STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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 residents were provided an environment that was free from accident hazards for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to ensure Resident #1's mattress overlay was properly secured to prevent her from falling out of bed. This failure could place residents at risk of falls and resulting injuries. Findings included:Record review of Resident #1's quarterly MDS, dated [DATE], reflected the resident was admitted to the facility on [DATE] with diagnoses which included stroke affecting her left side, dysphasia (inability to swallow), aphasia (inability to speak), and breathing difficulty requiring the placement of a tracheostomy (breathing tube in her neck). Her BIMS score was not completed due to her medical conditions. Her Functional Ability assessment indicated she was totally dependent on staff for all her ADLs. Record review of Resident #1's care plan, dated 06/16/25, reflected she was a fall risk with actual falls with interventions which included staff ensuring the resident had safe and proper positioning in bed on her air mattress. Record review of Resident #1's Fall Risk assessment, dated 05/31/25, reflected she was at high risk for falls with a score of 13. Observation of video footage submitted by Resident #1's family member, dated 08/20/25, revealed Resident #1 lying on her bed with her head to the left side of the bed. The resident then fell off the bed headfirst, landing on the fall mat beside the bed. The video footage also showed the resident's mattress overlay sliding off the bed with her. Record review of Resident #1's nursing progress notes reflected LVN A documented the following entries:- 08/20/25 at 8:30 AM: Observed patient lying on floor to left side of the mat. Lying on left side. No signs of distress observed. Assessed patient for injuries. No injuries visible at the time. Carefully, transferred patient from floor to the bed with coharts [sic]. Vitals checked. [Family] notified. Patient transferred to [hospital] at family's request. DON informed of most recent events.- 08/20/25 at 9:30 AM family informed of pick up time.Observation on 09/03/25 at 10:35 AM revealed Resident #1 was positioned in her bed with her left side tilted up with pillows. There were fall mats on both sides of the resident's bed, and the resident's bed was in the low position. The air mattress had bolsters built into it to help keep the resident from sliding out of bed. The resident had no bruising to her head or face. Interview on 09/03/25 at 12:35 PM with Resident #1's Family Member revealed the facility had notified the Family Member about Resident #1's fall. The Family Member was informed the resident had no obvious injury. The Family Member stated they requested the resident be sent to the hospital for evaluation. The Family Member stated the resident was seen in the ER, where she diagnosed with a UTI (an infection in any part of the urinary system which includes the kidneys, ureter, bladder, and urethra). The Family Member stated the resident was sent back to the facility the same day. Interview on 09/03/25 at 10:37 AM with LVN B revealed at the time of Resident #1's fall on 08/20/25 her mattress was fitted with an overlay, with built-in bolsters that went on top of her air mattress, which was secured to the bed frame with several straps. LVN B stated one of the straps was not secured, which allowed the overlay to slide with the resident, when she slid off the bed instead of staying in place and preventing the resident from sliding out of bed. She stated the air mattress was now fitted with a different type of cover that was more secure than the previous one. Interview on 09/03/25 at 10:40 AM with the DON revealed his investigation into Resident #1's fall revealed the resident's mattress overlay did not have the top right strap secured. When the resident began to slide to her left, the overlay slid with her instead of staying in place, which prevented the built-in bolsters from doing their job of making it harder for her to slide out of bed. The DON stated it was the responsibility of the nurses and CNAs to check the overlay and make sure it was properly secured. He stated he initiated an in-service on proper use of the overlays, as well as resident neglect. The DON stated there was only one other resident in the facility with the type of overlay Resident #1 had. Observation on 09/03/25 at 10:55 AM of Resident #1's mattress overlay revealed it was properly secured to the bed frame with three straps on each side of the mattress. Interview on 09/03/25 at 12:50 PM with CNA C revealed she was familiar with the residents, who were at risk for falls, and she rounded on them more frequently. She stated the fall risk residents were also in a binder at the desk and on the Kardex (a documentation system that summarizes important details and quick access for essential patient data) for those not familiar with the residents. She stated Resident #1 was known to move about a little and work her way to one side of the bed or the other. Interview on 09/03/25 at 1:00 PM with CNA D revealed the nurses told the CNAs when there was a new resident, who was a fall risk, and the residents were also in a binder on the desk. She stated those residents were rounded on more frequently. She stated Resident #1 was