

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER The Stayton at Museum Way		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Museum Way Fort Worth, TX 76107	
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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement an admissions policy that did not request or require residents to waive potential facility liability for loss of personal property for 2 of 2 residents (Resident's #1 and #2) reviewed for loss of personal property. The facility failed to ensure the admission agreement did not request or require residents to waive potential facility liability for losses of personal property. This could place residents at risk of misappropriation of their personal property. Findings included: Record review of Resident #1's 5-day MDS assessment, dated 07/16/2026, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's diagnoses included heart failure (when the heart cannot pump enough blood efficiently), hypertension (high blood pressure) and respiratory failure (when the lungs cannot get enough oxygen to the blood or when they cannot remove carbon dioxide from the blood). Resident #1's BIMS score was 14, indicating intact cognition. Record review of Resident #1's EHR reflected that she was discharged on 07/21/2026. Record review of Resident #1's grievance dated 07/12/2026, completed by the Administrator, reflected son reports money missing from resident wallet between Friday 07/10/26 PM and Sunday 07/12/26 AM. The amount was between \$140 and \$200. Further review reflected that the item had not been located, no one confessed to taking the item and it was reported to HHSC. Record review of Resident #2's admission MDS assessment, dated 07/05/2026, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's diagnoses included hypertension (high blood pressure), aftercare following joint replacement surgery, and presence of left artificial knee joint (knee replacement). Resident #2's BIMS score was 15, indicating intact cognition. Record review of Resident #2's EHR reflected that she was discharged on 07/17/2026. Record review of Resident #2's grievance dated 07/17/2026, completed by the Administrator, reflected Resident called my phone and stated she discharged home today. Upon returning home stated she thought she is missing \$100 cash. Further review reflected that the item had not been located, staff interviewed did not see a purse or wallet, and incident was reported to HHSC. Interview on 07/22/2026 at 1:12 PM, the Administrator stated the incidents were reported to him, he completed grievances and investigations, and the results were inconclusive for both incidents. He stated their policy was that they were not responsible for lost items. The Administrator stated he had been there since March [2026] and this was the first time an incident like this happened. In a follow up interview on 07/22/2026 at 3:13 PM, the Administrator stated the admission agreement was from the previous company and the policy had not been changed since they had their change of ownership. He stated the facility would remove the statement that required the residents to waive their rights while they waited for the new company's admission agreement. Record review of the facility's undated Skilled Nursing admission and Care Agreement reflected the following: .B. DUTIES (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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AND OBLIGATIONS OF THE RESIDENT Resident or Responsible Party where allowed by law agrees to: 1. Provide personal clothing, personal effects, spending money, as needed or desired by Resident. [Facility Name] shall not be responsible for any Resident's property which is lost, damaged, or stolen.		