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	07/29/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who is was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 2 of 5 residents (Resident #12 and Resident #21) reviewed for ADL care. 1. The facility failed to ensure Resident #12's fingernails were cut and clean. 2. The facility failed to provide Resident #21 with personal hygiene and grooming during showers, leaving her with facial hair on her chin consisting of at least 10 strains of hair approximately an inch long as of 07/27/25. These failures could place residents at risk of not receiving hygiene care which could cause skin breakdown, a loss of dignity and self-worth. Findings included: 1. Review of Resident #12's MDS reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes, stroke, non-Alzheimer's dementia, hemiplegia (weakness or paralysis affecting one side of the body), muscle wasting, and cognitive communication deficit. The resident had short and long term memory impairment and his cognitive skills were severely impaired and his speech was unclear. The MDS further reflected the resident required substantial/maximal assisted for personal hygiene. Review of Resident #12's care plan edited on 06/02/25 reflected he required assistance with activities of daily living. Goals included the resident would maintain a sense of dignity by being clean, dry, odor free and well groomed. Observation on 07/27/25 at 10:10 AM of Resident #12 revealed he was in bed with his eyes fixated on the TV. The resident was not able to speak but was able to make eye contact when he was being spoken to. The resident's legs appeared to be contracted but was able to move his hands. Resident #12's fingernails were about 1/2 inch long and both thumbs had dark substance underneath the nail. Interview on 07/27/25 at 12:06 PM with CNA A revealed Resident #12 was a diabetic therefore the nurse was responsible for cutting his fingernails. CNA A said the resident has long fingernails as long as she could remember and thought it was the resident's preference to have them that long therefore, she had not said anything to the nurse about having the fingernails cut. Interview on 07/29/25 at 1:49 PM with LVN B revealed she was on her third week working at the facility she was not sure who was responsible for cutting Resident #12's fingernails. LVN B said she had noticed the resident's fingernails were long and dirty and she had thought about cutting and cleaning them but had not gotten around to it. LVN B further stated it was important to keep resident's fingernails cut and clean because it was part of their hygiene needs. Interview on 07/29/25 at 1:57 PM with ADON C revealed resident fingernails were cut by the CNA's and if the resident was a diabetic, they would but cut by the nurses. ADON C said Resident #12 was a diabetic so his fingernails should have been cut by the charge nurse. ADON C said resident fingernails should be check during shower days and during skin assessments and cut as needed because the resident could cut themselves and get an infection. Interview on 07/29/25 at 2:20 PM with the DON revealed nail care was done by the CNA's and if the resident was a diabetic, it would be done by the nurses. The DON said it was important to keep nails clean and cut to keep germs out of the fingernails and to prevent injuries if the resident were to scratch themselves. 2. Record review of Resident #21's undated admission Record reflected she was a [AGE] year-old female admitted to the facility on [DATE] and last return 04/11/25. Record review of Resident #21's comprehensive MDS, dated [DATE], reflected a BIMS score of 11 indicating moderate cognitive impairment. Her Functional Status evaluation indicated she required substantial/maximal assistance with her personal hygiene. Diagnosis included high blood pressure, Renal Insufficiency (reduced blood flow to the kidneys), high blood sugar, traumatic brain injury (external force that disrupts normal brain function), seizure disorder (abnormal electrical activity in the brain), anxiety disorder (significant and uncontrollable feelings of fear), depression. Record review of Resident #21's care plan, last edited 06/27/25, reflected she had an ADL self-care deficit: Resident #21 has impaired functional mobility; requires assistance with ADLs due to history of traumatic brain injury and history of fracture. Goal: Resident will be clean, dressed appropriately to weather, participate to preferred activities and stable weight. Interventions included assess the degree of functional impairment. [NAME] with ADLs base on the current level of mobility. Encourage independence. Praise any attempt of independence. Encourage resident to perform self-care to the maximum ability. Observation and interview on 7/27/25 at 11:32 AM Resident #21 were noted to have facial hair on her chin, consisting of 10 hairs approximately an inch long. Resident #21 stated she was aware of the hair on her chin and tried to pull them as fast as she could. Resident #21 stated she did not like the idea of having any facial hair, made her feel uncomfortable; like everyone noticed them

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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)

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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 observation, interview and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 3 residents (Resident #35) reviewed for enteral nutrition.The facility failed to follow Resident #35's physician orders for enteral feeding when LVN E flushed with 30 cc's of water instead of 60 cc's before and after feedings on 07/29/2025. These failures could affect residents receiving enteral nutrition/hydration and place them at risk of dehydration. Findings included:Record review of Resident #35's undated admission Record reflected she was a [AGE] year-old female admitted to the facility on [DATE].Record review of Resident #35's comprehensive MDS, dated [DATE], reflected a BIMS score of 07 indicating moderate cognitive impairment. Her diagnosis included heart failure, high blood pressure, stroke, depression, asthma, and a use of a feeding tube. Record review of Resident #35's care plan, last edited 04/29/25, reflected Resident #35 required tube feeding related to diagnosis of stroke. Goal: Resident #35 will not exhibit signs of complications from feeding tube or enteral feeding solution. Interventions included to Assess for dehydration, assess for complications, monitor for signs of malnutrition, monitor weight, record, and monitor intake and output every shift. Administer feeding by feeding tube as ordered. Check for tube placement before feeding, water flush and medication administration. Flush feeding tube as ordered.Record review of Resident #35's physician order dated 04/18/25 revealed Enteral Feeding: Flush tube with 60 cc warm water before and after bolus feeding administration.Record review of Resident #35's physician order dated 06/28/25 revealed Enteral Feeding: Formula - Osomlite 1.5 Give 270 mL by bolus per feeding tube 5 times per day. Observation and interview on 07/27/25 at 1:32 PM with resident in her room just finished a shower. Resident has limited communication, Resident #35 points to her stomach when asked about her feeding tube. Interview on 07/27/25 at 1:35 PM with LVN F who stated Resident #35 does have a feeding tube, Resident #35 also pleasure feeds in the theater room to be observed by staff. Interview on 07/28/25 at 2:32 PM with ADON who stated Resident #35 did bolus feeding around 1:00 PM by LVN E. ADON revealed record review that LVN E administered feedings at 8:00 AM, 11:00 AM, 2:00 PM on 07/28/25. ADON expressed that nurses were responsible for administering tube feedings, and they were to check for placement, residual, and follow physician orders for the feedings.Observation of Resident #35's bolus feeding on 07/29/25 at 10:49 AM with LVN E revealed Resident #35 laid in bed. According to LVN E she prepared 60 cc of water for flushing, 1 carton of Osmolite 1.2 formula, gloves and gown due to Resident #35 on enhanced barrier precautions. LVN E lifted head of bed to 45-degree angle, observation of the feeding tube area dated 07/29/25 without any redness or signs of infection. LVN E stated residual was 10 cc's. LVN E stated she flushed the tube with 30 cc's of water. LVN E administered the formula by gravity with no complications. LVN E stated she was now going to flush with 30 cc of water . LVN E then ensured feeding tube was locked and resident had no concerns and LVN E performed doffing her gown and gloves and completed hand hygiene. Interview on 07/29/25 at 11:05 AM with LVN E who stated she provided Resident #35 with 30 cc's of water before and after feeding; that was what she normally did as facility protocol and she was told to do so by the ADON . Upon review of Resident #35's physician orders she revealed the orders called for 60 cc before and after feeding. According to LVN E she was responsible for administering Resident #35 with feedings, and that she should have followed physician orders to flush with 60 cc of water before and after each feeding. LVN E stated not doing so placed Resident #35 at risk of dehydration. LVN E stated she would contact the physician and advise him of her error. Interview on 07/29/25 at 11:10 AM with ADON who stated the facility does have a protocol to flush tube feedings with 30 cc of water before and after feedings. ADON stated she and LVN E went over the process for feeding due to surveyor request to observe Resident #35's feeding and she advised LVN E to follow facility protocol. ADON stated although we have a protocol, LVN E should have followed physician orders to flush with 60 cc of water before and after feedings, ADON stated nurses should review physician orders before the task and always follow the order. ADON stated not following physician orders to flush with 60 cc of water before and after feeding placed Resident #35 at risk of dehydration. Record review facility policy revised 05/05/23 titled Gastrostomy Tubes reflected:The facility must ensure the following:POLICY: Gastrostomy tubes may be used for residents who require enteral feedings to maintain nutrition the patient/resident will maintain acceptable parameters of nutritional status to include usual body weight or desirable body weight range, and electrolyte balance, unless the patient/resident clinical condition

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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. (continued on next page)

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F 0880 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 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 1 of 5 residents (Resident #38) reviewed for infection control. CNA A failed to wear a gown when providing care to Resident #38, who was on enhanced barrier precautions. This failure could place residents at risk of being infected by staff in contact with other residents with infections. Findings included: Review of Resident #12's MDS reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included the following: diabetes, stroke, non-Alzheimer's dementia, hemiplegia (weakness or paralysis affecting one side of the body), muscle wasting, and cognitive communication deficit. The resident had short and long term memory impairment and his cognitive skills were severely impaired, and his speech was unclear. The MDS further reflected Resident #12 had a feeding tube. Review of Resident #12's care plan edited on 06/02/25 reflected Resident #12 was at risk for aspiration due to presence of feeding tube related to the diagnosis dysphagia (difficulty swallowing food or liquids) related to a CVA (stroke). Approaches included to administer feeding via g-tube as ordered. Further review of the resident's care plan reflected Resident #12 had a stage 4 pressure wound on his left lateral foot. Approaches included to turn and reposition frequently and keep boots on foot to offload. Observation on 07/27/25 at 10:07 AM revealed there was PPE hanging from Resident #12's room that included gloves, gowns, and masks. There was a sign on the door that reflected the following: Enhanced Barrier Precautions.everyone must wear gloves and gown for the following high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting.wound care: any skin opening requiring a dressing. Observation on 07/27/25 at 10:10 AM of Resident #12 revealed he was in bed with his eyes fixated on the TV. The resident was not able to speak but was able to make eye contact when he was spoken to. The resident's legs appeared to be contracted, and he had on a potus boot (boots that can be used for individuals who are bedridden or have limited mobility). on each foot. Prior to entering Resident #12's room CNA A she put on some gloves and no gown and then proceeded to take the boots off the resident so to check the skin integrity of the resident's feet and finally repositioned the resident in bed. Interview on 07/29/25 at 12:06 PM with CNA A revealed who stated if a resident was on enhanced barrier precautions staff needed to put on a gown and gloves prior to entering their room. CNA A said when she before she entered Resident #12's room she should have put on a gown but she said she asked another aide, but did not say who, and CNA A was told a gown did not need to be worn if they were just checking on the resident. CNA A further stated PPE should be worn to protect the residents from infections because they are providing care from room to room. Interview on 07/29/25 at 1:57 PM with the ADON revealed who stated gown and gloves should be worn prior to caring for Resident #12, who is was on enhanced barrier precautions, to prevent the spread of infection from resident to resident. Interview on 07/29/25 at 2:20 PM with the DON revealed who stated all residents on enhanced barrier precautions including Resident #12, staff must wear gown and gloves prior to entering the resident's room to provide care. It was important for the correct PPE to be worn because the staff could come in contact with bodily fluids, and it would help spread infections as staff go from room to room to provide care. Review of the facility's policy titled Transmission Based/Standard Precautions, and Enhanced Barrier Precautions revised May 2023 reflected the following: Policy 1. The facility will use transmission-based precautions when the routes of transmission is not completely interrupted using standard precautions alone. Procedures: Enhanced Barrier Precautions (EBP)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:. 2) Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube.) B. EBP will be implemented during the following high-contact resident care activities:1. Dressing2. Bathing/showering3. Transferring4. Providing hygiene 5. Changing lines6. Changing briefs or assisting with toilet C. EBP requires the following PPE: 1. Gloves 2. Gown 3. Face protection is performing activity with risk of splash or spray.