STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2024
NAME OF PROVIDER OR SUPPLIER: Estates Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 2 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to ensure Resident #1's comprehensive person-centered care plan was not implemented and did not include measurable outcomes related to signs and symptoms of dehydration such as decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. Findings included: Record review of Resident #1 admission record dated 10/04/24 reflected the resident was a [AGE] year-old male, who initially admitted to the facility on [DATE] with a readmission on 10/03/24. Resident#1 was diagnosed with: unspecified intellectual disability acquired absence of right leg below the knee, anemia chronic kidney disease, Type 2 diabetes mellitus with unspecified complications, protein calorie malnutrition and retention of urine unspecified. Record review of Resident#1's discharged MDS dated [DATE] reflected: the resident required substantial/maximal assistance, Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort, for toileting hygiene, shower/bathe self and lower body dressing. The MDS also reflected Resident #1 was always continent. Record review of Resident#1's Entry MDS dated [DATE] reflected Resident#1 had no BIMS assessement documented. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#1's care plan dated 08/21/24 reflected Problem: The resident has potential fluid deficit r/t decreased mobility, recent admit to facility. Intervention: Monitor/document/report to MD PRN s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record review of Resident#1's care task for the month of October 2024 reflected no care task related to monitor, document and report to medical director signs and symptoms of dehydration: decreased or no urine output, concentrated urine and strong odor. Record review of Resident #1's October 2024 TAR/NMAR reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. Record review of Resident #1's October 2024 eMAR reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine, and strong odor. Record review of Resident#1's September and October 2024 eMARs reflected the resident had a 16 French 30 cc urinary catheter for a diagnosis of urine retention, for one time a day for urine retention. The facility staff placed a check mark in the AM (morning) box. Record review of Resident#1's progress notes from 09/10/24 to 10/03/24 reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration such as decreased or no urine output, concentrated urine, and strong odor. Observation on 10/04/24 at 1:00 PM revealed Resident#1's catheter urine collection bag had no urine output. Observation on 10/04/24 at 1:42 PM revealed Resident#1 had a case of water in his room. Observation on 10/04/24 at 3:30 PM revealed Resident#1's catheter urine collection bag had no urine output. Observation on 10/05/24 at 10:00 PM of Resident#1's catheter urine collection bag revealed no urine output. Interview on 10/04/24 at 1:04 PM with MA F revealed Resident#1 just returned from the hospital today after being gone for about three weeks. MA F stated Resident#1 had a catheter and both his legs were amputated. MA F stated Resident#1 would call out if he needed help. Interview on 10/04/24 at 1:42 PM with Resident #1 reveled staff had not emptied his catheter bag since early in the morning before breakfast. Resident#1 stated that he was doing okay, and he had just come back from the hospital. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/04/24 at 2:10 PM with the Treatment Nurse revealed Resident #1 was not on her wound care list, and the resident had just returned from the hospital today. She stated urine would need to be monitored if it was cloudy and had sediment in it. She stated Resident #1 kept bottled water in his room to drink. Interview on 10/04/24 at 9:34 PM with MA C revealed Resident #1's urine output was monitored, and the information was given to the charge nurse to put in the system. MA C stated Resident #1 was one of the residents, who were monitored for urine output, and the resident just returned from the hospital today, Interview on 10/05/24 at 9:42 PM with RN D revealed Resident#1's urine output information was put in the resident's electronic record by her or the charge nurse by the end of each shift. RN D stated urine retention output monitoring was needed to be done to determine if the resident's medications were working or not. Interview on 10/05/24 at 10:00 PM with LVN E revealed if the DON had not updated the eMAR with the resident urine output instructions, the information should have been put in the nursing progress notes. LVN E stated if the urine output was not being monitored, the resident could have blockage, dehydration, or bladder issues. LVN E had not worked with Resident# 1 since he had returned from the hospital. Interview on 10/05/24 at 10:15 PM with the ADON revealed the order on the eMAR was to make sure that staff checked the catheter bag. The ADON stated that was not for monitoring and measurements of urine retention. Telephone interview on 10/06/24 at 12:05 AM with the Administrator and the DON revealed if the resident's urine output was not being monitored, the resident could develop a UTI or be dehydrated. The DON stated all the nursing staff were responsible to make sure urine output was monitored. The DON stated the care plans were updated and revised during IDT meetings as needed, which were done daily and consisted of the head of each department. The Administrator stated they must stay on top of the care plan interventions and make sure those were being done to keep the residents safe. The Administrator and DON stated Resident #1 was admitted to the hospital on 09/10/24 and returned to the facility on [DATE]. Record review of the facility's current Nursing Policy and Procedure Manual, reflected the following undated policy: Comprehensive Care Plan The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bladder with an indwelling catheter received appropriate treatment and services for 1 of 2 residents (Residents #1) reviewed for incontinent care and for indwelling urinary catheters. The facility they failed to monitor and document signs and symptoms of dehydration, decreased or no urine output, for Resident#1. This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. Findings included: Record review of Resident #1's admission record dated 10/04/24 reflected the resident was a [AGE] year-old male, who initially admitted to the facility on [DATE] with a readmission on 10/03/24. Resident#1's diagnoses included intellectual disability, acquired absence of right leg below the knee, anemia chronic kidney disease, Type 2 diabetes mellitus with unspecified complications, protein calorie malnutrition and retention of urine. Record review of Resident#1's discharged MDS dated [DATE] reflected the resident required substantial/maximal assistance, Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort, for toileting hygiene, shower/bathe self and lower body dressing. The MDS reflected Resident #1 was always continent of bladder. Record review of Resident#1's Entry MDS dated [DATE] reflected Resident#1 had no BIMS assessment documented. Record review of Resident#1's care plan dated 08/21/24 reflected: Problem: The resident has potential fluid deficit r/t decreased mobility, recent admit to facility. Intervention: Monitor/document/report to MD PRN s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Record review of Resident#1's care task for the month of October 2024 reflected no care task related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. Record review of Resident #1's October 2024 TAR/MAR reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's October eMAR reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. Record review of Resident#1's September and October 20234 eMAR reflected the resident had a 16 French urinary catheter 30 cc for a diagnosis of urine retention, for one time a day for urine retention. The facility staff placed a check mark in the AM (morning) box. Record review of Resident#1's the progress notes from 09/10/24 to 10/03/24 reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. Record review of Resident#1's progress notes reflected no care related to monitoring, documenting, and reporting to the physician signs and symptoms of dehydration, such as decreased or no urine output, concentrated urine and strong odor. Observation on 10/04/24 at 1:00 PM revealed Resident#1's catheter urine collection bag had no urine output. Observation on 10/04/24 at 1:42 PM revealed Resident#1 had a case of water in his room. Observation on 10/04/24 at 3:30 PM revealed Resident#1's catheter urine collection bag had no urine output. Observation on 10/05/24 at 10:00 PM revealed Resident#1's catheter urine collection bag had no urine output. Interview on 10/04/24 at 1:04 PM with MA F revealed Resident#1 just returned from the hospital today after being gone for about three weeks. She stated Resident#1 had a catheter and both his legs were amputated. She stated Resident#1 would call out if he needed help. Interview on 10/04/24 at 1:42 PM with Resident #1 revealed staff had not emptied his catheter bag since early in the morning before breakfast. Resident#1 stated that he was doing okay, and he had just come back from the hospital. Interview on 10/04/24 at 2:10 PM with the Treatment Nurse revealed Resident#1 was not on her wound care list, and he returned from the hospital today. She stated the resident's urine would need to be monitored if it was cloudy and had sediment in it. She stated Resident#1 kept bottled water in his room to drink. Interview on 10/04/24 at 9:34 PM with MA C revealed Resident#1's urine output was monitored and the information was given to the charge nurse to put in the system. MA C revealed Resident#1 was one of the resident's, who were monitored for urine output, and he just returned from the hospital today. Interview on 10/05/24 at 9:42 PM with RN D revealed Resident#1's urine output information was put in the resident's electronic record by her or the charge nurse by the end of each shift. RN D stated urine retention output monitoring was needed to be done to determine if the resident's medications were working or not. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/05/24 at 10:00 PM with LVN E revealed if the DON had not updated the eMAR with the resident urine output instructions, the information should have been put in the nurses' progress notes. LVN E stated if the urine output was not being monitored, the resident could have blockage, dehydration, or bladder issues. LVN E had not worked with Resident# 1 since he had returned from the hospital. Interview on 10/05/24 at 10:15 PM with the ADON revealed the order on Resident #1's eMAR was to ensure staff checked the catheter bag. The ADON stated that was not for monitoring and measurements of urine retention. Telephone interview on 10/06/24 at 12:05 AM with the Administrator and the DON revealed if the resident's urine outpoint was not being monitored, the resident could develop a UTI or be dehydrated. The DON stated all the nursing staff were responsible for ensuring urine output was monitored. The Administrator and DON stated Resident#1 was admitted to the hospital on 09/10/24 and returned to the facility on [DATE]. Record review of the facility's current Nursing Policy and Procedure Manual reflected the following undated policy: Comprehensive Care Plan The comprehensive care plan will describe the following The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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	675028	A. Building B. Wing	10/06/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46403 Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals were stored in locked compartments for 1 of 6 medication carts located on hall 200 observed for drug storage. 1. The facility failed to ensure one medication cart found on 200 hall was not left unlocked and unattended by LVN A on at 10/04/24 at 12:30 PM. 2. The facility failed to ensure one medication cart found on 200 hall was not left unlocked and unattended by LVN B on 10/05/24 at 9:26 PM. This failure could place residents at risk of access and ingestion medications. Findings included: Observation on 10/04/24 at 12:30 PM revealed one medication cart on Hall 200 was unlocked and unattended with the drawers facing the hallway. At 12:45 PM, the DON walked past the medication cart on Hall 200 hall and locked it. Observation on 10/05/24 at 9:10 PM revealed LVN B drove up to the facility at the same time as the surveyor and they walked into the building together. At 9:26 PM, the medication cart on Hall 200 was unlocked and unattended with the drawers facing the hallway. Interview on 10/04/24 at 2:25 PM with LVN A revealed she never forgot to lock the medication cart, she apologized, and said she did not know what happened today. LVN A stated the residents could get into the medication cart and take medications that did not belong to them. The DON was in the conference room while LVN A was interviewed. Interview on 10/05/24 at 9:26 PM with LVN B revealed she did not know she had left the medication cart open. LVN B stated she had been in-serviced, and the cart was supposed to be locked when staff walked away. LVN B stated the residents could take the medications and staff could take medications. Interview on 10/06/24 at 12:05 AM with the Administrator in person and the DON via phone revealed the medication cart should be locked when not in use. The DON stated the nursing staff were responsible for making sure the medication cart was locked before walking away from the medication cart. Record review of the facility's Medication Administration Procedures policy revised 10/25/17 reflected: .8. After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured