STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676067	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Court	7021 Bryant Irvin Rd Fort Worth, TX 76132

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents fed by enteral means received the appropriate treatment to prevent complications of enteral feeding including aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 9 residents (Resident #1) reviewed for enteral feed care. The facility failed to ensure Resident #1's tube feeding was paused when the head of his bed was lowered for incontinence care. This failure could place residents at risk for aspiration of their feeding solution. Findings included:Record review of Resident #1's quarterly MDS assessment, dated 08/04/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke affecting his right side, and ability to swallow and to speak, required the placement of a feeding tube. His Functional Ability assessment revealed he was completely reliant on staff for his ADLs. Record review of Resident #1's care plan, dated 5/21/25, revealed he had a feeding tube and received continuous feeding via pump. Observation on 10/07/25 at 10:15 Resident #1 was in his bed with the head of the bed elevated about 30 degrees. Feeding pump was infusing at 70 ml/hr. Resident in no obvious distress. Observation on 10/07/25 at 10:22 AM revealed CNA A and CNA B providing Resident #1 incontinence care. CNA A lowered Resident #1's head to turn him for incontinence care. CNA A did not call a nurse in to pause Resident #1's feeding pump, nor did she pause it herself. The pump was infusing at 70 ml/hr. Incontinent care was completed, and the resident's head was raised again while the pump continued to infuse. In an interview on 10/07/25 at 9:12 AM, Resident #1's Family Member stated she monitored the resident's bed via electronic monitoring, and she expressed concerns about the resident's care, including staff not pausing his feeding pump when they lower the head of the bed. She stated she had brought her concerns to the Administrator and Resident #1's care seemed to have improved some since then. She stated the resident had not aspirated (inhaling stomach contents into the lungs) that she knew of. In an interview on 10/07/25 at 12:00 PM, the ADON stated any resident on a feeding pump was to have the pump paused by a nurse prior to having the head of their bed lowered, and the nurse was to restart the pump once the head of the bed was raised again. She stated leaving the pump running with the head flat could cause the resident to aspirate their enteral feed. The ADON stated after Resident #1's Family Member had spoken to the previous Administrator on 9/24/25, the DON had initiated an in-service on Enteral Feeding care, so staff should know about pausing the feeding pump. The ADON stated she would initiate another in-service immediately since the DON was not working. In an interview on 10/07/25 at 1:30 PM, CNA C stated she was just in-serviced by the ADON about the care of residents with feeding tubes. She stated she knew to have the nurse pause the pump before lowering the head of the bed and re-start it after she was done with care. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 1:34 PM, CNA D stated residents with a feeding pump infusing had to have a nurse pause it before lowering the head and re-start it after the head was raised up. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 1:44 PM, CNA E stated she was in-serviced by the ADON and knew to have a nurse pause and restart feeding pumps when the head of the bed had to be lowered for care. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 1:50 PM, CNA F stated she had been in-serviced by the ADON on feeding pump care and knew to have a nurse to pause and restart the feeding pump when the head of the bed was lowered. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 1:54 PM, CNA G stated she had just been in-serviced by the ADON on feeding pumps. She stated a nurse had to pause the pump before the head was lowered and then re-start when the resident's head was lifted back up. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 1:58 PM, CNA A stated she had been in-serviced by the ADON on feeding pumps and knew to have a nurse present to pause and re-start the feeding pump before and after care. CNA A stated she did not pause the feeding pump for Resident #1 earlier because she did not think about it. She stated she had also been in-serviced previously on feeding pumps, but she would get busy and having to wait for a nurse can really put her behind on her jobs. She knew the risk of lowering the head of the bed with the pump infusing was aspiration. In an interview on 10/07/25 at 2:01 PM, CNA B stated she was orienting with CNA-A and this was her first CNA job. She stated she did not know about pausing the feeding pump until she was in-serviced by the ADON. In an

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to 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 disease and infections for 1 of 5 residents (Resident #1) reviewed for infection control. CNA H and CNA I failed to wear the appropriate PPE for a resident on Enhanced Barrier Precautions when providing care to Resident #1. This failure could place residents at risk of exposure to infections from other residents. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 08/04/25, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke affecting his right side, and his ability to swallow and to speak, requiring the placement of a feeding tube. His Functional Ability assessment revealed he was completely reliant on staff for his ADLs. Record review of Resident #1's care plan, dated 5/21/25, revealed he was on Enhanced Barrier Precautions (infection control interventions designed to reduce the transmission of MDROs in nursing homes) related to his gastric tube and wounds. Observation and interview on 10/07/25 at 9:25 AM revealed there were postings outside Resident #1's room indicating he was on Enhanced Barrier Precautions, and PPE was stationed outside his room. CNA A stated Resident #1 was on precautions because he had a gastric tube as well as a wound on his leg. She stated staff had to wear a gown and gloves when providing care to the resident to prevent staff from transferring anything infectious from another resident to the resident on precautions. Observation on 10/07/25 at 11:05 AM of video footage supplied by Resident #1's Family Member revealed on 09/25/25 at 5:15 AM CNA H provided Resident #1 with incontinence care without wearing a gown. On 09/25/25 at 10:42 AM CNA I provided Resident #1 with incontinence care without wearing a gown. In an interview on 10/07/25 at 12:00 PM, the ADON stated residents with any artificial openings to their bodies were placed on Enhanced Barrier Precautions. She stated that included residents with gastric tubes, urinary catheters, wounds, and IVs. Staff were required to wear a gown and gloves while proving care to the resident, this prevented staff from introducing an infectious agent from another source to the resident that was on isolation precautions. After reviewing Resident #1's Family Member's video footage, the ADON stated the CNAs should have been wearing the proper PPE while they provided care. She stated there had been multiple in-services on infection control, so there was no reason for the staff not knowing when to wear PPE when it was indicated. Phone interview attempt on 10/07/25 at 1:06 PM with CNA H was unsuccessful, a voicemail was left. In an interview on 10/07/25 at 1:19 PM, CNA I revealed she had cared for Resident #1 multiple times. She stated she did not know what Enhanced Barrier Precautions meant, but she knew she had to wear a gown and gloves when taking care of Resident #1 but did not know the reason. CNA I stated she did not always wear a gown because she would get busy and forget. She acknowledged there was signage outside the rooms of residents on isolation, but she did not always pay attention to it. CNA I stated if the video from 09/25/25 showed she did not wear a gown, then she must not have worn one. Record review of the facility's Infection Prevention and Control policy, dated 05/15/23 reflected: 1. Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high- contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.A. EBP will be implemented for All residents with the following:1) Infection or colonization with a MDRO when Contact Precautions do not otherwise apply2) Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization statusB. EBP will be implemented during the following high-contact resident care activities:1) . Changing briefs or assisting with toilet.