STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455881	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dfw Nursing & Rehab	900 W Leuda St 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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for4 (Res#1, Res#2, Res#3 and Res#4) of 5 residents reviewed for updated care plans. The facility failed to provide Resident#1,2,3,4 with updated care plans to reflected concerns for health and safety when leaving the facility unsupervised. An IJ was identified on 08/21/25. The IJ template was provided to the facility on [DATE] at 5:53 pm While the IJ was removed on 08/22/25, the facility remained out of compliance at a scope of potential for more than minimal harm that is not Immediate Jeopardy and a severity level of pattern because all staff had not been trained on 08/22/25. This failure can affect residents health, safety and possible death.Findings included:Record review of Resident#1's face sheet dated 08/20/25 reflected, he was a [AGE] year old male who was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with Paraplegia (symptom of paralysis that mainly affects your legs (though it can sometimes affect your lower body and some of your arm abilities, too), Anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Hyperlipidemia (have high lipid levels), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations), Cerebral infarction (an ischemic stroke, it is the most common form of stroke) personal history of traumatic brain injury (a brain injury that is caused by an outside force), chronic pain(lasts months or years and can affect any part of your body), essential hypertension (abnormally high blood pressure), pressure ulcer (forms on an area of the skin with prolonged pressure due to immobility) of right buttock, stage 4 (Full-thickness tissue loss with exposed bone, tendon, ligament, fascia, cartilage, or muscle)-onset 07/23/25, and Sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) -unspecified organism-08/08/25 onset. Record review of Resident#1's MDS, dated [DATE] reflected his BIMS score was 14 which indicated cognitive intact. Record review of Resident#1 care plan, dated 07/14/25 reflected, no documentation of resident health and safety being addressed when leaving the facility unsupervised. Record review of Resident#2's face sheet, dated 08/22/25 reflected, he was a [AGE] year-old male who or was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with Epilepsy (neurological disorder characterized by recurrent, unprovoked seizures), depression, mid cognitive impairment of uncertain unknown etiology (cognitive issues like memory and thinking problems are present but the specific underlying cause hasn't been identified), depression, unspecified convulsions, hyperlipidemia (a condition characterized by high levels of lipids (fats) in the blood, including cholesterol and triglycerides), hypothyroidism (happens when your thyroid gland doesn't make enough thyroid hormones to meet your body's needs), and tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an airway and facilitate breathing.) Record review of Resident#2's MDS, dated [DATE] reflected his BIMS score was 14 which indicated cognitive intact. Record review of Resident#2 care plan, dated 08/18/25 reflected, no documentation of resident health and safety being addressed when leaving the facility unsupervised. Record review of Resident#3 s face sheet, 08/21/25 reflected, she was a [AGE] year-old female who was originally admitted on [DATE] and diagnosed with unspecified Dementia (a condition where cognitive decline is present, but the specific underlying cause cannot be identified), bipolar disorder, anxiety disorder and cerebral infraction (occurs when blood flow to the brain is interrupted, leading to cell death and brain damage), unspecified. Record review of Resident#3's MDS, date reflected her BIMS score was 13 which indicated cognitive intact. Record review of Resident#3 care plan, dated 07/14/25 reflected, no documentation of resident health and safety being addressed when leaving the facility unsupervised. Record review of Resident#4 face sheet, dated 08/22/25 reflected, he was a [AGE] year-old male who was originally admitted [DATE] and readmitted [DATE] and diagnosed with major depressive disorder, diffuse traumatic brain injury (a type of brain injury that occurs when the brain experiences rapid acceleration or deceleration forces, causing widespread damage to the white matter tracts) with loss of consciousness of unspecified, conversion disorders with seizures or convulsions (involves real physical symptoms that resemble epileptic seizures but result from psychological factors) Epileptic seizures related to external causes not intractable

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observations and record review, the facility failed to ensure 1 (Resident#1) out of 4 received adequate supervision when reviewed for accidents. The facility failed to provide Resident#1 with adequate supervision on 08/01/25 when Resident#1 left the unsupervised for 3 day's The facility was not made aware until 08/04/25 that Resident#1 had been admitted the hospital. An IJ was identified on 08/21/15. The IJ template was provided to the facility on [DATE] at 4:45 pm. While the IJ was removed on 08/22/25, the facility remained out of compliance at a scope of potential for more than minimal harm that is not Immediate Jeopardy and a severity level of isolated because all staff had not been trained on 08/22/25. Thia failure could affect all resident's health, safety and possible death. Findings included:Record review of Resident#1's face sheet, dated 08/30/25 reflected, he was a [AGE] year old male who was originally admitted on [DATE] and readmitted on [DATE] and diagnosed with Paraplegia (symptom of paralysis that mainly affects your legs (though it can sometimes affect your lower body and some of your arm abilities, too), Anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Hyperlipidemia (have high lipid levels), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations), Cerebral infarction (an ischemic stroke, it is the most common form of stroke) personal history of traumatic brain injury (a brain injury that is caused by an outside force), chronic pain(lasts months or years and can affect any part of your body), essential hypertension (abnormally high blood pressure), pressure ulcer (forms on an area of the skin with prolonged pressure due to immobility) of right buttock, stage 4 (Full-thickness tissue loss with exposed bone, tendon, ligament, fascia, cartilage, or muscle)-onset 07/23/25, and Sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) -unspecified organism-08/08/25 onset. Record review of Resident#1's MDS, dated [DATE] reflected his BIMS score was 14 which indicated cognitive intact. Record review reflected no behaviors noted on the MDS. Record review of Resident#1 care plan, dated 07/14/25 reflected, no documentation of resident leaving the facility unsupervised. Record review of Resident#1's progress notes dated, 07/25/25 to 08/20/25 reflected in part:On 08/01/25 Nurse noted reflected. Resident signed out on pass at 2145. Still out of the facility. Completed by LVN A. On 08/02/25 Nurse notes reflected, Resident still out on pass. Completed by LVN G On 08/03/25 Nurse note reflected, out on pass. Completed by LVN I On 08/04/25 Administration notes reflected, Resident on leave. Completed by LVN G On 08/07/25 communication with physician noted reflected, Spoke with nurse he is doing fine. Vitals are fine he is still on IV antibiotics for an infection once he has completed his antibiotics, he should be ready to discharge. Completed by nursing. Record review on 08/20/25 of sign out/in sheet from sign out/in booklet from the receptionist desk reflected, Resident#1 did not sign out on 08/01/25.Record review of hospital records dated 08/21/25 reflected Resident#1 arrived at the hospital on [DATE] at 12:35 pm. Resident#1 chief complaint reflected Resident#1 checked himself out, been sitting out in the rain and heat for 3 days. Record review of hospital record did not detail how Resident#1 arrived at the hospital.Diagnosed reflected:*Sepsis (serious condition in which the body responds improperly to an infection) due to Pseudomonas aeruginosa (severe infections, particularly in immunocompromised individuals) and Beta hemolytic streptococci group C infected decubitus ulcer (Bedsores are injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time)* Fever 101.2 (fever is defined as a temperature above 100.4 F)*Tachycardia (heart rate over 100 beats a minute)*Leukocytosis (high white blood cell count, can indicate a range of conditions, including infections, inflammation, injury and immune system disorders.)*Foul drainage from woundPolysubstance use disorder reflected, a history of methamphetamine (a potent central nervous system (CNS) stimulant that is mainly used as a recreational), cannabis (which can also be called marijuana, weed, pot, or bud, refers to the dried flowers, leaves, stems, and seeds of the cannabis plant) and opiate (are natural or synthetic chemicals that bind to receptors in your brain or body to reduce the intensity of pain signals reaching the brain) abuse.*Repeated drug toxic screened positive for amphetamines, benzodiazepines (benzos, are a class of central nervous system (CNS) depressant drugs), cannabinoids and cocaine (Central nervous system stimulant and tropane alkaloid derived primarily from the leaves of two coca species.Requested EMS report online from city on 08/22/25 and have not received at this time. Record review of progress notes dated 08/01/25 to 08/04/25 reflected no documentation of emergency contact was