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	01/13/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 32227 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents. CNA A failed to get assistance from another staff member when providing Resident #1, who required two staff for assistance with all ADLs, a bed bath on 12/05/24. During the bed bath, CNA A asked Resident #1 to turn to her side. When the resident turned she fell to the floor, which resulted in the resident sustaining a fracture of her right femur (thigh bone). The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 12/05/24 and ended on 12/05/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), seizure disorder, cellulitis of right lower limb (bacterial infection that affects the skin and underlying tissue), fibromyalgia (chronic condition that causes widespread pain and tenderness in the body), and muscle wasting. The resident had a BIMS score of 9 which indicated her cognition was moderately impaired. The MDS further reflected Resident #1 was dependent for shower/bathing which indicated the helper did all the effort or the assistance of two or more helpers was required for the resident to complete the activity. Record review of Resident #1's care plan revised on 12/16/24 reflected the resident had an ADL self-care performance deficit. Interventions included the resident required the assistance of two staff for bathing and bed mobility. Record review of Resident #1's bathing status in the Kardex system (documentation system used by reference key resident information for their nursing care plan) printed on 01/13/25 reflected the resident required the assistance of two staff members. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report dated 12/05/24 reflected the following: The resident experienced a fall while in bed during care by the CNA [CNA A]. The CNA [CNA A] notified the nurse and had discovered the resident on the floor, resting against the bed. The resident has skin tears on both great toes, the let wrist, and beneath the right breast The resident reports generalized pain, with a particular emphasis on greater discomfort in her legs compared to other areas. When inquired about the incident, the resident explained 'I threw my foot over too far and fell .' The resident was transferred to the hospital due to experiencing pain the X-ray indicated a fracture in the left femur (left femur was facility documentation error; fracture was on the right leg). The resident subsequently underwent surgery to address the fracture Record review of Resident #1's hospital records dated 12/05/24 reflected the resident was diagnosed with a comminuted distal femoral fracture (a broken bone that has been shattered into multiple pieces and are usually caused by severe trauma) of the right leg. Observation and interview on 01/08/25 at 10:26 PM revealed Resident #1 in bed watching television. The resident was alert and oriented and able to recall the incident when she fell during care. The resident said CNA A was giving her a bed bath, and the aide asked her to turn to her side. The resident said she was turning over onto her side as she was holding on the repositioning bar and fell on the floor. She said CNA A was usually able to catch her when she rolled over, but this time she was not able to. Resident #1 said she was sent to the hospital and had surgery on her leg, as she pointed to her right leg. Resident #1 stated CNA A usually bathed her alone and never had a helper. The resident stated she preferred two people because she felt safer. Resident #1 said she was not experiencing much pain from her fracture but had discomfort due to the cellulitis in her legs. Interview on 01/08/25 at 1:05 PM with CNA A revealed she was giving Resident #1 a bed bath and asked the resident to turn to her side. She stated the resident grabbed the repositioning bar on the bed, threw her leg over her left leg and that was when the resident fell over on to the floor. CNA A stated she then called for the nurse to assist, and the resident was assessed. CNA A stated Resident #1 was on an air mattress, and it was inflating at the time the resident was turning to her side. CNA A said she was aware Resident #1 required two staff for care, but she was not able to find someone to help her. CNA A said she asked another CNA, whose name she could recall, for help. She stated she did not get any help, so she bathed the resident alone. She stated she had bathed the resident alone in the past. The CNA said she felt safe bathing the resident alone because the resident was able to help turn in bed. Interview on 01/13/25 at 1:23 PM with LVN B revealed she was called by CNA A to Resident #1's room and noticed the resident was on the floor. CNA A told her the resident was trying to turn in bed during a bed bath, and the resident fell . LVN B said during Resident #1's assessment, the resident was complaining of pain and noticed the resident's toes were bleeding and other areas of her body such as her side, so she was transferred to the hospital via EMS. LVN B stated Resident #1 required two staff member for care because she was a bariatric resident and for safety. The LVN said she did not know CNA A was caring for Resident #1 alone, and she did not recall the aide asking anyone for help during the bed bath. LVN B further stated the aides could look in the Kardex system to verify if a resident required one or two staff members during care or ask a charge nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/08/25 at 1:28 PM with CNA D revealed she had worked at the facility for about a year and cared for Resident #1. CNA D said Resident #1 was bed bound per choice and required two staff members for assistance for all care because the resident was bariatric and could not be care for by one staff member. Interview on 01/08/25 at 2:07 PM with CNA E revealed she worked with Resident #1 and the resident was bed bound. CNA E said the resident required two staff members for all care including bed baths because she was bariatric and needed more support. CNA E further stated Resident #1 had never been a one-person care resident. Interview on 01/08/25 at 2:39 PM with RN F revealed Resident #1 was bed bound and required two staff members for all care including bed baths because the resident was bariatric and one staff member could not adequately care or clean the resident up during ADL care. Interview on 01/08/25 at 2:29 PM the ADON revealed Resident #1 was bed bound and rarely got out of bed. She said the resident was a two-person assist for all care at all times because she was on an air mattress and could easily roll out of bed and for overall safety. The ADON was made aware CNA A had bathed Resident #1 alone, but the aide was not able to explain why she had not requested for help but only stated she had not seen anyone else. The ADON stated it appeared to her that CNA A had not looked for anyone to help her with the resident. The ADON further stated they immediately began to re-in-service (training) for all nursing staff re-educating them on the importance of using two staff member if the resident required it. They also identified all the residents that required two staff members for care they were monitoring and making observations to ensure two staff were assisting when needed. The monitoring began after the incident with Resident #1 and would be on-going for six weeks to ensure safety. Interview on 01/13/25 at 8:36 AM with the DON revealed she was told Resident #1 was getting a bed bath by CNA A and while the resident was turning to her left side with the assistance of the repositioning rail, Resident threw her leg over too far and continued to roll until she fell out of the bed. Resident #1 was assessed, and they noticed she had bruising to the top of her feet and was complaining of pain throughout her body but mostly to her right knee. The resident was transferred to the hospital where she was diagnosed with a right leg fracture. The DON said Resident #1 required two staff members for care due to being a bariatric resident and for safety. The DON stated CNA A admitted knowing Resident #1 required two staff members for care, but the aide told them she had not been able to find assistance but if she would asked her (DON) she would have assisted. The DON also said if aides did not know if a resident was a one or two person for care, they could look in their Kardex computer system. After the incident, CNA A was suspended pending their investigation and had a 1:1 counseling and re-in-service (training) on resident care and the aide was pulled from working with Resident #1. The other nursing staff were re-educated on using the Kardex computer system to ensure a resident required a one- or two-person assistance during care. The DON further stated they had identified all the residents that required two people and were going to monitor but watching care for those resident for 6 weeks. Record review of the facility's Safe Patient Handling policy revised December 2005 reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility has a program to promote and assure safe patient handling for both the resident and the employee. The policy includes identification, assessment and interventions to provide a comfortable, safer transfer, repositioning and resident movement. .3. Nurses will be educated in the identification, assessment and control of risks of injury to resident and nurses during patient handling .5. Nurses will be educated regarding correct safe handling procedures, to report concerns or the inability to perform resident handling or movement that the nurse believes in good faith will expose a resident or nurse to an unacceptable risk of injury Record review of 1:1 in-service with CNA A dated 12/05/24 revealed she had been re-educated on using the Kardex system to communicate the resident's needs and information to all the CNA's to ensure appropriate resident care. CNA was also re-educated on fall prevention strategies and safe patient handling and abuse and neglect policy. Record review of in-services dated 12/05/24 with all direct nursing reflected the staff had been re-educated using the Kardex system to communicate the resident's needs and information to all the CNAs to ensure appropriate resident care. CNAs were also re-educated on fall prevention strategies and safe patient handling and abuse and neglect policy. Interview on 01/08/25 at 1:05 PM with CNA A revealed she had been re-in-serviced 1:1 on abuse and neglect, ensure to always use two staff members during care for residents that required it and using the Kardex system to check the care of the residents if they were unsure. Interviews on 01/08/25 from 11:12 AM to 5:14 PM and on 01/13/25 from 10:01 AM to 1:23 PM with nursing staff from various shifts to include LVN B, CNA C, CNA D, CNA E, RN F, LVN G, CNA H, CNA I, CNA J, and CNA K all revealed they have been in-serviced on abuse/neglect, using the Kardex system to verify if a resident required one or two staff members for care, and fall prevention to avoid accidents. Record review of the direct care monitoring sheets reflected it included to watch at least 10 episodes of incontinent care or assist with bed mobility weekly to ensure staff was performing correctly and the care-planned number of staff were assisting. The monitoring dates reviewed began 12/05/24 and would continue for 6 weeks, and end on 01/15/25. Observation on 01/08/25 at 11:07 AM revealed Resident #2 was transferred from the bed to the chair via mechanical lift by two staff members. Observation on 01/13/25 at 3:32 PM revealed Resident #3 was transferred to bed via mechanical lift by two staff members.