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	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dfw Nursing & Rehab	900 W Leuda St Fort Worth, TX 76104

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility; the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would otherwise be endangered; and failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions for one of five residents (Resident #1) reviewed for transfers and discharges. 1) The facility failed to ensure when Resident #1 was issued a 30-day discharge notice, on 12/12/25, citing behavioral issues, the clinical documentation contained clear evidence which documented the resident's needs could not be met in the facility and posed a danger that could not be managed through care planning or IDT intervention.2) The facility failed to ensure a safe and orderly transfer and discharge process when they sent Resident #1 to a behavioral hospital through an order of protective custody (OPC) and then refused to readmit Resident #1 following the inpatient psychiatric stabilization when he was stable.These failures could place residents at risk for inappropriate discharge, prolonged institutionalization and disruption of continuity of care. Findings include:Record review of Resident #1's Quarterly MDS Assessment, dated 12/01/25, reflected a [AGE] year old male who was admitted to the facility on [DATE]. Resident #1 had active diagnoses which included Parkinsonism (a neurological syndrome characterized by motor symptoms like tremor, slowness, rigidity and postural instability), seizure disorder (chronic neurological condition characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical surges in the brain), anxiety (excessive fear, worry, and physical symptoms like rapid heart rate, dizziness, and restlessness that interfere with daily life), depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and physical pain) and schizophrenia (a chronic, severe brain disorder characterized by a detachment from reality through hallucinations, delusions, and disorganized thinking). Resident #1 had a BIMS score of 03, which indicated severe cognitive impairment. Resident #1 had fluctuating signs and symptoms of delirium which included inattention and disorganized thinking. He had symptoms of feeling depressed and little interest noted as a mood issue. Resident #1 was noted to feel sometimes isolated around those around him. Resident #1 had no potential indicators of psychosis and no behavioral symptoms of physical or verbal aggression. Resident #1 had no rejection of care issues and no wandering behaviors. Resident #1 was ambulatory, did not use a mobility aide and had no range of motion issues. For walking 10-150 feet, Resident #1 required supervision or touching assistance. Resident #1 was administered the following high-risk medications during the assessment period: an (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antipsychotic, antianxiety, antidepressant, antibiotic and anticonvulsant medications. Record review of Resident #1's care plan, initiated 12/29/23 and last revised 01/12/26, reflected the following areas focus areas: 1) Signs of disorganized thinking and auditory hallucinations (initiated: 03/09/24), 2) Has a female resident that he looked at as his companion (initiated: 03/27/24). Interventions included to administer medications as ordered, allow ample time to answer questions, introduce changes slowly and monitoring by nursing every hour for his whereabouts. Resident #1 also was care planned as having a history of behaviors, refused medication at times, had a history of aggressive behavior towards other residents when he is made fun of. Care planned dates of aggression incidents were 09/16/25 when he hit another resident thinking he was making fun of him and on 01/12/26 when he pushed another resident. Additional interventions included not to argue with Resident #1 and Assist [Resident #1] to selection of appropriate coping mechanisms, ensure that other residents are safe when [Resident #1] exhibits aggressive behaviors, Illicit help from family members when [Resident #1] has aggressive behaviors, Monitor and document [Resident #1's] behaviors, Notify PCP.Refer to psych services when exhibiting behaviors, Social services to evaluate and visit with [Resident #1], Talk to him in a calm voice when behavior is disruptive.Record review of Resident #1's Physician Order Summary reflected he was prescribed the following psychotropic medications: -Lorazepam 1mg three times a day for anxiety disorder (start date: 03/13/25) -Lexapro 10 mg once a day for depression (start date 04/30/24) -Lithium Carbonate 300 mg twice a day for bipolar disorder (start date 03/14/24)-Risperdal 2 mg once in the evening for schizophrenia (start date 09/24/25)-Divalproex Sodium 250 mg twice a day for schizophrenia (start date 09/24/25)-Mirtazapine 15 mg in the evening for mood/appetite (start date 04/29/24)Record review of Resident #1's December 2025 and January 2026 MAR reflected he was administered his psychotropic medications as ordered, however, he had periodic medication refusals throughout the two months as documented by the nurses and medication aides on the MAR. Record review of Resident #1's psychological services progress note, by LPC, dated 12/11/25, reflected he had no current risk factors, which included self-injury, sexual acting out, homicidal and aggressive behavior. His appearance was neat, judgement within normal limits and he was alert and oriented to person/place/time/day/year. His attention was average and he had restless psychomotor symptoms (connection between mental states and physical movement, manifesting as either extreme agitation or severe slowing). He had tangential speech and a sad, labile, anxious and stressed affect. His mood was worried and depressed and his speech was impoverished. Short-term therapy goals were for Resident #1 to verbalize feelings about his current situation during sessions, identify and discuss at least two positive coping skills, reduce frequency of behavioral disturbances by 50% for four weeks and he will report two positive social interactions daily that improve his mood. Resident #1's response to intervention per the clinician's notes was, Engaged and interactive in session. Met in day area, where he is isolating; acknowledged insight into mood changes when isolating. Praised pt for recognizing patterns and symptoms of avoidance/disengaging. Encouraged his progress with new awareness. Record review of a 30-day Discharge Notice for Resident #1, dated 12/12/25, reflected he was formally notified that he would be discharged from the facility on 01/10/26 due to 1) The safety of other individuals is endangered, 2)The health of other individuals in the Health Care Center is endangered, and 3) Your needs cannot be met by the Health Care Center.Record review of Resident #1's Psychiatric Subsequent Assessment, dated 01/07/26, by PMHNP reflected he was being seen for medication management. The assessment reflected, Collateral Information: According to staff, the resident refuses medications at times, exhibits sx of paranoia, auditory hallucinations and anxiety. Resident is currently on hourly checks due to behavioral concerns. An increase of 0.5mg added of Risperdal daily was added with a start (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back. This has been very triggering for the patient and has caused setbacks in his treatment. As a facility, we would require at least 72 hours of medication compliance prior to discharge to assure stabilization. She stated Resident #1 had been stable and had not had any additional outbursts and a discharge location was still pending. The DCS stated it was her understanding their social worker had spoken with the facility's SW and it was understood the facility would be accepting Resident #1 back until the facility could locate a placement, as his 30-day discharge notice was not up until 02/10/26 per her understanding. The DCS stated, In the case of the nursing home, since the patient was still legally their resident, they should be responsible for locating placement as we (nursing facility) were not a long-term facility and the patient's 30 day was not up. It appears they started this process, sent him to us, then stopped assisting the patient's family member once he was in our (nursing facility) care. Although the group home placement agency stated they were working with [facility SW], [facility SW] informed me on 1/29/2026 that she 'had not set up a group home for the patient', indicating they did not attempt to locate safe placement for their patient from 1/10/2026 when the 30 day was issued until his admission here on 1/14/2026. The DCS stated the facility told the inpatient behavioral hospital staff they would not accept him back. She said her social worker was in contact with the facility and if she would have known, she would have been attempting to locate placement had she been told he was not accepted back. She said per the group home placement agency, who showed up to the behavioral hospital, on Resident #1's date of discharge, the group home was ready. The DCS stated, Then when we sent the patient there, the group home was a vacant home. The patient was brought back to my facility, [behavioral hospital SW] could not explain why the group home she came to divert the patient to was empty, and [facility SW] reports she didn't set up a group home. The patient's [family member] then called us (She had not responded to any contacts prior to this) and said the group home would be ready Saturday, 1/30, and agreed to pick the patient up. On Saturday, she refused and stated the group home won't be ready until March. The DCS stated similar situations had occurred with the facility where they would send residents and then decline to take them back. She stated there was no discharge planning assistance provided by the nursing home despite issuing 30-day notices. The DCS stated she felt the facility issued a 30-day notice to Resident #1 and did not do any discharge planning for him and sent him to an inpatient behavioral hospital for them to take on responsibility for him. She stated there was currently no clear plan for Resident #1's discharge, but