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	03/05/2026

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 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** Based on interview and record review the facility failed to ensure that an alleged violation involving abuse was reported immediately, but not later than 2 hours after the allegation was made for 1 (Resident #1) of 10 residents reviewed for abuse, neglect, exploitation, or mistreatment. LVN B failed to immediately report an allegation of sexual abuse on 02/17/26 at 3:00 AM after Resident #2 wandered into the wrong room, and Resident #3 alleged that Resident #1 was molested by Resident #2. The Administrator was made aware of the allegation by Resident #3 on 02/17/26 at 11:00 AM and reported it to the state agency at that time. This failure could place residents at risk for continued abuse.Findings included: Record review of Resident #1's Discharge MDS Assessment, dated 02/17/26, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] and discharged on 02/17/26. The resident's BIMS score was not indicated. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required maximal assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident # 1's active diagnoses included: hypertension (high blood pressure), acute embolism and thrombosis (sudden onset of blood clots), acute respiratory failure (sudden onset of lungs inability to adequately transfer oxygen to the blood or remove carbon dioxide), dysphasia (language impairment), and reduced mobility (difficulty walking or standing). Record review of Resident #1's Care Plan, dated 01/30/26, reflected the resident had a BIMS score of 10, which indicated cognition was moderately impaired, with interventions that included: asking yes/no questions to determine needs, using consistent and simple communication, cueing and reorienting as needed, keeping consistent routines, a referral to speech language pathology, and using step-by-step tasks. Record review of Resident #2's Discharge MDS Assessment, dated 02/19/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 02/19/26. The resident's BIMS score was not indicated. The MDS Assessment under Section B-Hearing, Speech, and Vision, reflected no indication of any deficits. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #2 required supervision or touch assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident # 2's active diagnoses included: diabetes mellitus (body's inability to control blood glucose levels), chronic kidney disease (long-term loss of kidney function), hypertension (high blood pressure), vascular dementia (progressive cognitive decline caused by reduced blood flow to the brain, often due to stroke), delirium (severe confusion). Record review of Resident #2's Care Plan, revised 02/18/26, reflected the resident was at risk for elopement, with interventions that included: using activities to divert the resident from exit-seeking behavior and provide for safe wandering. The care plan also reflected Resident #2 wandered into a female's room and was noted to be touching resident by straightening her blanket while she was lying on bed, with no noted injuries and interventions that included: anticipating Resident #2's needs, intervening as necessary to protect the rights and safety of others, and providing one-on-one care until further notice. Record review of Resident #3's Discharge MDS Assessment, dated 02/20/26, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE] and discharged on (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/20/26. The resident's BIMS score was 11, which indicated cognition was moderately impaired. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #3 required setup or clean-up assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident # 3's active diagnoses included: diabetes mellitus (body's inability to control blood glucose levels), myocardial infarction (heart attack), dysphasia (language impairment), muscle weakness (reduction in strength). Record review of Resident #3's Care Plan, dated 12/31/26, reflected there was no focus that indicated the resident made false allegations. Record review of an intake investigation worksheet (incident), dated 02/17/26, reflected in part the following: Incident informationDate and Time of the Incident: 2/17/2026 3:00 AM Date facility first learned of Incident? 2/17/2026 11:00 AM Who made or reported the allegation: Resident/Client Other who made/reported the allegation:Incident Category: Abuse On what shift incident occur? Night . Narrative of The Incident A resident [Resident #3] reported during the night, a male resident [Resident #2] entered her room, went to her roommate [Resident #1] and molested her. The female resident [Resident #1] allegedly molested, had no memory of the event or no new acute psychologic symptoms noted. Roommate [Resident #3] placed call light on and staff came to room. Upon entrance, it was noted the female resident [Resident #1] was resting with eyes closed and blankets were pulled up to her clavicle (collarbone) and were still in an orderly fashion, not disturbed.As staff redirected male resident [Resident #2] out of room, the roommate [Resident #3] followed the staff out and said to the staff, He molested her. Actions and Notifications Skin assessments completed and no new areas of concern were noted. There also were no psychological changes were noted. 1:1 started with male resident [Resident #2]. During an interview on 03/05/26 at 12:42 PM, LVN B stated she worked at the facility since 07/15/25. She stated she worked with Resident #1 on 02/17/26, when there was an incident of alleged sexual abuse. LVN B stated Residents #1 and #3 were roommates, and Resident #2 resided on the same hall. LVN B stated she was doing rounds at approximately 3:00 AM when she noticed the bathroom light on in Residents #1 and #3's room, and she went in to find Resident #2 feeling around on Resident #1's bed like he was trying to find his way back to bed. She stated Resident #2 was visually impaired and would often wake up in the middle of the night to use the bathroom and wander into the wrong room. LVN B stated as she and the aide escorted Resident #2 back to his room, Resident #3 followed behind them and started yelling He molested my roommate. LVN B stated when she checked on Resident #1, she was sound asleep with the covers pulled all the way to her neck and undisturbed. LVN B stated Resident #1 was very sensitive and would have been hollering in discomfort if her sleep had been disturbed in any way. She stated overnight was not her normal shift and there was a lot going on that night, so it slipped her mind to report the allegation to the Administrator; however, she did write it down on a note pad. LVN B stated she had been a nurse for a long time and was also trained on abuse and neglect at the facility, so she knew the protocol for reporting abuse. LVN B also stated based on her observations, she did not feel Resident #1 had been sexually abused. LVN B stated she did not complete a head-to-toe assessment of Resident #1 to check for any injuries or signs of abuse and only took a general inspection of the resident's state. LVN B stated later that morning during the shift change meeting, she heard that Resident #3 reported the allegation to someone and that was when she remembered that she forgot to tell the Administrator. LVN B stated not reporting allegations could place residents at risk of harm and she was suspended from work for not doing so. During an interview on 03/05/26 at 1:45 PM, Resident #2's RP stated Resident #2 was currently at a different nursing facility with a secured unit due to his wandering. The RP stated Resident #2 had vision loss due to complications from diabetes and a stroke, and he would often get lost while wandering around trying to find his room or the bathroom. The RP stated Resident #2 did not have a history of aggression or sexually inappropriate behaviors and would not harm anyone. An attempted interview on 03/05/26 at 2:10 PM with Resident #3's RP was unsuccessful due to no response to call. During an interview on 03/05/26 at 3:31 PM, the DON stated she learned of the alleged incident from the Administrator. The DON stated she told LVN A, who was the wound care (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse, to complete a head-to-toe assessment on Resident #1 and there were no findings of any injuries. The DON stated Resident #2 was visually impaired and had a history of wandering into the wrong room; however, the resident did not have a history of having sexually inappropriate behaviors. The DON stated she was shocked by the allegation. The DON stated she trained all staff on recognizing and reporting abuse and neglect at least monthly, so LVN B should have known to report the allegation immediately or within the 2-hour timeframe. The DON stated LVN B did not report the allegation, it was reported by Resident #3. During an interview on 03/05/26 at 4:20 PM, the Administrator stated he was informed that Resident #3 wanted to speak with him in her room. The Administrator stated he went to speak with Resident #3, and she informed him that Resident #2 wandered into her room and was rubbing on Resident #1. The Administrator stated Resident #3 demonstrated by rubbing up and down on the front of her thighs and waist area. The Administrator stated Resident #3 told him that she turned on her call light and before she could get out of bed and into her wheelchair, staff were in the room. The Administrator stated this was reported to him on 02/17/26 at approximately 11:00 AM and the alleged incident occurred at approximately 3:00 AM. The Administrator stated he immediately started an investigation and reported the allegation to the state agency. The Administrator stated LVN B reported when she entered Residents #1 and #3's room, she found Resident #2 feeling around on Resident #1's bed near her legs and the covers were pulled up to her neck. The Administrator stated LVN B informed him that Resident #1 did not appear to be disturbed; however, Resident #3 was yelling that Resident #1 had been molested by Resident #2. The Administrator stated Resident #2's RP informed that when the resident was home, he would often wander during the night, get confused and end up trying to get in her bed; however, Resident #2 did not have any inappropriate behaviors. The Administrator stated even with the alleged incident occurring at 3:00 AM, the expectation was for LVN B to notify him immediately, especially for an allegation of sexual abuse. The Administrator stated LVN B reported that her observations did not indicate that the allegation occurred and this was based on the condition Resident #1 was found in and Resident #2's history of wandering. However, the Administrator stated it was not for LVN B to make that determination as it was his responsibility to investigate allegations. The Administrator stated LVN B was suspended for 3 days and given a final warning because that was not her first time being slow to report an incident. The Administrator stated it was important to report alleged abuse within the specified timeframe to prevent further abuse and protect the integrity of the investigation. During an interview on 03/05/26 at 5:00 PM, LVN C stated she worked at the facility for about 7 months. She stated she was trained on abuse and neglect prevention upon hire and several times monthly. LVN C was able to describe abuse and neglect and stated she would report an allegation of abuse to the Administrator, who was the abuse coordinator, immediately no matter what time it occurred. LVN C stated she worked overnights and had called the Administrator during the middle of the night or early morning to report incidents before. During further interview on 03/05/26 at 5:45 PM, the Administrator stated it was his understanding that the timeframe for reporting alleged abuse did not start until he was notified; however, his expectation was for staff to report it to him immediately. The Administrator reiterated that he reported the allegation to the state agency as soon as he was made aware of it. He also stated LVN B's reason for not reporting the allegation was because she did not have cause to suspect that the abuse really occurred. During an interview on 03/10/26 at 12:23 PM, Resident #1's RP returned the surveyor's call and stated the facility notified her of the alleged incident on 02/17/26. The RP stated Resident #1 was visited by family that morning and she reported that a male entered her room, but she did not know what he wanted. The RP stated Resident #1 was very coherent and would have reported to the family if she was abused in any way. The RP stated she had no concerns for Resident #1 being abused at the facility. Record review of the facility's Chapter 3: Abuse, Neglect, and Exploitation policy, dated 10/04/22 and reviewed 06/17/24, reflected in part the following: Abuse - Identification of Types PolicyIt is the policy of this facility to identify abuse, neglect, and exploitation of residents and misappropriation of resident property. This includes but is (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not limited to identifying and understanding the different types of abuse and possible indicators. Procedure The facility will apply the following definitions to identify abuse, neglect, and exploitation. 2. Facility staff should report any suspected abuse, neglect, or exploitation noted based on thebelow definitions to the Executive Director or Director of Nursing. Refer to the Abuse -Reporting and Response Policy for additional direction.Risk Factors that May Provoke Reactions in Residents, Staff, or Visitors The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke areaction by staff, residents, or others, such as: .e. Wandering into other's rooms/space; . Record review of the facility's policy titled Chapter 3: Abuse, Neglect, and Exploitation, dated 10/04/2022, revised 04/09/2024, and reviewed 06/17/2024, reflected in part the following: Abuse - Reporting and Response - Suspicion of a Crime PolicyThe facility will ensure reporting reasonable suspicion of crimes against a resident or individualreceiving care from the facility within prescribed timeframes to the appropriate entities, consistentwith Section 1150B of the Elder Justice Act The facility will ensure that all covered individuals, i.e., the owner, operator, employee, manager,agent or contractor, report reasonable suspicion of crimes, as required by Section 1150B of theElder Justice Act. The facility will provide annual notification to each covered individual of their obligation tocomply with the reporting requirements under section 1150B(b) of the Elder Justice Act.Reporting Procedures 1. Once an associate or other covered individual at the facility (e.g., medical director) forms areasonable suspicion that a crime has been committed against a resident or other individualreceiving services at the facility, he or she must immediately notify the Executive Directorof their suspicion. 2. The Executive Director must then notify Law Enforcement and the applicable State SurveyAgency of the suspected crime within the time period as indicated above.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 3 residents (Resident #15, Resident #27 and Resident #33) reviewed for comprehensive care plans. 1. The facility failed to develop a comprehensive care plan for Resident #15 that addressed the cleaning and storage of BIPAP machine (a noninvasive ventilatory device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation to include cleaning or storage of the machine) and equipment.2. The facility failed to develop a comprehensive care plan for Resident #27 that addressed the changing and labeling of her oxygen tubing and water bottle. 3. The facility failed to develop a comprehensive care plan for Resident #33 that addressed her use of a BIPAP machine.These failures could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. 1. Record review of Resident #15's quarterly MDS dated [DATE] revealed he was a [AGE] year-old male that was admitted on [DATE]. His BIMS score was 12 which indicated a moderately cognitive impairment. The MDS indicated Resident #15 required Partial/moderate assistance for ADL care due to a deficient r/t multiple diagnosis. Resident #15's active DX: Obstructive sleep Apnea (adult) (is when you stop breathing during sleep because of a blockage in your windpipe.) Section O-Special Treatments, procedures, and programs addressed respiratory therapy. Record review of Resident #15's care plan dated 12/09/2025 reflected that he has altered respiratory status/difficulty breathing r/t Sleep Apnea. Goal: The resident will have no s/sx of poor oxygen absorption through the review date. Interventions included assist resident with putting on and taking off BIPAP mask every night at bedtime and remove every morning. Resident #15's BIPAP use, storage, and cleaning were not addressed in her care plan.Record review of Resident 15's MD order dated 08/15/2025 reflected Oxygen with BIPAP: Large Mask with heated humidification at IPAP 19 EPAP 14 cm H2O every shift for Sleep apnea.BIPAP on while sleeping/napping and off while awake . BIPAP mask with warm soapy water, rinse and air dry as needed for sleep apnea BIPAP Clean reservoir with warm soapy water, rinse; set out to dry every day shift every 7 day(s) for sleep apnea.During an observation and interview with Resident #15 on 03/05/2026 at 10:40 AM resident was in his wheelchair watching television. His BIPAP mask was observed on his nightstand. The mask cushions and hose were observed with small greasy and cloudy film from facial daily use lying on his nightstand with other stored items. Resident #15 stated that the staff removed this mask this morning.2. Record review of Resident #27's admission MDS Assessment, dated 02/26/2026, reflected that she was [AGE] years old and was admitted on [DATE]. Resident #27 had a BIMS score of 12, which indicated she was moderately impaired cognitively. Resident #27 was dependent on staff and required maximal assistance with ADLs r/t musculoskeletal impairment (Musculoskeletal impairment refers to conditions affecting muscles, bones, joints, and connective tissues, resulting in pain, reduced mobility, and limited functions.) and femur (thigh bone) fracture that was obtained prior to admissions. Resident 27's active DX included unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified displaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing. wedge compression fracture of first thoracic vertebra, subsequent encounter for fracture with wedge compression fracture of first thoracic vertebra, subsequent encounter for fracture with routine healing, wedge compression fracture of second thoracic vertebra, subsequent encounter for fracture with routine healing, contusion of other part of head, subsequent encounter, and Chronic Obstructive Pulmonary Disease a progressive, incurable lung disease-primarily caused by (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking-that causes severe breathing problems due to damaged airways and trapped air). The MDS Assessment indicated in Section O-Special Treatments, procedures, and programs addressed respiratory oxygen treatments.Goal: The resident will display optimal breathing patterns daily through review date. Record review of Resident #27's admission care plan, 02/21/2026, reflected that the resident was diagnosed with COPD (is a progressive, incurable lung disease-primarily caused by smoking-that blocks airflow and makes breathing difficult), (with respiratory failure Goal: the resident will display optimal breathing patterns daily through review dated. Interventions and Task: Head of bed elevated during episodes of difficulty breathing. Observe and report PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (thick mucus) (document the amount, color and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing.Observe for s/sx of acute respiratory insufficiency (not enough): Anxiety (excessive worrying), Confusion, Restlessness (unable to rest), SOB at rest. oxygen settings: 02 via nasal prongs @4L/M. Resident #27's care plan did not address the frequency of oxygen tube changing or labeling. Record review of Resident #27's MD order dated 02/20/2026 reflected Oxygen at 4 liters/minute continuously per nasal cannula. Document every shift. MD order dated 03/05/2026 at 1:15 PM reflected Change oxygen tubing, nebulizer circuit and humidifier bottle every night shift every Sun Label when changed and every 24 hours as needed when visibly soiled. Label when changed Oxygen sat rates every shift Oxygen sat rates every shift may titrate to keep above 90%.During an observation and interview on 03/05/2026 at 10:35 AM, Resident #27 was observed lying awake in bed wearing an undated nasal cannula. Resident #27 denied having any concerns with oxygen machines. 3. Record review of Resident #33's 's admissions MDS Assessment, dated 02/22/2026 and completed on 02/28/2026reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. The resident had a BIMS score of 14, which indicated her cognition was intact. Resident #33 used a wheelchair and walker for mobility. She was dependent on staff for ADL care of Toileting Hygiene showers, dressing, putting on and taking off footwear, and transfers. The MDS indicated that Resident #33's active diagnoses included: Obstructive sleep apnea (ADULT), unspecified asthma (a chronic respiratory disease that causes inflammation, swelling, and tightening of the airways.), Asthma, (inflamed lungs). Record review of Resident #33's 's care plan dated 02/20/2026 reflected the resident has hypertension Give anti-hypertensive medications as ordered. Observe for side effects such as LPN orthostatic hypotension and increased heart rate and effectiveness. Obtain blood pressure readings prior to administering medications. Section O-Special Treatments, Procedures, and Programs. Resident #33's BIPAP use, storage, and cleaning were not addressed in her care plan.Record review of Resident #33's MD orders dated 02/18/2026 Monitor every shift. Does resident experience S/SX of Shortness of Breath (SOB) when lying flat or avoid lying flat due to S/SX of SOB? (increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations, gasping for air, interrupted speech pattern, use of accessory muscles, anxiety, restlessness etc.). Order dated 02/18/2026 Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 3 ml inhale orally via nebulizer every 6 hours as needed for Shortness of Breath: Wheezing. Order dated 02/27/2026 BIPAP 12/6 rate of 10, apply upon availability.During an interview on 03/05/2026 at 5:45 PM the DON stated the Clinical staff were responsible for updating the care plans and DON reviews for accuracy. The DON stated that the EMR provides prompts for updates. The DON stated she expected the care plan to be updated when at admissions and as needed as resident individual plan changes. The DON stated an accurate care plan was important because it individualized the resident's care. The DON did not state that the resident should have been addressed in the care planned when asked. The DON did not provide an explanation for missing respiratory treatments in the care plan for Residents #15, # 27, and #33, however, she acknowledged that the residents were receiving respiratory treatments per MD orders.During an interview on 03/05/2026 at 5:55 PM the Administrator stated the DON was responsible for monitoring and ensuring resident care tasks are addressed and accurate. The Administrator stated care plans (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	address the residents' individual medical needs and treatments. The Administrator did not provide additional information in the interview for non-compliance with care plans. Record review of a facility policy, titled Comprehensive Care Plans and Revision dated 03/02/2022 and reviewed on 08/29/2025 reflected The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.Procedure The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. 2. When these changes occur, the facility should review and update the care plan to reflect the changes to care delivery, this can include a. Additional interventions on existing problems, b. Updating goal or problem statements c. Adding a short-term problem, goal, and interventions to address a time limited condition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 4 residents (Residents #15, #27, and #33) reviewed for respiratory care.1. The nursing facility failed to clean, store, and document the use of a BIPAP (a noninvasive ventilatory device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation) for Resident #15 and Resident #33. 2. LVN-E failed to change and label Resident #27's nasal cannula (a tube with two prongs used to deliver supplemental oxygen to patients) and water bottle on 03/05/26. These failures could place residents at risk for respiratory infections. Resident #15Record review of Resident #15's quarterly MDS dated [DATE] revealed he was a [AGE] year-old male that was admitted on [DATE]. His BIMS score was 12 which indicated a moderately cognitive impairment. The MDS indicated Resident #15 required Partial/moderate assistance for ADL care due to a deficient r/t multiple diagnosis. Resident #15's active DX: Obstructive sleep Apnea (adult) (is when you stop breathing during sleep because of a blockage in your windpipe.).Record review of Resident #15's care plan dated 12/09/2025 reflected that he has altered respiratory status/difficulty breathing r/t Sleep Apnea. Goal: The resident will have no s/sx of poor oxygen absorption through the review date. Interventions included assist residents with putting on and taking off BIPAP mask every night at bedtime and remove every morning. BIPAP Settings: BIPAP (noninvasive ventilator used to assist breathing) with medium/large face mask with heated humidification IPAP 19 EPAP (BIPAP devices deliver separately adjustable inspiratory positive airway pressure (IPAP) and expiratory positive airway pressure (EPAP). The IPAP and EPAP levels are adjusted to maintain upper airway patency, and the pressure support (PS = IPAP-EPAP) augments ventilation.) 14CM H2O (HˆO is the chemical formula for water.).Elevate head of bed at least 30 degree's when sleeping.Observe for changes in orientation, increased restlessness, anxiety, and air hunger.Observe for s/sx of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry (measures oxygen and saturation) (Saturation means reaching a point where something is filled completely and can't absorb more); Increased heart rate, Restlessness; Confusion; Cough. Record review of Resident #15's MD order dated 08/15/2025 reflected Oxygen with BIPAP: Large Mask with heated humidification at IPAP 19 EPAP 14 cm H2O every shift for Sleep apnea.BIPAP on while sleeping/napping and off while awake . BIPAP mask with warm soapy water, rinse and air dry as needed for sleep apnea BIPAP Clean reservoir with warm soapy water, rinse; set out to dry every day shift every 7 day(s) for sleep apnea.During an observation and interview with Resident #15 on 03/05/2026 at 10:40 AM resident was in his wheelchair watching television. His BIPAP mask was observed unbagged lying on top of his nightstand with other resident property. Observation of the mask revealed greasy substance. Resident #15 said the staff removed his mask this morning and placed it on his nightstand. Resident #15 said the staff did not clean his mask and store it in a bag. Resident #15 denied having any concerns with her BIPAP machine. Resident #27Record review of Resident #27's admission MDS Assessment, dated 02/26/2026, reflected that she was a 66-years-old and was admitted on [DATE]. Resident #27 had a BIMS score of 12, which indicated she was moderately impaired cognitively. Resident #27 was dependent on staff and required maximal assistance with ADLs r/t musculoskeletal impairment (Musculoskeletal impairment refers to conditions affecting muscles bones, joints, and connective tissues, resulting in pain, reduced mobility, and limited functions.) and femur (thigh bone) fracture that was obtained prior to admissions. Resident 27's active DX included unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, unspecified displaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing. wedge compression fracture of first thoracic vertebra, subsequent encounter for fracture with wedge (continued on next page)

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	675935	A. Building B. Wing	03/05/2026

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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