

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2025
NAME OF PROVIDER OR SUPPLIER Dfw Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the residents had the right to be free from abuse for 1 of 5 residents (Resident #2) reviewed for abuse, neglect, and or exploitation. The facility failed to ensure Resident #2 was free from repeated resident-to-resident abuse by Resident #3, which occurred on 05/24/2025, 08/17/2025, and 10/03/2025. A past Immediate Jeopardy (IJ) was found on 08/17/25 and the immediacy was removed on 10/05/25. While the IJ was removed on 10/025/25, the facility remained out of compliance at a severity of actual harm due to the facility's need to monitor the effectiveness of their corrective systems. These failures could place residents at risk for continued abuse, decreased quality of life, decreased self-esteem and increased anxiety. Findings included: Record review of an undated admission Record revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 had the admitting diagnoses of Alzheimer's Disease, Unspecified (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), Type 2 Diabetes Mellitus without Complications (chronic condition where persistently high blood sugar levels are caused by the pancreas not being able to make enough insulin), Dementia in other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (dementia where the specific cause is unknown and the person does not exhibit behavioral issues like agitation or aggression), Major Depressive Disorder, Recurrent, Unspecified (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), Cerebral Infarction, Unspecified (a stroke where the exact cause and location of the brain damage are unknown), Chronic Obstructive Pulmonary Disease, Unspecified (a group of lung diseases that cause airflow obstruction and breathlessness), Chronic Respiratory Failure, Unspecified (condition where there is not enough oxygen or too much carbon dioxide is in the body), and Presence of Cerebrospinal Fluid Drainage Device (long term device, or shunt, that allows excess fluid from the brain to drain to another part of the body relieving pressure). Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 03 indicating Severe Cognitive Impairment. Resident #2 was documented as having no (zero) behavioral symptoms. Resident #2 showed to be independently ambulatory with no functional limitations in range of motion. Record Review of Resident #2's Care Plan, dated 08/30/2025, revealed a focus added on 03/15/2023 of resident having a history of intruding on others privacy with interventions and tasks of place in area where frequent observation was possible, redirect when wandering into other resident rooms, and monitor and document behavior. Focus added on 01/14/2024 of displays socially inappropriate/ disruptive behavior due to known for taking personal items from her roommate and other peers that do not belong to her. When she is called out on this disruptive behavior, she curses at staff and peers, calls everyone names and refuses to listen to staff due to her cognitive status, Psych. diagnosis with interventions and tasks of administer medication as ordered, discuss options for appropriate channeling of anger, talk in calm voice when behavior is disruptive, Social Services to evaluate and visit routinely, and monitor and document behavior. Focus of at risk of being taken advantage of r/t impaired cognition updated on 10/03/2025 when Resident #3 slapped Resident #2 after she took his cup with interventions and tasks of allow Resident #2 to express concerns about safety, anticipate Resident #2's needs, encourage Resident #2 to sit in common areas that are well populated, observe Resident #2 frequently throughout the day, psych services are available as needed, and on 10/03/2025 added intervention of place Resident #2 on 1:1 monitoring until alternate placement is found. Record Review of Resident #3's undated admission Record revealed Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had the admitting diagnoses of Bipolar Disorder, Unspecified (psychological condition that causes dramatic changes in a person's mood, ability to think clearly, and energy; involves periods of mania and depression; unspecified is diagnosed when symptoms do not meet the criteria for other types), Depression, Unspecified (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), Anxiety Disorder, Unspecified (repeated episodes of sudden feelings of intense anxiety, and fear or terror that reach a peak within minutes), Impulse Disorder, Unspecified (group of behavioral conditions that make it difficult to control your actions or reactions), Mild Intellectual Disabilities (neurodevelopment disorder characterized by significant limitations in intellectual and adaptive functioning), Cerebral Infarction, Unspecified (a stroke where the exact cause and location of the brain damage are unknown). Other</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>(continued on next page)</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the ombudsman of the transfer or discharge before transferring or discharging the resident for 1 of 1 resident (Resident #1) reviewed for Discharge Rights. The facility failed to notify the ombudsman in writing of the transfer/ discharge of Resident #1 to a behavioral hospital, the reason for the transfer/discharge, and the right to appeal. This failure could affect the residents at the facility by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings included: Record review of Resident #1's face sheet dated 10/14/2025 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 was discharged to hospital for a behavioral evaluation on 09/28/2025. Resident's diagnosis included Schizophrenia, Unspecified (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania); Unspecified Psychosis Not Due to a Substance or Known Psychological Condition (used when psychotic symptoms are present but a specific cause, like drugs, other mental disorders, or a medical condition hasn't been identified or confirmed yet); and Major Depressive Disorder, Recurrent, Unspecified (used when a person has significant symptoms of depression that cause distress or impairment, but they do not meet the full diagnostic criteria for a more specific depressive disorder, or there is not enough information to provide one). Record review of Resident #1's MDS assessment dated [DATE], noted his BIMS Score to be 12 which reflected moderate cognitive impairment. Resident #1 Review of Resident #1's progress notes reflected that on 09/28/2025, the facility initiated a referral to transfer the resident to the hospital for a psychological evaluation due to the resident having an increase in his verbal, physical, and violent behavior towards the staff. Family member notified by phone concerning Resident #1's transfer. Resident #1 was his own responsible party. Record review on 09/29/2025 of social services notes revealed that SW spoke with Resident #1's family member about how his behavior had not gotten better since giving him the 30-day notice before. SW informed family member about Resident #1 threatening staff. Family member stated she has never known Resident #1 threaten to kill anyone and that the staff are triggering him. DSS said this was done after staff redirected him while breaking rules. Resident #1 was contacted by SW that he was being provided an immediate discharge from the facility r/t his violent behavior towards the staff and other residents in the facility. Resident #1 refused to give verbal consent by phone. SW planned for Resident #1 to move to a residential group home in the community upon discharge from hospital. Resident #1 was transferred to a group home and has adjusted well to the move. On 10/13/2025 at 1:12 p.m., an interview with the family member revealed that Resident #1 had not been at the facility for some time. Family member could not give the specific time he was discharged to hospital for a psychological evaluation. Family member stated that Resident #1 is now in another place but cannot remember the name of the group home he moved to. Resident #1 has his own room, is stable, and happy. Family member stated Resident #1 had schizophrenia and did not understand he could not smoke anytime he wanted when he was at the facility. When he acted up at the facility, the staff would contact the family member to come to the facility to calm him down. Family member stated she told the staff it was their job to take care of him. Family member stated that Resident #1 is glad he is no longer at that facility because the staff stated he was threatening to kill others and kill himself. Family member did not believe what they told her. Family member did not state if she was aware of the 30-day notice. On 10/14/2025 at 2:32 p.m., an interview with SW revealed that she contacted the Ombudsman (person who acts as an independent and neutral intermediary to help resolve complaints and disputes fairly between individuals and an organization or government agency) and left a message concerning Resident #1's immediate discharge. SW did not document that a message was left on Ombudsman's voicemail and could not provide a date when she left the message. SW could not provide a copy of the first 30-day notice that was given to Resident #1 and could not provide the date. SW provided a copy of the immediate discharge notice given to Resident #1. Record review of an email conversation with the Ombudsman on 10/14/2025 at 4:33 p.m. revealed she did not receive a phone call or email r/t a notification before or after Resident #1's discharge on [DATE]. On 10/14/2025 at 4:17 p.m., an interview with DON revealed that Resident #1 exhibited behaviors that placed residents' and staff's safety at risk. He was non-compliant with facility smoking rules, would go out to the laundry, take staff's food from the employee breakroom, and verbally threaten to harm the employees.</p>		

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide behavioral health services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (Resident #2) of five residents reviewed for behavioral health services. The facility failed to ensure Resident #2 received a psychology consultation or assessment after three incidents (5/24/2025, 08/17/2025, 10/03/2025) of resident-to-resident abuse where Resident #2 was the victim. This failure could place residents at risk for not receiving behavioral health services and a decline in quality of life. Findings included: Record review of an undated admission Record revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. 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