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	12/03/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to must provide each resident with the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and care plan by ensuring a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene for 1 of 4 residents (Resident #1) reviewed for ADL care. The facility failed to provide Resident #1 assistance with timely incontinence care for at least 4 hours on 10/23/25, which resulted in Resident #1 being soaked with urine and soiled through her brief, draw sheet, and bed sheets. This failure could place the residents at risk for decreased feeling of self-worth, skin breakdown, and infection. Findings included: Record review of Resident #1's face sheet, dated 10/23/25, reflected Resident #1 admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Significant Change in Status MDS assessment, dated 09/25/25, reflected Resident #1 had moderate cognitive impairment, with a BIMS of 09. Resident #1 was noted to be dependent on staff for all transfers and substantial/maximum assistance with toileting. The MDS noted that Resident #1 was always incontinent of bowel and bladder. The resident's active diagnoses included hemiplegia (paralysis that affects one side of the body), seizure disorder (condition causing repeated seizures from abnormal brain activity), anxiety disorder (excessive fear or worry that can disrupt daily life), depression (condition causing persistent sadness and loss of interest), bipolar disorder (condition causing extreme mood swings between mania and depression), and cerebral palsy (disorder caused by brain damage that affects movement, muscle control, and coordination). Record review of Resident #1's care plan, dated 10/01/25, reflected Resident #1 had bowel and bladder incontinence. The care plan reflected: Intervention: Check resident every two hours and assist with toileting as needed. Problem: [Resident #1] has an ADL self-care performance deficit r/t weakness, impaired decision-making ability, impaired mobility, left sided weakness, cerebral palsy. Goal: The resident will improve current level of function in ADL's through the review date. Intervention:. Personal Hygiene/Oral Care: The resident requires max/total assist x 1 or 2 staff for personal hygiene and oral care. Toilet Use: The resident requires max/ total assist of 1 or 2 staff for toilet use. Transfer: The resident requires max/total assist of 1 or 2 staff for transferring. Observation and interview on 10/23/25 at 9:39 AM revealed a strong smell of urine in Resident #1's room. Resident #1 revealed she was currently wet and needed to be changed. Resident #1 stated the last time she had been changed was around 4:00 AM. Resident #1 stated she could not recall if she let a staff member know that she needed to be changed or the last time a staff member was in her room. Resident #1 stated she knew how to use the call light but preferred not to bother the staff. Observation and interview on 10/23/25 at 10:45 AM, revealed CNA A pulled back the sheets on Resident #1. CNA A stated the urine had soaked through the sheets. CNA A asked RN B to get new sheets before starting incontinence care. Interview on 10/23/25 at 10:50 AM, CNA A revealed night shift had changed Resident #1 last. CNA A stated she started her shift at 6:00 AM, but it was difficult to check on residents every 2 hours. She stated she had not checked on Resident #1 yet. Observation on 10/23/25 at 11:00 AM, revealed CNA A and RN B providing Resident #1 with incontinence care. When Resident #1 was turned onto her side during incontinence care, it was noted that urine had soaked through the resident's brief, draw sheet, fitted sheet, and was wet up to Resident #1's back and gown. When the fitted sheet was removed, there was a pool of urine on the mattress. No skin issues or redness was noted to Resident #1's perineal area. Interview on 10/23/25 at 11:07 AM, Resident #1 revealed she did not typically soak through the sheets. Resident #1 stated she had not been changed yet this shift, but she understood because staff got busy. Resident #1 stated she was happy with the care she received in the building and did not have concerns. Interview on 10/23/25 at 1:08 PM, CNA A revealed she was expected to perform rounds on all residents every 2 hours. CNA A stated she tried to check on residents every 2 hours, but that it could be hard to do that. She stated her assignment had changed which caused a delay. CNA A stated residents, who could use their call light, got incontinence care more frequently. CNA A stated dependent residents unable to use their call light still got incontinence care, but it could take longer. CNA A stated it was not normal for Resident #1 to have urine soaked through the sheets. She stated it was due to the resident lying in urine for a longer period. CNA A stated she had not changed Resident #1 on her shift yet, and Resident #1 told her the last time she had been changed was 4:00 AM. CNA A said it could have been around 7 hours since the