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	11/20/2025

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 - Actual harm 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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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident's right to be free from abuse for two (Resident #1 and #2) of 3 residents reviewed for abuse, in that: On 11/01/25 the facility failed to ensure that Resident #2 was not hit by Resident #1 causing Resident #2 to defend himself with his cane resulting in a laceration to Resident #1's left eyebrow. This failure could affect residents and result in abuse and injuries. Findings include: Record Review of Resident #1's Face sheet reflected she is a [AGE] year-old female admitted to the facility on [DATE]. Record Review of Resident #1's Quarterly MDS dated [DATE] reflected in part diagnoses including bipolar disorder (a mental condition marked by alternating periods of elation and depression), anxiety disorder, dementia, and mood affective disorder (affects your emotional state). A BIMS score of 11 indicated moderate cognitive impairment. Record Review of Resident #1's Care Plan dated 11/13/25 reflected Resident #1 was at risk for bleeding and bruising due to taking Aspirin. Resident #1 was at risk of hitting another resident in the back on 03/29/25. Intervention included residents were separated and assessed for injuries-no injuries noted. Repeatedly hit another resident and then made threatening and intimidating remarks about her to another resident on 04/05/25. Intervention included residents, were separated and assessed for injuries-no injuries noted. Called another resident the N word on 04/26/25. Interventions included Resident #1 was redirected and told that that her words were inappropriate. The 2 residents were separated. Received physical aggression from another resident and then retaliated back and hit a resident on 05/19/25. Interventions included residents separated, Resident #1 assessed for injury. Full skin assessment completed. Physician and Fort Worth police were notified. Identify causes for behavior and reduce factors that may provoke the resident. Resident to be redirected. Record Review of Resident #2's Face sheet reflected he is a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #2's Quarterly MDS dated [DATE] reflected in part diagnosis including schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). A BIMS score of 11 indicated moderate cognitive impairment. Record Review of Resident #2's Care Plan dated 11/06/25 reflected #2 was at risk for bleeding and bruising due to taking Aspirin. Resident #2 was also at risk for displaying socially inappropriate/disruptive behavior, cursing, provoking other residents, Psych diagnosis, and deliberately rammed his wheelchair into another resident, provoking an altercation on 09/16/25. Interventions in part included psychiatric services as needed. Record Review of Resident #1's hospital record dated 11/01/25, indicated Resident #1 was treated for a facial laceration and wound irrigation was performed. In an interview on 11/19/25 at 4:41 PM, Receptionist A stated on 11/01/25 Resident #1 had just come in the building to take her medicine then she went to smoke break, she sated Resident #1 already seemed flustered. Receptionist A stated that Resident #2 was walking outside to go to smoke break and both residents exchanged words at the door. Receptionist A stated Resident #2 sat down outside and Resident #1 stood over Resident #2 fussing at him and grabbing on his pants to provoke a fight. Receptionist A stated they decided to hold off on smoke break and her and Housekeeper B separated the residents. Receptionist A stated that Housekeeper B and Resident #1 went back into the building and Resident #1 was taken to her room. Receptionists A stated Resident #1 was in her room still fussing and yelling. Receptionist A stated that she was at her desk, and she heard a loud commotion, and she ran outside to the smoking area. Receptionists A stated she did not see what happened when Resident #2 went back outside but before she was able to get out the door, she observed blood on Resident #1. Receptionist A stated that Resident #2 was trying to get away from Resident #1, but Resident #2 was pulling on Resident #1's pants still trying to fight. Receptionist A stated LVN C called 911 immediately. Receptionist A stated she tried her best to calm down Resident #2 until the police came, but she was still trying to fight Resident #1. Receptionist A stated that Resident #1 was in shock, and he was observed shaking. In an interview on 11/20/25 10:27 AM, LVN D stated he did not see the whole altercation, but what he observed was Resident #1 and #2 were arguing in the smoking area. LVN D stated that Resident #1 was standing over Resident #2 and hit him and that's when Resident #2 put his cane up to keep Resident #1 from hitting him. LVN D stated that he then told Resident #2 to go to her room so that he could assess her. LVN D stated 5 minutes later Resident #1 was back outside in the smoking area, but he didn't see anything else from that point. LVN D stated that he heard Resident #1 calling Resident #2 the (N word) and calling him cripple. LVN D stated that someone called 911, and he assessed Resident #1 he said she had a cut on her forearm, and

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 interviews and record review the facility failed to ensure allegations of abuse were thoroughly investigated, prevent further potential abuse and mistreatment while the investigation was in process, and report the results of all investigations to the administrator or his or her designated representative and other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for 1 (Resident #4) of 3 reviewed for abuse. The facility failed to immediately investigate, protect the residents, and report allegations of abuse on 08/29/25 when Resident #4 reported a nurse hit her while in the shower, and the facility did not investigate or implement measures to protect the residents from further abuse. This failure could place residents residing in the facility at risk of abuse. Findings included: Record review of Resident #4's face sheet dated 11/21/25 reflected [AGE] year-old woman admitted to the facility on [DATE] with an initial admission date of 08/20/24 with a primary diagnosis of major depressive order, anxiety disorder, mood disorder and schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Record Review of Resident #4's care plan dated 10/14/25 reflected on 08/29/25 Resident #4 has a habit of calling 911 and stating, I am on drugs Resident #4 was observed on the floor and crawling to the hallway refusing to allow staff to help her up, insisting on going to the hospital. Interventions included instruct resident when behavior is inappropriate or unacceptable in a calm manner, Access Resident #4 for injuries when putting herself in unsafe situations and carefully explain procedures to resident, do not argue with the resident, drug test as needed, Psych services as needed. Record Review of Resident #4's MDS dated [DATE] reflected a BIMS score of 7, indicating severely impaired cognition. PIR was requested from the DON on 11/19/25 at 10:15 AM, and the wrong PIR was given to surveyor from the DON. Record Review of a progress note dated 08/29/25 reflected Resident #4 requested a shower even though she normally gets her shower on the 2-10 shift. Staff went on to assist resident #4 with her shower. Resident started calling staff names and throwing things at staff as they were assisting her with her shower. Staff assisted Resident #4 back to her room and wanted to assist her dressing, but resident would not let staff assist her and she laid down on the floor naked, saying I want to go to [Hospital Name 2], I want to go to [Hospital Name 2], don't touch me. Record Review of another progress note dated 08/29/25 reflected Incident Description- Resident #4 requested a shower even though she normally gets her shower on the 2-10 shift. Staff went on to assist resident #4 with her shower. Resident started calling staff names and throwing things at staff as they were assisting her with her shower. Staff assisted resident back to her room and wanted to assist her with her dressing, but resident would not let staff assist her and she laid down on the floor naked, saying, I want to go to [Hospital Name 2], I want to go to [Hospital Name 2], don't touch me. Nurse informed medical director who ordered resident to be sent out to the hospital. Resident #4 was transported out to [Hospital Name 2] for further evaluation. Resident #4 unable to give description. Immediate Action Taken - Nurse couldn't examine resident for injuries or get vital signs because resident would not let staff members touch her. Nurse informed medical director who ordered resident #4 be sent to the hospital. Nurse called the ambulance to get resident to the hospital. Residents were transported out to [Hospital Name 2] for further evaluation. Resident #4 is her own responsible party. Record Review of intake 1034343 dated 09/03/25 indicated the allegation of the incident was abuse. On 11/20/25 at 10:15 AM, surveyor requested PIR for intake 1034343. At 11:17 AM, the DON stated that she was looking for the PIR. Surveyor requested all information that was done for the investigation. At 11:45 AM, the DON presented a progress note from the incident and stated that's all she could find from the investigation. Resident #4 was unable to be interviewed due to being in the hospital at the time of the visit. In an interview on 11/20/25 at 11:46 AM, Med Tech F stated Resident #4 was given a shower and Resident #4 seemed agitated already and the aid that assisted Resident #4 could not get her dressed in the showers, so the aid brought her back to the resident's room to get her dressed. Med Tech F stated she couldn't remember the name of the aid that was assisting Resident #4 at the time. Med Tech F stated when the aid went to try and get Resident #4 dressed Resident #4 laid down on the floor and kept stating she did not want to get dressed and she just wanted to go to [Hospital Name 2]. Med Tech F stated [Hospital Name 2] is Resident #4's hospital of choice whenever she wants to be sent out to the hospital. Med Tech F stated Resident #4 did not fall and she willingly got on the floor. Med Tech F stated Resident #4 was not injured at all. Med Tech F stated Resident

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 1 (Resident #3) for accuracy of records. The facility failed to accurately transcribe the admitting diagnoses for Resident #3. This failure can affect residents by putting them at risk for inaccurate and incomplete records. Findings include:Record review of Resident #3's face sheet dated 11/19/25 reflected a [AGE] year-old man admitted to the facility on [DATE] with a primary diagnosis of HIV (a virus that attacks cells that help the body fight infection), severe protein-calorie malnutrition (inadequate intake of protein and calories), seizures, hypertension (pressure in your blood vessels is too high), atrial fibrillation (irregular and often very rapid heart rhythm), congestive heart failure (heart can't pump enough blood), cerebral infarction (reduces blood flow to a region of the brain), end stage renal disease (kidneys no longer work as they should to meet your body's needs), and anemia. Record Review of Resident #3's face sheet reflected a diagnosis of Dementia. Record review of Resident #3's MDS dated [DATE] reflected a BIMS score of 11, indicating moderately impaired. In an interview on 11/19/25 at 12:32 PM, an Anonymous family member stated the day of the incident with Resident #3 they received a call from a nurse at [Hospital Name 1]. They stated they hung up the phone because they thought someone had the wrong number and they didn't have any children at [Hospital Name 1]. Anonymous family member stated that he received another phone call from a nurse and police from [Hospital Name 1] and informed them that Resident #3 had been at [Hospital Name 1] for two hours and he couldn't find his way back to [Facility Name]. Anonymous family member stated that he immediately called [Facility Name] and asked the receptionist how Resident #3 was doing today, and the receptionist replied that Resident #3 was doing fine. Anonymous family member stated he then asked the receptionist how he is fine, and he is not in the building. Anonymous family member stated the receptionist left the phone and never came back. Anonymous family member stated when they arrived at the facility later that day, he kept asking the staff how does someone with dementia sign themselves out, they said no one was able to answer that question. Surveyor informed Anonymous family member that they were unable to find a diagnosis of Dementia for Resident #3 in the medical records the [Facility Name] has for Resident #3. Anonymous family member stated that they would send an email of a document from Resident #3's doctor with evidence Resident #3 had Dementia. In an email on 11/19/25 at 3:34 PM, Anonymous family member sent a clinical record from [Hospital/Clinic Name] that reflected a diagnosis of HIV/AIDS with HIV Dementia and Vascular Dementia with alcoholic neurological disease component. In an interview on 11/19/25 3:51 PM with the DON, she stated that diagnosis for the residents is transcribed in the database by charge nurses, the MDS coordinators, the ADON, and her. Record Review of Resident # 3's clinical record dated 09/03/25 from [Hospital Name 2] reflected a diagnosis of Dementia. Record Review of the list of Residents Who cannot leave the building or Must be supervised reflected resident #3, resident #5, resident 6, resident #7, resident #8, resident #9, resident #10 and resident #11. Record Review of Resident #3's Wander Assessment, not dated indicated a score of 9. A score of 0-8 indicates low risk, a score of 9-10 indicates a risk to wander, and 11 and above indicates high risk to wander. In an interview on 11/20/25 at 12:45 PM, the ADON stated she wouldn't say Resident #3 has Dementia, but his cognitive status can be deceiving because when he is asked his name, he knows it, but if you continue to talk to him, you can tell he is not aware and he doesn't always know where he is at. The ADON stated Resident #3 doesn't wander but he will walk up to the front of the building and say he wants to sign out and go somewhere and he would usually come back. The ADON stated she recommends that he can sign out but only with supervision. There is a book at the receptionist's desk titled Residents Who cannot leave the building or Must be supervised, receptionists will look in the book before letting a resident sign out to determine if the resident is listed in the binder. The ADON stated that she was not at work the day of the incident, but she stated Resident #3 asked to sign out the very next day on Sunday and Resident #3 asked to sign out again and she informed him that it's not safe for him to go out on his own. The ADON stated when Resident #3 was admitted and she did his assessment his BIMS score was okay for him to sign out, but when she reassessed him on 11/15/25, she stated that's when she noticed he was not safe to go out on his own any longer[JM4] . The ADON stated since the incident Resident #3 has been placed in the Residents Who cannot leave the building or Must be supervised list, and a wander guard has been placed on the