

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 08/07/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 3 of 5 residents (Residents #2 and #3, and #4) Record reviewed for abuse.1. The facility failed to ensure Resident #1 did not verbally abuse Resident #2 on 03/18/25 .2. The facility failed to ensure Resident #1 did not verbally abuse Resident #3 on 06/28/25. 3. The facility failed to ensure Resident #4 had the right to be free from abuse when CNA A threatened to hit the resident back on 06/06/25. This failure could place residents at risk for abuse. Findings included:1. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included non-Alzheimer's dementia (various types of dementia that do not involve Alzheimer's disease, including dementia with Lewy bodies, vascular dementia, and frontotemporal dementia), anxiety disorder (mental health issues characterized by excessive fear and anxiety that interferes with ADLs), and depression (a mood disorder characterized by persistent feelings of sadness and loss of interest). Resident #1 had a BIMS of 15 which indicated his cognition was intact. The MDS further reflected the resident did not exhibit physical or verbal behaviors. Record review of Resident #1's care plan initiated on 06/28/25 reflected the resident was at risk for behaviors related to history of initiating verbal aggression toward previous roommate. Interventions included to educate the resident on boundaries related to appropriate communication techniques, problem solving, techniques, and who to discuss with, without becoming verbally aggressive with people. Other interventions included to take resident triggers into consideration with considering roommate placement. Record review of Resident #2's annual MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and his diagnoses included non-Alzheimer's dementia. Resident #2 had a BIMS of 9 which indicated his cognition was moderately impaired. The MDS further reflected the resident did not exhibit physical or verbal behaviors. Record review of undated Resident #2's current care plan did not reflect any physical or verbal behaviors. Record review of Resident #2's progress noted dated 03/18/25 documented by LVN B reflected the following: This nurse went to picked [sic] up morning trays after resident ate breakfast from [hall] and heard both resident [sic] were exchanging words. This nurse went to resident's room and asked both of them to stop. [Resident #1] was verbally abusing his roommate and stated he will knock him out. This nurse told him to moved [sic] back to his space and to stopped [sic] verbally abusing and threatening his roommate. This nurse moved the other resident out of the room an brought him to the nursing station. Observation and interview on 08/06/25 at 10:25 AM with Resident #1 revealed he was in his room sitting on his rolling walker and did not have a roommate at the time. The resident said he had trouble with previous and stated Resident #2 alleged Resident #1 had threatened to kill him but that never happened. Resident #1 further stated he now had a room to himself and hope he would not get a new roommate because he like it peaceful. Observation and interview on 08/07/25 at 12:47 PM with Resident #2 revealed he was in his recliner and appeared to be hard of hearing. The resident was asked about the incident with Resident #1 (03/18/25), and Resident #2 said it has occurred a long time ago. Resident #2 said he and Resident #1 argued about the room temperature and Resident #1 had threatened him, but he did not recall what was said. Resident #2 said he was not scared at the time because he knew Resident #1 was just talking to talk and he knew how to defend himself if he needed to. Resident #2 stated he was moved to another room, and he did not have any concerns and felt safe at the facility. Interview on 08/06/25 at 1:26 PM with LVN B revealed Resident #1 did not like to have roommates and he had been moved a couple of times due having issues with prior residents. LVN B said she was making rounds, did not recall how long ago, when she heard Residents #1 and #2 argue and when she entered the room Resident #2 wanted to turn the AC up because he was cold, and Resident #1 did not want that. LVN B said she told both residents to calm down and Resident #2 said he was going to punch the shit out of him. LVN B said she separated both residents and took Resident #2 to another room and also said Resident #2 did not appear to be afraid with the threat. LVN B stated she had never seen Resident #1 have any behaviors towards others and he only bickered with roommates because he wanted a room to himself. Interview on 08/06/25 at 1:17 PM with LVN D revealed Resident #1 was pleasant and socialized with others, staff and residents. LVN D stated she had never heard Resident #1 be verbally abusive towards other and the resident normally stayed in his room on his computer. Interview on 08/06/25 at 1:44 PM with the ADON revealed she recalled the</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin source and misappropriation of resident property are reported immediately but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 5 residents (Resident #2) Record reviewed for reporting. The facility failed to report to the Administrator when Resident #1 verbally threatened Resident #2 on 03/18/25. This failure places residents at risk for further abuse. Findings included:Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. Resident #1 had a BIMS of 15 which indicated his cognition was intact. The MDS further reflected the resident did not exhibit physical or verbal behaviors. Record review of Resident #1's care plan initiated on 06/28/25 reflected the resident was at risk for behaviors related to history of initiating verbal aggression toward previous roommate. Interventions included to educate the resident on boundaries related to appropriate communication techniques, problem solving, techniques, and who to discuss with, without becoming verbally aggressive with people. Other interventions included to take resident triggers into consideration with considering roommate placement. Record review of Resident #2's annual MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and his diagnoses included non-Alzheimer's dementia. Resident #2 had a BIMS of 9 which indicated his cognition was moderately impaired. The MDS further reflected the resident did not exhibit physical or verbal behaviors. Record review of Resident #2's undated current care plan did not reflect any physical or verbal behaviors. Record review of Resident #2's progress noted dated 03/18/25 documented by LVN B reflected the following: This nurse went to picked [sic] up morning trays after resident ate breakfast from [hall] and heard both resident were exchanging words. This nurse went to resident's room and asked both of them to stop. [Resident #1] was verbally abusing his roommate and stated he will knock him out. This nurse told him to moved [sic] back to his space and to stopped [sic] verbally abusing and threatening his roommate. This nurse moved the other resident out of the room an brought him to the nursing station.Observation and interview on 08/06/25 at 10:25 AM with Resident #1 revealed he was in his room sitting on his rolling walker and did not have a roommate at the time. The resident said he had trouble with previous and stated Resident #2 alleged Resident #1 had threatened to kill him but that never happened. Resident #1 further stated he now had a room to himself and hope he would not get a new roommate because he like it peaceful. Observation and interview on 08/07/25 at 12:47 PM with Resident #2 revealed he was in his recliner and appeared to be hard of hearing. The resident was asked about the incident with Resident #1 (03/18/25), and Resident #2 said it has occurred a long time ago. Resident #2 said he and Resident #1 argued about the room temperature and Resident #1 had threatened him, but he did not recall what was said. Resident #2 said he was not scared at the time because he knew Resident #1 was just talking to talk and he knew how to defend himself if he needed to. Resident #2 stated he was moved to another room, and he did not have any concerns and felt safe at the facility. Interview on 08/06/25 at 1:26 PM with LVN B revealed Resident #1 did not like to have roommates and he had been moved a couple of times due having issues with prior residents. LVN B said she was making rounds, did not recall how long ago, when she heard Residents #1 and #2 argue and when she entered the room Resident #2 wanted to turn the AC up because he was cold, and Resident #1 did not want that. LVN B said she told both residents to calm down and Resident #2 said he was going to punch the shit out of him. LVN B said she separated both residents and took Resident #2 to another room and also said Resident #2 did not appear to be afraid with the threat. LVN B stated she had never seen Resident #1 have any behaviors towards others and he only bickered with roommates because he wanted a room to himself. Interview on 08/06/25 at 1:17 PM with LVN D revealed Resident #1 was pleasant and socialized with others, staff and residents. LVN D stated she had never heard Resident #1 be verbally abusive towards other and the resident normally stayed in his room on his computer. Interview on 08/06/25 at 1:44 PM with the ADON revealed she heard both residents had to be separated because they were not getting along but did not recall the details. The ADON said she did not report the incident to the Administrator but assumed he had been told about the incident by the Previous DON.Interview on 08/06/25 at 3:32 PM with the Previous DON revealed she recalled there had been an incident between Resident #1 and #2 but</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have evidence that all alleged violations in response to allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 of 5 residents (Resident #5) Record reviewed for abuse. The facility failed to thoroughly investigate and an incident when CNA A asked Resident #5 for \$0.50 to buy a soda on 07/23/2025. This failure places the residents at risk for misappropriation and exploitation. Findings included: Record review of Resident #5's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. The resident had a BIMS of 14 which indicated her cognition was intact. Record review of Resident #5's care plan dated 05/06/25 reflected the resident was noted to be making false accusations against staff, stating staff are not answering her call light or attending to her needs, states they make her stay in wet brief for hours when staff are in the room every time she puts call light on and at least every hour to attend to her needs. Interventions included anticipate and meet the resident's needs and if reasonable, discuss the resident's behaviors and reinforce why behavior is inappropriate and/or acceptable to the resident. Record review of the facility's Provider Investigation Report dated 07/30/25 reflected the following: When was the allegation made? 07/23/25 Investigation Summary CNA stated she did request \$.50 for drink from resident. CNA provided ED with \$.50 and the money was returned to resident. CNA was terminated. Action to prevent recurrence CNA was suspended pending outcome of investigation and safety rounds were completed on residents on D Hall. Agency Action Post-Investigation Associate was terminated and education was completed regarding ANE prevention and reporting. Further review of the provider investigation report revealed there was no evidence of staff education and/or interviews and there was no evidence and other resident interviews were submitted during the time of the incident. Observation and interview on 08/06/25 at 10:07 AM with Resident #5 revealed she was in bed watching TV and when asked if staff has asked her for money recently, she said aide (CNA E) asked her for \$.50 and she (Resident #5) did not know what to do so she just gave it to her. Resident #5 said she did not want to give her the money but felt like she had to so after that Resident #5 said she reported it to the Administrator. Resident #5 said that was the first time CNA E has asked her for money and no one else has done so since. Resident #5 said the Administrator took care of the issue and she felt safe at the facility. Interview on 08/06/25 at 10:07 AM with the Administrator revealed Resident #5 called him (07/23/25) and said CNA E asked to borrow \$.50 and it sounded like the resident did not want to but felt forced. The Administrator said he spoke with CNA E who admitted asking Resident #5 for the money and also said she knew it was wrong. CNA E was suspended pending the investigation and later terminated for the incident. Interview on 08/07/25 at 2:03 PM with CNA E revealed she did not ask Resident #5 for \$.50 (07/23/25) but it was the resident who wanted to give her \$1 for a soda. CNA E said that she already had \$.50 on her and only accepted \$.50 from the resident so she could buy her soda but had planned to pay the resident back. CNA E admitted knowing it was wrong to accept the money from Resident #5 but because she knew she was going to pay her back CNA E did not think much about it. The following day after the incident, the Administrator approached her (CNA E) to ask about the money and she told him she had taken the money and also said she had the money in her pocket to pay Resident #5 back so the Administrator took the money from her and said he would give it back to the resident. Interview on 08/07/25 at 2:09 PM with the Interim Social Worker revealed she only did 2 safe surveys with residents and was told to stop by the Administrator because she had new admissions to work on. Further interview on 08/07/25 at 1:48 PM with the Administrator revealed his investigation with Resident #5 and CNA E was complete because the aide had admitted to asking and taking money from Resident #5 and there was nothing else to complete. The Administrator said the facility held fire drills around the same time as the incident so during the fire drill staff were talked to about taking money from residents. Record review of documentation provided by the Administrator on 08/06/25 reflected there was a fire drill completed on 07/31/25. Record review of an email sent by the Administrator on 08/11/25 reflected there 8 resident safe surveys conducted on 07/29/25 in which one of the questions included: Has an associate asked to borrow your personal belongings including money for their own use? with no concerns. Record review of the facility's Abuse-Conducting an Investigation policy, dated May 2025, reflected the following: Policy It is the policy of this facility that allegations of abuse (abuse, neglect, mistreatment, including injuries of unknown origin</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 5 residents (Resident #5) reviewed for wound care . The facility failed to ensure Resident #5's stage 4 pressure ulcer wound her sacrum was covered with a dressing.This failure could place residents at risk of severe pain, and lead to systemic infections causing harm for residents.Record review of Resident #5's entry MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE] and readmitted on [DATE]. The resident had moderate cognitive impairment with a BIMS score of 11, and her diagnoses included diabetes mellitus, and the MDS reflected she had a Stage 4 pressure ulcers.Record review of Resident #5's care plan dated 06/26/25 reflected: Focus: Resident#5 has actual impairment to skin integrity. admitted with Stage 4 pressure ulcer to sacrum. Goal: [Resident #5] Risk for developingnew pressure ulcers will be minimal with nursing interventions through the Record review date. Interventions: Assess location, size and treatment of skin injury. Report abnormalities, failure to heal, sign and symptoms of infection and maceration. Treatment as ordered.Record review of Resident #5's physician order dated 07/23/25 reflected: Cleanse Sacrum with NS, pat dry, apply Santyl, and cover with gauze island with border dressing everyday shift AND as needed if soiled or dislodged.Observation and interview on 08/07/24 at 9:12 AM with the Wound Care Nurse of Resident #5's Stage 4 pressure ulcer on her sacrum revealed the pressure ulcer did not have a wound care dressing. The Wound Care Nurse asked Resident #5 what happened to the wound dressing, and the Wound Care Nurse told the resident to let somebody know when the dressing fell off. The Wound Care Nurse stated she was not aware Resident #5 did not have a dressing on. Observation of the pressure ulcer revealed there were no signs of infection noted. Interview on 08/07/25 at 9:32 AM revealed Resident #5 was lying in bed. Resident #5 stated she was doing well. Resident #5 stated she admitted to the facility with wounds on her sacrum. Resident #5 stated she was not aware the dressing was off. She stated CNA K performed incontinence care on her around 8:00 AM to 8:30 AM. Interview on 08/07/25 at 9:39 AM with CNA K revealed she was the CNA assigned to Resident #5. She stated she had provided incontinence care to Resident #5. She stated she noticed the resident's dressing was peeling off, and it had fecal matter on it, so she removed the dressing. She did not recall the time when she provided Resident #5 with incontinence care. She stated she knew she was supposed to notify the nurse or the treatment nurse about the soiled dressing, but she did not. She stated it had slipped her mind, and she forgot to notify the nurse. She stated she was in a hurry to finish giving another resident a shower on another hall because that resident had an early pick up of around 8:30 AM for appointment. She stated she was aware she was not allowed to remove dressings, and she knew she was supposed to call the nurse to come and replace the soiled peeling dressing with a clean dressing but not for her to remove it. She stated Resident #5 did not complain of pain. CNA K stated she should have notified the nurse. She stated the risk of not having a dressing on would be infection and wound getting bigger. She stated she had done training on calling the nurse if a dressing had become soiled and not to removing the dressing. Interview on 08/07/25 at 9:48 AM with the Wound Care Nurse revealed Resident #5 had a physician's order to cleanse and cover the wound daily and an order for as needed in case the dressing get soiled or dislodged. She stated she was not made aware that Resident #5's dressing had come off. She stated when she completed wound care yesterday (08/06/25) on Resident #5, she had applied a dressing over it. She stated her expectations were for the nurses to monitor the dressing every shift and if the dressing came off, they had as needed treatment orders to follow. She stated C N A's were not supposed to touch or remove the dressing. She stated her expectation was for CNA K to call her or the nurse to replace the soiled dressing. She stated the potential risk if the dressing comes off would be a decline in the wound status and infections. She stated she prefer the C N As to notify the nurses because they could leave the wound open and the resident happen to have a bowel movement and that also predisposes Resident#5 to the risk of infection. She stated she had provided staff with training regarding turning and repositioning. She provided a training record dated 02/21/25, which reflected CNA K was not in attendance as she was newly hired to the facility in April.Interview on 08/07/25 at 9:54 AM with the RN J, who was the charge nurse, revealed she was not made aware that Resident #5's dressing had come off. She stated her expectation was for CNA K to report to her so that she could replace</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 2 of 3 residents (Residents #5 and #7) reviewed for infection control. 1. CNA G failed to wear a PPE when she provided Resident #5, who was on enhanced barrier precautions, with incontinence care on 08/06/2025 with a physician order for PPE dated 07/16/2025. 2. CNA H failed to perform proper hand hygiene practices to include changing her gloves and washing/sanitizing her hands when she provided Resident #7 incontinence care on 08/07/2025. These failures placed residents at risk of cross contamination and the spread of infection.</p> <p>1. Record review of Resident #5's entry MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE] and readmitted on [DATE]. The resident had moderate cognitive impairment with a BIMS score of 11, and her diagnoses included diabetes mellitus, and the MDS reflected she had a Stage 4 pressure ulcers. Record review of Resident #5's care plan dated 06/26/25 reflected: Focus: Resident#5 has actual impairment to skin integrity. admitted with Stage 4 pressure ulcer to sacrum Goal: [Resident #5] Risk for developing new pressure ulcers will be minimal with nursing interventions through the Record review date. Interventions: Enhanced barrier precaution. Record review of Resident #5's physician order dated 07/16/25 reflected: Enhanced barrier precautions for wound requiring dressing. Observation on 08/06/25 at 03:29 PM revealed CNA G was preparing to provide Resident #5 with incontinent care. Resident #5's door had the following sign: enhanced barrier precautions -providers and staff must also wear Gown and Gloves. There was PPE hanged on the door. CNA G performed hand hygiene and donned a pair of gloves. She put all the supplies together and without putting on a PPE gown, CNA G then provided Resident #5 with incontinent care. Interview via phone on 08/07/25 at 11:32 AM, CNA G stated she did not know whether Resident #5 was on enhanced barrier precautions. She stated she was aware that PPE was supposed to be worn during care for residents on precautions. She stated she knew she did wear a gown while providing the resident incontinence care, but she did not explain why she did not wear a gown. She stated she was aware Resident #5 had wounds. She stated the risk of not putting on PPE was that it could lead to the spread of infection. She stated she had done training on enhanced barrier precautions for residents with wounds, gastronomy tubes, and Foley catheters. 2. Record review of Resident #7's comprehensive MDS assessment dated [DATE] reflected the resident was [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's cognition was severely impaired with a BIMS score of 0. The resident's diagnoses included hypertension (high blood pressure) and aphasia (a language disorder that affects a person's ability to communicate). Record review of Resident #7's care plan dated 05/10/2025 reflected: Focus: Resident#7 was incontinent of bladder and bowel rule out dementia. Goal: Resident will be clean, dry and odor free with no occurrence of skin impairment through next Record review date Interventions: Observe for non-verbal cues resident may need to use the toilet. Observation on 08/07/25 at 10:03 AM revealed CNA H providing Resident #7 with incontinence care after the resident had had a bowel movement. CNA H cleansed the resident's abdominal folds and the perineal area inside out. She helped the resident to turn using the draw sheet. She cleansed the resident's buttocks while still using one hand to hold the resident in place. She did not change her gloves after cleansing bowel movement on Resident #7. She went directly to applying a clean brief without changing her gloves or performing hand hygiene. She left resident comfortable and then removed her gloves and washed her hands. Interview on 08/07/25 at 10:15 AM with CNA H revealed she was supposed to change her gloves and perform hand hygiene after cleansing the bowel movement and before applying a clean brief, but she did not. She stated she forgot, and she knew she was supposed to remove her soiled gloves and wash her hands while moving from a dirty to clean environment. She stated changing gloves and performing hand hygiene during incontinence care would prevent contamination which could cause infection. She stated she had done training on infection control, to include changing gloves and hand washing. Interview on 08/07/25 at 1:04 PM, the ADON stated she expected staff to wear a gown and gloves while providing care to a resident, who was on enhanced barrier precautions. She stated she was not sure of what the facility policy reflected regarding when providing incontinence care on resident with wounds. She stated she expected when staff saw the PPF by a resident's door they should wear the PPE. She stated wearing PPE would prevent cross</p>		