STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675028	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews, and record reviews, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 10 residents (Resident #2) reviewed for call lights. Resident #2's call light was not within reach. The call button was on the other side of the privacy curtain draped over a vacant bed. This failure could place residents at risk of not having their needs and preferences met and a decreased quality of life. Finding included: Record review of Resident #2's Face Sheet dated 10/01/2024, reflected the resident was an [AGE] year-old female who was originally admitted to the facility at 07/16/2024. Diagnoses included: Unspecified dementia without behavioral disturbance (a group of symptoms that may affect, memory, thinking and interferes with daily life), lack of coordination, anemia (deficiency of healthy red blood cells in the blood), hypothyroidism (decreased productions of thyroid hormones), and dysphasia (impacts the ability to speak and understand spoken language). Record review of Resident #2's Initial MDS Assessment, dated 07/24/2024, reflected a BIMS score of 11 which indicated moderately cognitively intact. She required maximum assistance for toileting and showers. She was frequently incontinent of bowel and bladder. Record review of Resident #2's Care Plan dated 07/22/2024 reflected: Focus: [Resident #2] is risk for falls. Intervention: Anticipate and meet [Resident #2's] needs. Be sure [Resident #2's] call light is within reach and encourage the resident to use it or assistance as needed. Staff x 1 to assist with transfers. Focus: [Resident #2] has an ADL Self Care Performance Deficit. Interventions: Encourage [Resident #2] to use bell to call for assistance. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 10/01/2024 at 11:30 AM, Resident #2 was in her room resting on her bed, which was close to the window. The call button was observed draped over the A bed's headboard, which was closest to the door in the room. The privacy curtain covered the area between the two beds. Resident #2's wheelchair was beside her bed. Resident #2 said she did not know where her call light was. When asked about it, she looked around the room but was not able to find it. When asked how she called for staff if she needed assistance, she said she did no call for help. She said she did transfer herself and did have a fall about a month ago but did not hurt herself. She said she lost her balance when she was transferring to her wheelchair from her bed. In an observation and interview on 10/01/2024 at 1:30 PM, the DON accompanied this state surveyor to Resident #2's room. The call button was observed draped over the A (closest to the door) bed's headboard in the room. The privacy curtain covered the area between the two beds. The DON said the call button should be accessible to Resident #2 so she could call for assistance if she needed to. She said Resident #2 did have a recent fall and required assistance to transfer and reminders to use her call light. In an interview on 10/01/2024 at 1:40 PM, LVN A said she did not know Resident #2's call light was not in her reach. She said the call light should be accessible to all residents to ensure they can call for assistance if they need it. In an interview 10/01/2024 at 2:06 PM, CNA B said she worked in all halls. She said she did not notice that Resident #2's call light was not accessible to her. She said it should be accessible to Resident #2 so she could call for assistance if she needed to. In an interview on 10/01/2024 at 2:14 PM, the Regional Compliance Nurse said all residents needed to have a call light accessible to them to ensure they could call for assistance as needed. In an interview on 10/01/2024 at 2:37 PM, CNA C said she was not aware that Resident #2's call light was not accessible to her. CNA C said she rounds constantly and typically checks to ensure call lights were placed. She said residents have a right to be able to call for assistance whenever they needed it. She said she did receive in-servicing on placing call lights but did not recall when the last time was. In an interview on 10/01/2024 at 3:25 PM, the Administrator stated his managers completed Champion Rounds, every morning. She said they look at things like call lights, room condition, resident needs and the information was discussed in the facility's morning meeting for follow up. He said he expected all residents to have access to call lights for their safety and to ensure their needs were met. Record review of the facility's Resident Rights policy, dated 2003, reflected: We believe each resident has a right to a dignified existence, self -determination, and communication with and access to persons and services inside and outside our facility . his facility complies with all applicable provisions of the Human Resources Code Title 2, Chapter 102.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 10 residents reviewed for accidents. The facility staff failed to ensure Resident #1 was safe from accidents and hazards when she fell from her bed on 09/28/2024 and was found face down on the floor with a bruise on her forehead. Resident #1 did not have a fall mat placed on both sides of her bed. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet dated 10/01/2024, reflected the resident was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included: Alzheimer's disease (brain disorder worsening over time), dysphasia (impacts the ability to speak and understand spoken language), and unspecified dementia without behavioral disturbance (a group of symptoms that may affect, memory, thinking and interferes with daily life), muscle weakness, and history of falls. Record review of Resident #1's Initial MDS Assessment, dated 09/13/2024, reflected a BIMS score of 2 which indicated severely cognitively impaired. She was on hospice care, dependent for toileting, showers, and transfers. She was always incontinent of bowel and bladder. Record review of Resident #1's Care Plan dated 06/06/2023, reflected: Focus: [Resident #1] has a hx of falls r/t impaired cognition, poor safety awareness, and is very impulsive. She is at risk for future falls and injury from falls. Interventions: Anticipate and meet the resident's needs. Dycem (to stop from sliding out of seat) wheelchair seat. Ensure bed is in lowest position while resident is in bed. Focus: The resident has a communication problem. Intervention: Anticipate and meet needs. Ensure/provide a safe environment: Call light in reach, Adequate low glare light. Bed in lowest position and wheels locked, Avoid isolation. The care plan was updated on 10/01/2024, by the Corporate Compliance Nurse, to include, Ensure that the resident's floor mat is in place in both sides of the bed while the resident is in bed. There was no orders for fall mats and fall mats were not listed as fall interventions prior to 10/01/2024. Record review of progress note, signed by RN D, and dated 09/28/2024 at 12:02 AM, reflected: during midnight round [Resident #1] noted lying with her face facing the floor, [Resident #1] assisted back to bed with the help of an aid, a complete head to toe done with a slight laceration and redness noted on her forehead, vs wnl a prn pain pill administered. Bed in low position, call light within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of progress note, signed by RN D, and dated 09/28/2024 at 12:28 AM, reflected: hospice nurse notified, advised to continue with neuro checks and they will send someone in the morning. Rp called several times with no response. left a voice message to call back. Record review of progress note, signed by RN D, and dated 09/28/2024 at 5:28 AM, reflected: [Responsible party] called back and this nurse explained to her what happened, after talking to RP she arrived at the facility and suggested we don't send pt to hospital since she doesn't want to go back through the process of enrolling back to hospice, RP notified the hospice nurse in on her way coming, at this time pt is stable vs wnl, neuros in progress. The oncoming nurse made aware to follow up with hospice. In an interview on 10/1/2024 at 1:40 PM, the DON stated RN D informed her on 09/28/2024 that Resident #1 was found on the flood beside her bed. She said there was a fall mat on the left side of Resident #1's bed but not on the right side. She said Resident #1 was often combative and needed to be transferred using a mechanical lift. Her bed was not against the wall, so it was easier for staff to assist her. She said the facility had an IDT meeting and informed hospice of the need for a second fall mat which was added today, 10/01/2024. She said not haveing the fall mats in place put the resident at risk of injury if she fell from the bed. In an interview on 10/01/2024 at 1:54 PM, the Hospice RN said RN D did call the on-call hospice nurse who went to the facility the next morning. She said Resident #1 was assessed and had a small bruise on her forehead. She said hospice did bring a mall met for the resindet and it should be in place when Resident #1 was in bed to prevent injury if she fell out of bed. She said the facility did neurological and ordered x-rays because the fall was unwitnessed. In an interview on 10/01/2024 at 2:14 PM, the Regional Compliance Nurse stated Resident #1 rolled out of bed and was found on the floor by CNA F. She said LVN D assessed the resident and started neurologicals with no results outside of Resident #1's baseline, then contacted hospice and the family. She said it was her understanding that a fall mat was in place on the left side of Resident #1's bed but not on the right side. She said since the bed was not against the wall, they could have put a fall mat on the right side of the bed to ensure Resident #1's safety. In an interview on 10/01/2024 at 2:40 PM, RN E stated she came in to work on 09/28/2024 at 6:00 AM and was told about Resident #1's the fall by LVN D. She said when she checked, Resident #1 was in bed, the bed was low, and a fall mat was in place on Resident #1's left side of the bed. She said Resident #1 had a small bruise on her forehead. She said LVN D ordered x-rays as directed by hospice, but they had not come yet. She said Resident #1 showed no signs of pain and she continued neuros. In an interview on 10/01/2024 at 3:06 PM, LVN D said CNA F told her about midnight on 09/28/2024 that she found Resident #1 on the floor in her room. LVN D said when she went into the room, Resident #1 was face down on the right side of her bed, on the floor. She said there was a fall mat in place on the right side of the bed and the bed was in its lowest position. She said she did not recall if there was a fall mat on the resident's left side of the bed. She said she did a head-to-toe assessment and Resident #1 had a small bruise on her forehead. She said Resident #1 made no indications of pain, did not favor any part of her body or grimace when they moved her. She said she notified the RP and hospice. LVN D said when the family called her back, they did not want Resident #1 sent to the hospital because they did not want to restart hospice. She said she expected CNAs to round at least every two hours to ensure residents were okay. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 10/01/2024 at 4:21 PM, CNA F stated she found Resident #1, face down, on the floor between the hall wall and the bed. She said Resident #1 was on the fall mat. She said she did not think there was a fall mat on the other side of the bed. She said Resident #1 leaned towards the right side of the bed (the side where the dresser was) which was why the fall mat was placed on that side. She said Resident #1 should have a fall mat on both sides of her bed to ensure she was not hurt if she fell of the bed. She said she did rounds every two hours and did not seen any issues with Resident #1 prior to her being found on the floor. Record review of undated photos provided by Resident #1's family member reflected Resident #1 in bed, a quarter size bump on her left forehead, a geri-chair on Resident #1's left bedside and a trash can and an oxygen concentrator on Resident #1's right bedside. A fall mat was not visible in the picture on either side of the bed. Record review of the facility's Fall Risk Assessment policy, dated 02/01/2007, reflected: High Risk for Injury: Goals: 1. The resident will be free from injury. 2. The resident incorporates personal safety tips into daily routines to prevent falls. 3. The resident recognizes factors that may increase risk of injury from falls . Procedure: Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall . Environmental interventions include keeping beds in the lowest position with brakes on, grab bars in the bathroom, night-lights, and nonskid wax on floors.