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	09/10/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility to protect the resident's right to be free of sexual abuse by a resident for one (Resident #2) of twelve residents reviewed for abuse. The facility failed to protect Resident #2 from sexual abuse by another resident when Resident #1 led Resident #2 into his room on 09/07/2025 and sexually assaulted her. An IJ was identified on 09/08/2025. The IJ template was provided to the facility on [DATE] at 1:54 PM. While the IJ was removed on 09/10/2025, the facility remained out of compliance at a scope of Isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. This failure placed residents at risk of subsequent abuse resulting in potential mental anguish, emotional distress, and physical harm. Findings included: Review of Resident #1's admission Record, dated 09/08/25, reflected he was a [AGE] year-old male, admitted on [DATE], with diagnoses of paraplegia (loss of voluntary movement and sensation in the lower half of the body), depression, anxiety, cerebral infarction (stroke), and traumatic brain injury (sudden injury to the brain usually caused by a blow or jolt to the head.) Resident #1 was his own responsible party. Review of Resident #1's MDS, dated [DATE], reflected Resident #1 was able to understand others, and be understood by others, and had a BIMS score of 14, indicating he was cognitively intact. He exhibited no signs of delirium or psychosis, and was not depressed, but did sometimes feel socially isolated. He had no behaviors during the assessment period. Resident #1 used a wheelchair for locomotion, and needed little assistance with his ADLs. Resident #1 required partial to moderate (helper does less than half the effort) assistance with toileting, showering, and lower body dressing. He required only supervision or touching assistance with personal hygiene and upper body dressing. Resident #1 was able to move himself around in bed, and sit and lie down with no assistance. Review of Resident #1's care plans reflected the following care plans:- 07/24/25 for impaired comprehension related to his history of traumatic brain injury- 08/22/25 for potential for disruption of continuity of care related to signing himself out of the facility to gather off the facility property with other residents to smoke and socialize-08/25/25 for a psychosocial well-being problem related to a history of drug and alcohol use- 09/07/25 for sexually inappropriate behavior with another resident. This careplan had a goal of the resident not displaying any sexually inappropriate behavior through the target date of 10/23/25, and had interventions which included trauma assessment, not arguing with resident, monitoring and documenting behavior, notifying psych services when inappropriate behavior is noted, notifying Medical Director when inappropriate sexual behaviors occurred, and speaking in a calm voice when behavior was disruptive. The care plans did not include any other care plan for sexual behavior, or care plan for drug use which had occurred while he was a resident in the facility. Review of Resident #1's psychological services note, dated 09/05/25 reflected he was seen for hallucinations and delusions. The document noted that Resident #1 told the counselor that he had been served with a 30-day discharge notice due to alleged drug use, but denied using drugs. The document also noted that he provided inconsistent information and had difficulty articulating or focusing. Under Risk Factors the note included Sexual Acting Out: None. Review of Resident #1's progress notes reflected the following:- A note on 09/05/25 at 11:30 PM by LVN C reflected Resident was in A hall knocking at a female resident's room (female resident not identified). Resident was informed that the female resident was asleep. This resident was insisting that the female resident needs to come out, but the female resident told this writer with the A hall nurse and a female CNA that she does not want to be disturbed. When this resident was told what the female resident said, he did not want to move away from the hallway to his hall. He then came to the front lobby and sad [sic] he was waiting for a female visitor. Resident was informed that visitation time ends at 8 pm. He then said, I am a [AGE] year-old man, I can go out whenever I want. He then went to the patio. - A note on 09/06/25 at 12:35 PM by LVN B reflected Resident in room door closed, staff member open door togive lunch tray to resident strong drug order [sic] in room. DON and Ad min [sic] notified - A note on 09/06/25 at 2:59 AM by LVN C reflected (.) Resident noncompliant to instructions. Earlier on the shift, resident was knocking at the female residents rooms (identities of female residents unknown) and refused being redirected to his room. - A note on 09/06/25 at 10:26 PM by LVN C reflected, Resident outside (female resident #13's) knocking at the door. Resident redirected back to his room but non-compliant with instructions, refused to go and started talking to a female resident (identity unknown) inquiring her room number. - A note on 09/07/25 at 4:30 AM by RN A reflected This writer and another nurse were at A hall

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 interview and record review, the facility failed to ensure that an allegation of abuse was reported immediately but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse to Health and Human Services for one (Resident #3) of twelve residents reviewed for abuse and neglect. The facility failed to report an allegation by Resident #3 (a discharged resident) that Resident #1 put drugs in a beer he gave her on 08/31/25 or 09/01/25. This failure could place residents at risk of being abused and lack of oversight by a state agency. Findings included: Review of Resident #1's admission Record, dated 09/08/25, reflected he was a [AGE] year-old male, admitted on [DATE], with diagnoses of paraplegia (loss of voluntary movement and sensation in the lower half of the body), depression, anxiety, cerebral infarction (stroke), and traumatic brain injury (sudden injury to the brain usually caused by a blow or jolt to the head.) Resident #1 was his own responsible party. Review of Resident #1's MDS, dated [DATE], reflected Resident #1 was able to understand others, and be understood by others, and had a BIMS score of 14, indicating he was cognitively intact. He exhibited no signs of delirium or psychosis, and was not depressed, but did sometimes felt socially isolated. He had no behaviors during the assessment period. Resident #1 used a wheelchair for locomotion, and needed little assistance with his ADLs. Resident #1 required partial to moderate (helper does less than half the effort) assistance with toileting, showering, and lower body dressing. He required only supervision or touching assistance with personal hygiene and upper body dressing. Resident #1 was able to move himself around in bed, and sit and lie down with no assistance. Review of Resident #1's Careplans reflected the following care plans:- 07/24/25 for impaired comprehension related to his history of traumatic brain injury- 08/22/25 for potential for disruption of continuity of care related to signing himself out of the facility to gather off the facility property with other residents to smoke and socialize-08/25/25 for a psychosocial well-being problem related to a history of drug and alcohol use Review of Resident #1's psychological services note, dated 09/05/25 reflected he was seen for hallucinations and delusions. The document noted that Resident #1 told the counselor that he had been served with a 30-day discharge notice due to alleged drug use, but denied using drugs. The document also noted that he provided inconsistent information and had difficulty articulating or focusing. Review of a note on 08/31/25 at 1:10 AM by RN A reflected At about 12am, this writer and another nurse were doing nurse's rounds and observed that resident was in his room with another female resident with door slightly opened. Resident stated that we are just watching a movie. Shortly after, his door was closed and this writer and another nurse went to check on patient. When we knocked on patient's door, he answered and stated that i am enjoying myself. We observed both residents lying in bed having sex. We provided privacy. (Medical Director), Administrator and DON notified. Review of Resident #3's admission Record, dated 09/10/25 , reflected the resident was a [AGE] year-old female with diagnoses of bipolar disorder, anxiety disorder, COPD (a condition which makes it difficult to breathe) and post-traumatic stress disorder. Review of Resident #3's MDS assessment, dated 09/01/25, reflected Resident #3 was usually understood, and usually able to understand others. She had diagnoses of depression, mild cognitive impairment, and personal history of suicidal behavior. She had a BIMS score of 11, which indicated moderate cognitive impairment. During the assessment period she showed no signs of delirium, psychosis, or behavioral problems. She had one-sided impairment of her upper extremity, and was able to use her wheelchair with only supervision or touching assistance. Review of Resident #3's careplans reflected the following:- 03/15/25 a history of suicidal ideation (thoughts of killing oneself)- 03/15/25 impaired cognitive function- 03/17/25 impaired comprehension- 05/12/25 a history of verbal aggression with staff, residents and transport drivers, and socially in appropriate/ disruptive behavior, sexually inappropriate behavior, cursing, and throwing things.- 05/21/25 puts herself in dangerous situations, and rolling walker inside and outside, and wandering into unsafe situations re: cognitive status- 05/21/25 After discovering (Resident #3) was sexually [sic] she disclosed her triggers were men, and aggressive people. She also said that constant stares triggers her. An 08/31/25 note added to this careplan that on that date she was observed by a nurse having sexual relations with another resident. - 08/21/25 potential for disrupting continuity of care due to signing out and sitting outside socializing with other residents.08/25/25 history of alcohol and drug used, and goes out on pass regularly. A note added to this careplan on 09/01/25 reflected the resident called 911 and requested to go to the hospital as a result of another resident putting drugs in her beer when they were outside. Review of Resident #3's progress notes reflected the following: -

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0656 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, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for five (Residents #1, #8, #9, #11, and #12) of eight residents reviewed for care plans related to sexual activity with other residents. The facility failed to create care plans addressing known sexual relationships between residents for Residents #1, #8, #9, #11, and #12. This failure could affect residents by placing them at risk for not receiving care and services to meet their needs. Findings included: Review of Resident #1's admission Record, dated 09/08/25, reflected he was a [AGE] year-old male, admitted on [DATE], with diagnoses of paraplegia (loss of voluntary movement and sensation in the lower half of the body), depression, anxiety, cerebral infarction (stroke), and traumatic brain injury (sudden injury to the brain usually caused by a blow or jolt to the head.) Resident #1 was his own responsible party. Review of Resident #1's MDS, dated [DATE], reflected Resident #1 was able to understand others, and be understood by others, and had a BIMS score of 14, indicating he was cognitively intact. He exhibited no signs of delirium or psychosis, and was not depressed, but did sometimes feel socially isolated. He had no behaviors during the assessment period. Resident #1 used a wheelchair for locomotion, and needed little assistance with his ADLs. Resident #1 required partial to moderate (helper does less than half the effort) assistance with toileting, showering, and lower body dressing. He required only supervision or touching assistance with personal hygiene and upper body dressing. Resident #1 was able to move himself around in bed, and sit and lie down with no assistance. Review of Resident #1's Careplans reflected the following care plans:- 09/07/25 for sexually inappropriate behavior with another resident.- The care plans did not include any other care plan related to sexual behavior or relationships. Review of Resident #8's admission Record, dated 09/10/25, reflected the resident was a [AGE] year-old male admitted on [DATE], with diagnoses of epilepsy, depression, and mild cognitive impairment. Resident #8's family member was listed as his responsible party. Review of Resident #8's quarterly MDS assessment, dated 09/01/25, reflected the resident had a BIMS score of 11, which indicated moderate cognitive impairment. He was usually understood by others, and usually understood others. Resident #8 exhibited no signs of delirium or psychosis during the assessment period, and had no behavioral problems. Review of Resident #8's care plans, dated 09/03/25, reflected the following:- Resident was at risk for altered status due to a traumatic life experience, due to being raped as a young child.- Resident was a registered sex offender and must be supervised when he goes out on pass in a child safety zone.- The care plans did not include any other care plan related to sexual behavior or relationships. Review of Resident #9's admission Record, dated 09/10/25, reflected the resident was a [AGE] year-old male admitted on [DATE], with diagnoses of schizoaffective disorder (a mental health condition having symptoms of schizophrenia and a mood disorder), major depressive disorder, and generalized anxiety disorder. Resident #9 was listed as his own Responsible Party. Review of Resident #9's quarterly MDS assessment, dated 08/29/25, reflected the resident had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #9 was usually understood by others, and usually able to understand others. Resident #9 had fluctuating inattention and disorganized thinking during the assessment period, and no behavioral problems. Review of Resident #9's care plan, dated 09/04/25, reflected the following:- Resident has a history of frequently accusing other male residents that he is fixated on and (who he doesn't like) of raping his female companion, even though his female companion clearly states that I never told him that. That has never happened to me.- (Resident #9) experiences disorganized thinking due to Schizophrenia. He frequently makes false accusations againstothers. If he does not get his way he becomes angry and curses at others. He tries to manipulate staff into getting hisway. He recently has begun to say that people are beating the crap out of my girlfriend.- The care plans did not include any plan related to sexual behavior or relationships. Review of Resident #11's face sheet, dated 09/10/25, reflected the resident was a [AGE] year-old male, admitted on [DATE], with diagnoses of diffuse traumatic brain injury with loss of consciousness of unspecified duration (a type of traumatic brain injury that results from blunt injury to the brain which can lead to loss of consciousness), major depressive disorder, and bipolar disorder. Resident #11 was listed as his own Responsible Party. Review of Resident #11's quarterly MDS assessment, dated