3's care plan, dated 05/06/25, reflected Resident#3 had break in skin integrity initiated on 04/08/25. Minimize risk for symptoms of infection .Interventions included treatments as ordered. Record review of Resident #3's MAR, dated 05/06/25, reflected an active order dated 04/11/25, which reflected enhanced barrier precautions for skin opening requiring a dressing every shift. Record review of Resident #3's MAR reflected an active order, dated 04/07/25, which indicated monitor for s/s of infection to shunt/fistula site every shift. Observation and interview on 05/06/25 at 9:43 AM revealed Resident #2 did not have an enhanced barrier precaution sign and did not have PPE inside or outside Resident#2 door. The resident did not have PPE inside of her room. Observed CNA A start to move Resident #2 and the WCN told her to stop because they needed a gown and gloves to provide wound care. The WCN stated Resident #2 had just transferred rooms and she should be on enhanced barrier precautions because of her wounds. The WCN stated wearing PPE helped protect the residents from bacteria and cross-contamination. CNA A returned to Resident #2's room with PPE. Observation on 05/06/25 at 10:00 AM revealed Resident #2 had an enhanced barrier precaution sign outside the door which reflected enhanced barrier precautions everyone must: Clean their hands, including before entering and when leaving the room. Wear gloves and gown for the following high-contact residents care activities: Wound care any skin opening requiring a dressing. Interview on 05/26/25 at 10:02 AM, CNA A stated staff should use hand sanitizer before entering the room wash hands before exiting. CNA A stated PPE was used to protect the residents and staff . CNA stated PPE is usually located outside the residents doors. Interview on 05/26/25 at 2:37 PM, the staffing coordinator stated it was important to put on PPE because we have bacteria that could infect residents at any point of entry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/06/25 at 2:40 PM, the IP stated the sign and PPE outside of door reminded staff to put on PPE before high contact care. Resident #2 was transferred over to a different hall and the ending nurse and receiving nurse should have been responsible for putting the sign back up and PPE outside of the resident room. The IP stated, I'm ultimately responsible to check to make sure PPE is available and signage was up. The IP stated she would hook the PPE storage on Resident #3's room and then someone would take it down and she did not know who. IP stated nursing staff could find additional PPE central supplies. The IP stated she was responsible for providing training to the staff. The IP stated it was important to protect the residents from cross contamination . Interview on 05/06/25 at 2:53 PM, CNA B stated staff and visitors should wear PPE according to the sign outside the resident door. Each precaution was used to help prevent infection. Interview on 05/06/25 at 3:12 PM, the DON stated PPE was used to prevent residents with artificial opening from getting anything (bacteria, infection) in them. Record review of in-service on 03/28/25 by IP titled Enhanced Barrier Precautions: Enhanced barrier precautions were implemented for all residents who have PICC line, feeding tube, foley catheter, .a wound that requires a dressing. Please remember to wear your PPE during all required activities while caring for these residents. This is done to decrease the spread of MDROs (Multidrug-Resistant Organisms) from resident to resident that may be present on our clothing. This protects you as well as the resident. Record review of the facility's policy, titled Enhanced barrier precautions revised 04/25 reflected EBP are indicated for residents with any of the following . 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO .a) Wounds generally include chronic wounds, not shorter lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers .Enhanced Barrier Precautions (EBP)- refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Record review of the facility's policy titled Infection Prevention and Control Program (IPCP) and plan, revised 06/24 reflected: 16. Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices. c. Personal Protective Equipment (PPE)