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	05/01/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to ensure residents were free from abuse for 3 of 6 residents (Resident #4, Resident #6, and Resident #7) reviewed for abuse. 1. The facility failed to ensure Resident #4 was free from emotional and mental abuse. Video footage identified CNA A antagonizing Resident #4 when she went to check on him on 02/18/25 . The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 02/18/25 and ended on 02/19/25. The facility had corrected the noncompliance before the investigation began. 2. The facility failed to ensure Resident #6, and Resident #7 were free from abuse on 03/11/25 when Resident #6 verbally abused Resident #7 which cause Resident #7 to physically abuse Resident #6 by hitting him on the face. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 03/11/25 and ended on 03/14/25. The facility had corrected the noncompliance before the investigation began. These failures could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and psychological harm. Findings included: 1. Record review of Resident #4's Face sheet dated 05/01/25, revealed the resident was a [AGE] year-old male with an admitted [DATE] and readmitted on [DATE]. Record review of Resident #4's quarterly MDS, dated [DATE], reflected his diagnoses included anxiety disorder, vascular dementia, and mild cognitive impairment. Resident #4's BIMS score was 04 which indicated his cognition was severely impaired. The MDS Section E - Behaviors reflected Resident #4 did not exhibit any physical or verbal behaviors towards others. The MDS Section GG - Functional Abilities also reflected Resident #4 was dependent of staff to assist with ADLs. (continued on next page)

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	Record review of Resident #4's Care Plan revised date 03/11/25, reflected Focus: The resident has a behavior problem r/t hx of stroke, resident will become difficult to manage. Resident yells out loudly and will use cursive language. Resident is very adament toward care, sports, etc and will yell out at staff and curse. Goal: The resident will have fewer episode by review date. Interventions: Anticipate and meet the resident's needs. Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Redirection techniques will include offering alternatives to the current activity. Record review of the Provider Investigation Report dated 02/25/25 reflected, Resident responsible party had address to [Administrator] a concern of a staff member being rough with the resident when trying to readjust on the bed. When [Responsible party name], the resident's responsible party, entered [Administrator] office and informed [Administrator] of an incident that occurred the previous night, [Administrator] contacted the CNA [CNA A] to discuss the matter. [Administrator] informed her about the responsible party reported aggressive behavior toward the resident [Resident #4] and confirmed that she had indeed acted aggressively toward [Resident #4] due to [Resident #4] cussing at him and she was trying to correct him. [Administrator] informed her that she would be suspended until further notice. Safe surveys conducted no noted concern. Skin assessment completed and no noticed concerns, pain assessment no noted concerns, Trauma assessment no concerns noted. The Provider Investigation Report also reflected that the result of the investigation was inconclusive, but CNA A was terminated. Record review of CNA A's Statement dated 02/29/25, reflected Went to resident's room cause he was hanging off the bed and yelling. [CNA A] told the resident to put his legs back in the bed before he ended up on the floor. That's when the resident call me a bitch and to leave him alone. [CNA A] told him not till he in bed right that if keeps hanging out the bed like that he was going to be on the floor and the floor hursts and wins every time. He then proceeded to call me a bitch again. [CNA A] told him to don't be disrespectful to me cause [CNA A] wouldn't do him like that and that I'm someone sister daughter and mother and that he wouldn't like it if [CNA A] called the women in his family that name. [CNA A] also asked him what was wrong with him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation of Video Footage time stamped 02/18/2025 05:44:24 CST [5:44 AM] revealed: Resident #4 sitting at the edge of the bed. CNA A (who was a tall, heavy-set woman) entered Resident #4's room stating, What are you doing [Resident #4's name]. Resident #4 states What are you talking about bitch. CNA A stated what. Resident #4 stated What are you talking. CNA A standing in front of Resident #4. CNA A then proceed to tell Resident #4 twice to put those legs back in the bed. Resident #4 asked CNA A Why?". CNA A tells Resident #4 you can't walk [you] will end up on the floor. Resident #4 tells her No I won't. CNA A responded, Okay bet, but I am going to put your legs back on the bed. Resident #4 asked why again. CNA A responded, I don't have to explain why. Resident #4 asked CNA A why are [you] going too and CNA A stated, because I am going too. Resident #4 stated you not going too. CNA A observed leaning forward and grabbed the control for the bed. Resident #4 stated Get your fucking hands of me bitch, I will fuck you up. CNA A asked resident What did [you] say? and Resident #4 stated, I will fuck you up, get your fucking hands off of me. CNA A observed to lean forward put her right hand on Resident #4's right knee. CNA A then stated My hand is on you. What are [you] going to do? Nothing, and [you] better quit calling me out of my name because [you] wouldn't like if [I] called your momma, sister, or anybody in your family out of their name, don't be disrespectful to [me] because I am not being disrespectful to [you], [you] understand. Resident #4 agreed with CNA A and CNA A removed her hand from Resident #4's knee. CNA A states I don't know where you get that being disrespectful from, that [ain't] going to get you nothing , that [ain't] going to get you no help, that is going to get you talk ed about, don't be disrespectful, and you wait until someone comes in here to help you, you got me? CNA A proceed to adjust Resident #4's legs on the bed. Resident #4 stated I hear that CNA A states Alright then, I am not about to play with you, cause you end up on the floor, you end up on the floor and the floor hurts and it wins every time. Resident #4 stated yeah right. CNA A states Yeah right, you got a real smart mouth, what is wrong with you, what is your problem tonight. Resident state I got a problem with you. CNA response No, I [ain't] your problem, Resident stated oh yeah. CNA A stated, I just came in here to help you. CNA A proceeded to walk out the room and stated, you better act like you got some sense. Video was about 2 minutes long. CNA A hand was on Resident #4's knee for about 32 second. Interview on 04/30/25 at 11:14 AM, Resident #4 revealed he was doing well and feeling safe at the facility. Resident #4 was not a good historian; resident could not recall incident with CNA A. Interview on 04/30/25 at 12:46 PM, Resident #4 Family Member revealed she reviewed the video footage a day after the incident and notified the Administrator. She stated the incident happened on 02/18/25, Resident #4 was sitting on his bed and the staff was observed entering the room. She stated on the video footage it was observed Resident #4 being disrespectful toward the staff; however, the staff was rude and antagonizing the situation. She stated on the video it was observed Resident #4 saying keep your hands off of me and then staff proceed to put her hand on his knee. Family Member stated she agreed with the staff redirecting and telling Resident #4 to stop cursing at her; however, the staff putting her hand on him was what concerned her. She stated the staff was antagonizing the situation by putting her hand on Resident #4. Family Member stated after the Administrator was notified, the facility investigated the incident and terminated the staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview by phone on 05/01/25 at 9:27 AM, CNA A revealed she was doing her last round, when she heard Resident #4 screaming. She stated she entered the room and observed Resident #4 was hanging on the side of the bed. She stated she asked Resident #4 what he was doing, and Resident #4 started to curse at her and got mad because she told him to get back in bed. CNA A stated Resident #4 was calling her a bitch and being disrespectful to her. She stated she told Resident #4 to stop, to not called her like that because he would not like for someone to call his mom, sister or daughter that. She stated Resident #4 stated he would not like that. She stated she only touched Resident #4 when repositioning him back to bed. CNA A stated she was not supposed to correct Resident #4. She stated she was wrong for telling him to stop being disrespectful because they were told residents were always right. CNA A stated she never touched the resident or disrespected the resident. CNA A stated she was suspended and then let go. Interview on 05/01/25 at 2:16 PM, Corporate Compliance RN revealed she reviewed the video footage regarding CNA A and Resident #4. She stated CNA A should lose her license. She stated CNA A was verbally abusive towards Resident #4, she stated when CNA A put her hand on Resident #4' she was antagonizing the situation. She stated CNA A should had stepped away. Regional Compliance stated Resident #4 had no adverse effects from the incident. She stated CNA A was terminated. Interview on 05/01/25 at 2:36 PM, the Administrator revealed Resident #4 family informed him about the incident and he immediately suspended CNA A. He stated skin assessment was completed on Resident #4 with no injuries, safe surveys and quality of life checks were completed with no concerns. The Administrator stated after reviewing the video footage it was determined CNA A was considered being verbally abusive and was terminated for abuse. He stated CNA A admitted to what she did wrong. He stated his expectations were for his staff to respect residents, care for them and to report any abuse and neglect allegations to him to protect the residents. Record Review of CNA A's personnel file, reflected CNA A was suspended and terminated on 02/19/25. Record review of facility Abuse/Neglect policy, revised 09/09/24, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: Record review of Resident #4's Skin assessment, Pain assessment and Trauma Assessment completed on 02/19/25, no concerns noted. Record review of Safe surveys were completed on 02/19/25 with five residents with no issues noted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of facility In Service Training dated 02/19/25, provided by Administrator and Corporate Compliance RN reflected staff were In Serviced on Abuse and Neglect Policy to include - Arguing with, antagonizing, and touching a resident against their will is considered Abuse. If [you] see a staff member or resident engaging in this activity, the Administrator must be notified immediately. The Administrator is the abuse coordinator. If [you] can't get a hold of the administrator, notify the DON or ADON immediately. Staff should not continue to work their shift, they must be suspended immediately, Resident Rights Record review of facility In Service Training dated 02/19/25, provided by Corporate Compliance RN reflected staff were In Serviced on Abuse and Neglect, Resident Rights. Interviews on 04/30/25 from 1:21 PM through 05/01/25 to 3:45 PM with ADON Y, ADON U, BOM, FM, CNA B, LVN C, CNA D, CNA F, CNA H, CNA E, Van Driver, CNA I, CNA F, LVN G, LVN K, LVN L, CNA V, LVN X revealed the facility staff were able to verify education was provided to them. The nursing staff stated they were educated on different types of abuse/neglect and resident rights. Staff provided the types of abuse were physical, mental, financial, and verbal. Staff stated the three signs of abuse occur when the resident avoids eye contact, bruises, and the resident withdraws from care. Staff stated they would intervene if witness any type of abuse from a staff. Staff revealed they would report these and other signs to the Abuse Coordinator, the Administrator, immediately if they witness or observed any of these signs. 2. Record review of Resident #6's Face sheet dated 05/01/25, revealed the resident was a [AGE] year-old male with an admitted [DATE] and readmitted on [DATE]. Record review of Resident #6's quarterly MDS, dated [DATE], reflected his diagnoses included bipolar disorder, dementia, and cognitive communication deficit. Resident #6's BIMS score was 12 which indicated his cognition was moderately impaired. The MDS Section E - Behaviors reflected Resident #6 did not exhibit any physical or verbal behaviors towards others. The MDS Section GG - Functional Abilities also reflected Resident #6 needed substantial/maximal assistance with ADLs. Record review of Resident #6's care plan, revised 03/11/25, reflected Focus: The resident has a history of trauma that may have a negative impact. The trauma is r/t: Resident with hx of physical altercation with another resident. Goal: Maintain resident's safety and integrity post trauma episode, using appropriate interventions. Interventions: Perform the following de escalation techniques as required: redirection, and deep breathing. Psychiatric services adjusted medication. Record review of Resident #7's face sheet dated 05/01/25, revealed the resident was a [AGE] year-old male with an admitted [DATE] and readmitted on [DATE]. Record review of Resident #7's admission MDS, dated [DATE], reflected his diagnoses included anxiety disorder, major depressive disorder, schizoaffective disorder, restlessness and agitation and cognitive communication deficit. Resident #6's BIMS score was 13 which indicated his cognition was cognitively intact. The MDS Section E - Behaviors reflected Resident #7 did not exhibit any physical or verbal behaviors towards others. The MDS Section GG - Functional Abilities also reflected Resident #7 was independent for ADLs. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #7's care plan, revised 04/14/25, reflected Focus: The resident has potential to demonstrate physical behaviors related to paranoid schizophrenia, schizoaffective disorder as evidence by: Physical aggression demonstration due to being provoke when cussed at. Goal: The resident will seek out staff/caregiver when agitation occurs through the review date. Interventions: If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately. Record review of the Provider Investigation Report dated 03/18/25 reflected, [Speech and Language Therapist] witness [Resident #7] hit [Resident #6] due to an altercation they were having an immediately separate them both. During investigation, Resident #7 reported that Resident #6 was using inappropriate language to him and repeatedly told him to stop. When Resident #6 continued, Resident #7 became frustrated and end up hitting him. Upon witnessing the incident, [Speech Therapy] quickly intervene to separate the two residents and called for assistance. Both residents were promptly separated, and a 1:1 supervision was implemented until a psychiatric evaluation could be performed. Record review of Witness Statement from Speech and Language Therapist dated 03/11/25 reflected, My name is [Name]. [Speech and Language Therapist] am an employee at the [Facility Name]. [Speech and Language Therapist] am the speech language pathologist. At approximately 10:15 a.m., [Speech and Language Therapist] witnessed two residents [Resident #6 and Resident #7] in a physical altercation in the dining room. [Speech and Language Therapist] heard [Resident #7] say to [Resident #6] call me a bitch one more time. [Resident #6] responded and then [Resident #7] struck [Resident #6] about two times. Immediately, [Speech and Language Therapist] intervened to ensure both men were safe. [Resident #7] left the dining room. Once [Resident #7] left the dining room, [Speech and Language Therapist] asked [Resident #6] if he was okay and if he could tell me what happened. [Resident #6] replied, he's just mad because [Speech and Language Therapist] wouldn't give him a cigarette. Once both individuals were safe, [Speech and Language Therapist] immediately told [Administrator]. Interview on 04/30/25 at 10:45 AM, Resident #6 stated he was doing well. Resident #6 stated he had an incident with Resident #7. Resident #6 stated Resident #7 got frustrated with him, and Resident #7 kept telling him to not say anything to him. Resident #6 stated he told Resident #7 that he was coming in and needed him to get out of the way, he stated Resident #7 got more frustrated and hit him on the side of the face. Resident #6 stated the police was called but he did not pressed charges. Resident #6 stated he was only hit once on the side of his face. Resident #6 stated he was not hurt. Resident #6 stated he never called Resident #7 any names. Interview on 04/30/25 at 12:26 PM, Resident #7 stated he was doing well. Resident #7 stated he got into an altercation with Resident #6. Resident #7 stated for a week Resident #6 was messing with him and calling him out of his name. Resident #7 stated he never told anyone about it. Resident #7 stated on the day of the altercation Resident #6 called him a bitch and he asked Resident #6 to stop but he continued to call him a bitch. Resident #7 stated he got mad, and he hit him on the face once. Resident #7 stated he was tired of Resident #6 calling him a bitch. Resident #7 stated after the altercation, he keeps his distance from Resident #6. Interview on 05/01/25 at 9:49 AM, the Administrator revealed Speech and Language Therapist was out on leave. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/01/25 at 1:38P PM, ADON Y stated Resident #6 and Resident #7 had an altercation in the dining room on 3/11/25. She stated it was a witnessed altercation by Speech Therapy. She stated she was not sure what started the altercation, but Resident #7 got upset and hit Resident #6 in the face. She stated there had been no previous incidents between them. She stated both residents were assessed with no injuries and placed on 1:1 monitoring until psych services consult. She stated the incident was considered abuse from Resident #7 hitting Resident #6. Interview on 05/01/25 at 2:16 PM, Corporate Compliance RN revealed she was made aware of the incident between Resident #6 and Resident #7. She stated she was informed Resident #7 slapped Resident #6 on the face. She stated she was unsure what started the argument. She stated the incident was considered abuse from Resident #7 to Resident #6. She stated Resident #7 was placed 1:1 supervision, a psych services consult was completed, medications were adjusted, and Resident #7 was moved to another hall. Resident #6 had no injures to him and also received a psych service consult. Interview on 05/01/25 at 2:36 PM, the Administrator revealed Speech and Language Therapist observed Resident #6 and Resident #7 talking and then observed Resident #7 slapped Resident #6 on the face. He stated the Speech and Language Therapist intervene and separated both residents. The Administrator stated the police was called, skin assessment, trauma and pain assessment completed on both residents with no concerns. He stated families were notified of the incidents. The Administrator stated Resident #7 was placed on 1:1 monitoring, and then Resident #7 requested to go home after the incident. He stated two weeks later Resident #7 returned to the facility and he got a new room in a different hall. The Administrator stated both residents used to get along and joke with each other, he stated he was not sure what happened between them. The Administrator stated a resident-to-resident altercation was considered abuse, and every resident had the right to be free from abuse and neglect. Record review of facility Abuse/Neglect policy, revised 09/09/24, reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Resident to Resident - The above policy will apply to potential resident-to-resident abuse. Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: Record review Resident #6 progress notes dated 03/11/25 14:58 [2:58 PM] new order for busPirone HCL Oral tablet 15 mg (Buspirone HCl) Give 1 tablet by mouth every 12 hours for anxiety. Record review of facility 15 Minute Monitoring dated 3/11/15, reflected Resident #7 was being monitored every 15 minutes starting at 10:15AM and ended at 11:45 AM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review Resident #7 progress notes dated 03/11/25 15:24 [3:24 PM] Psych NP [Resident #7] telehealth with the resident. New order obtained for HydroXizne HLC tablet 25 MG give 1 tablet by mouth every 8 hours as needed for anxiety x 14 days and to monitor behaviors q shift. Record review Resident #7 progress notes dated 03/11/25 15:55 [3:55 PM] reflected, [Resident #7] the Psych NP discontinued 1:1 resident stable with no behavior issues exhibited at the moment. Record review of Resident #6 and Resident #7 Trauma Informed PRN Assessment, Skin Assessment and Pain Assessment completed on 03/11/25 with no concerns. Record review of Safe surveys were completed with 10 residents with no issues noted. Record review of facility In Service Training dated 03/11/25 and 3/13/25, provided by Administrator reflected staff were In Serviced on Abuse and Neglect, Resident Rights, Safe environment and De-escalation methods for residents with behaviors. Record review of facility In Service Training dated 3/14/25, provided by Corporate Compliance RN reflected staff were In Serviced on Abuse and Neglect, Resident Rights, Notification of Changes. Interviews on 04/30/25 from 1:21 PM through 05/01/25 to 3:45 PM with ADON Y, ADON U, BOM, FM, CNA B, LVN C, CNA D, CNA F, CNA H, CNA E, Van Driver, CNA I, CNA F, LVN G, LVN K, LVN L, CNA V, LVN X revealed the facility staff were able to verify education was provided to them. The nursing staff stated they were educated on different types of abuse/neglect, resident rights, notification of changes and de-escalation methods. Staff stated they monitor behaviors. Staff provided the types of abuse were physical, mental, financial, and verbal. Staff stated the three signs of abuse occur when the resident avoids eye contact, bruises, and the resident withdraws from care. Staff revealed they would report these and other signs to the Abuse Coordinator, the Administrator, immediately if they witness or observed any of these signs.

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F 0689 Level of Harm - 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** 41781 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 (Resident #5) of 3 residents reviewed for accidents. The facility failed to keep Resident #5 free of accidents after his anti-tippers were removed from his wheelchair during his dialysis treatment on 04/01/25 when he was on the van's lift and fell backwards, hitting his head on the grate of the lift and sustaining an injury. The noncompliance was identified as PNC. The noncompliance began on 04/01/25 and ended on 04/02/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of severe injury, hospitalization , and decline in quality of life. Findings included: Record review of Resident #5's Admission Record, dated 05/01/25, reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. Record review of Resident #5's Quarterly MDS Assessment, dated 04/12/25, reflected he had a BIMS of 15, indicating he did not have cognitive impairment. His active diagnoses included depression (mental disorder characterized by sadness, loss of interest or pleasure in activities, and persistent symptoms), obstructive uropathy (a condition characterized by a blockage that prevents normal urine flow), and diabetes (a chronic disease that affects how the body uses insulin and glucose). The assessment revealed he had not had any falls prior to 04/12/25. Further review revealed Resident #5 used a manual wheelchair, had no limitation to his range of motion on his upper extremities but did have limitation to his range of motion on his lower extremities. Record review of Resident #5's physician's orders, dated 05/01/25, reflected the following: -skull series 3 views r/t fall on 04/01/25. -Aspririn Oral Tablet Chewable 81 MG (Asprin), Give 1 tablet by mouth one time a day for Chest Pain -Eliquis Oral Tablet 2.5 MG (Apixaban), Give 1 tablet by mouth two times a day for Anticoagulant Record review of Resident #5's care plan, revised on 04/02/25, reflected the following: Focus: The resident is risk [sic] for falls r/t unsteady gait upon transition, decreased mobility. weakness. [sic] . Interventions: Anti-tip device to w/c .therapy to drop w/c. (continued on next page)

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	675028	A. Building B. Wing	05/01/2025

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #5's progress notes reflected the following: -Details: Chief complaint: Fall with injury Abrasion/Avulsion Occipital region / Abrasion to Right Elbow [sic] fell at Dialysis- Refused to go to acute Care Facility/ER .Notified by DON that patient fell outside of Dialysis clinic and refused to be transforted [sic] to ER for imaging (most likely CT Scan). Patient is on ASA and eliquis anticogulants [sic] and is advisable to have imaging to check brain injury or bleeding. DON and administrator tried to convience [sic] to reconsider came back [sic] to the facility. Ordered Skull series/ . Right [sic] arm xray. Hold ASA/ Eliquis [sic] x 2 days. Neuro checks per facility protocol. Patient is alert and oriented to baseline mentation and vital signs are normal. Nursing to monitor for problemswith [sic] mentation or sleepiness, nausea or vomiting. Patient advised he needed a CT of his head but refused. [Physician Z] aware. Nursing instructed to notify his [family member] of his refusal to go to acute care after his fall. Patient had a circular skin abrasion/Avulsion [sic] on occiptal [sic] region of the back of his head. Treatment nurse to clease [sic] and dress wounds on head and right elbow. Written on 04/01/25 at by Physician Z at 12:00 AM. -Resident had a fall. Location: Outside [sic] Fall information: Hit Head, . [sic] .Resident statement: ' I [sic] told dialysis center to remove tippers. I tried to put myself on life and fell over. I did it.' Interventions in place prior to fall: anti-tippers to back of w/c. Interventions initiated in response to fall: Therapy request to drop w/c, Anti-tippers re-applied. Facility education is ongoing, area maintenance director to inspect w/c. Written on 04/01/25 by the previous Interim DON at 3:45 PM -New order obtained for Skull [sic] series 3 views, results received indicating no evidence of displaced fracture or dislocation. The overlying soft tissues are unremarkable. Negative skull bones study. Limited single lateral view. Rp [sic] and the resident made aware of the results expressed gratitude. Written by ADON Y on 04/01/25 at 7:12 PM -Pt continues on Neuro checks. Pt able to answer questions with correct answers. Pt denies pain to the back of skull and elbows. [Physician Z] informed of results of Xray of skull 4 views with no evidence of displaced FX or dislocation Care ongoing. Written by LVN X on 04/02/25 Record review of Resident #5's electronic health record, specifically the assessments portion of his chart reflected neuro assessments and post fall assessments were completed from 04/01/25 to 04/04/25. Record review of Resident #5's Negotiated Risk Assessment, dated 04/01/25, reflected the following: Resident refused to be transported to ER for further evaluation post fall with head injury .Resident wishes to remain in facility and not seek further treatment .Head injury leading to further mobility and health deficits, infection, concussion, and death .Facility contacted residents [sic] [family member] to persuade resident to seek further treatment at ER. NP informed resident of recommendations for CT of head .Resident will remain in facility. Nurse to continue neuro checks per facility protocol. Treatment for abrasion to be provided by facility staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #5's fall risk assessment, dated 03/14/25, reflected a score of 6 (this was not indicated in the electronic health chart as being high risk). Record review of Resident #5's Incident Report, dated 04/01/25, reflected the following: CONCLUSION: Received call from facility transport driver stating that resident has sustained fall [sic]. Van driver facetimed DON. Resident noted on van lift with w/c tipped over. van [sic] is flushed with ground. DON instructed van driver to contact EMS to evaluate resident. Upon EMS arrival Resident [sic] refused to be transported to ER multiple times (times 4 attempts). Resident transported back to facility and neuro checks initiated upon arrival .INTERVENTION: Anti-tip device re-applied to w/c. Therapy to drop w/c. Neuro checks are ongoing. Admin to speak to dialysis center regarding servicing our equipment. Area Maintenance director [sic] inspected w/c upon resident's return to facility and found no defect. Skull series x-ray preformed [sic]. Record review of Resident #5's skin assessment, dated 04/01/25, reflected he had an abrasion described as RT LOWER LEG, back of head 6cm x 3.5cm [sic]. Record review of Resident #5's pain assessment, dated 04/01/25, reflected he had no complaints of pain. Record review of a provider investigation report, dated 04/08/25, reflected the following: Description of the Allegation: Resident had fallen when staff [the Van Driver] was attempting to assist the resident to be lifted in the facility van .Investigation Summary: Resident sustained fall while transferring to facility van lift. Per resident statement, resident was trying to place self on van lift with his back facing the driver seat. Facility van driver was present and instructed resident that she could not place him in the van in that direction. Resident continued to attempt to place self on lift in this manner. During this action resident tipped his wheelchair over sustaining fall on van lift. Lift was flush with ground at time of fall. Facility van driver called [ADON Y] and initiated face-time call with [ADON Y], Admin, and DON. DON instructed van driver to call 911 to evaluate resident. At time of EMS arrival resident refused to be transported to ER for further evaluation. Resident further stated that he had the dialysis center remove the anti-tip device on the back of his wheelchair because he did not like them. Resident returned to facility and neuro check initiated. Neuros are intact at this time. Abrasion noted to back of head measuring 6cm x 3.5cm. bright red blood noted, site cleared and dressed. Resident remains alert and oriented x4 and answers questions appropriately. No complaints of pain at any site reported at this time. BIMs=15. Resident remains able to recall details of incident .Facility Investigation Findings: Confirmed .Provider Action Taken Post-Investigation: Wheelchair evaluated: Ant [sic] Tip device placed back on the wheelchair Staff in-service: abuse and neglect, residents rights, Fall Prevention Transport Driver re educated on van. Safe Surveys conducted: No concerns noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a witness statement, dated 04/01/25, signed by Resident #5 reflected the following: I [Resident #5] was wheeling back on the lift plate of the van as it was on the ground. [The Van Driver] had told me to stop 3 times, but I continued to back my wheelchair on to the ramp and fell backward. The paramedics were called, and I refused to go to the hospital as I just wanted to go home. I am perfectly fine and do not want any medical attention I just wanted to go home at the time. I did have tilt bars on my wheelchair but I did not want them any more so I had asked the Dialysis [sic] staff to remove them and I placed on [sic] the side of my wheelchair. Phone interview on 04/30/25 at 2:25 PM and 2:37 PM with Resident #5's POA revealed the resident was in the hospital and not at the facility at the time. Resident #5's POA said the resident told him that he had tried to go down the ramp to the van at the dialysis center. Resident #5's POA said he flipped over backwards and hit his head, but that it was the resident's fault. Resident #5's POA said that's all the information he had about the situation from Resident #5. Interview on 04/30/25 at 2:41 PM with the Van Driver revealed Resident #5 came to the van, turned his wheelchair around with his back turned towards the van instead of facing it, and wheeled himself onto the ramp to the van. The Van Driver said she asked him to turn around multiple times but he refused. The Van Driver said Resident #5 made a motion in his wheelchair where he extended his arms on his armrests and then his wheelchair flipped backwards. The Van Driver said Resident #5 hit his head on the back of the ramp that was in an up position. The Van Driver said she asked Resident #5 if he was okay and called 911. The Van Driver said she then called the facility to let them know what happened as well. The Van Driver said the ambulance came and Resident #5 refused to leave with them or receive any treatment by them. The Van Driver said Resident #5 was stable and the EMT's picked the resident up and put him back in his wheelchair. The Van Driver said she transported Resident #5 back to the facility. The Van Driver said it depended on the day, but some times Resident #5 wheeled himself to the lift of the van and sometimes she would wheel him onto the lift of the van. The Van Driver said residents needed to be facing the van in order to be strapped in and safe to transport, and Resident #5 knew that. The Van Driver said Resident #5 appeared to be upset when he was approaching the van and she thought that was why he faced himself the opposite way when getting on the lift. The Van Driver said normally, Resident #5 had anti-tippers on his wheelchair but when he left the dialysis center he did not have them on his wheelchair. The Van Driver said Resident #5 told her that he had the dialysis center staff take off anti-tippers while he was there. The Van Driver said she did not notice the anti-tippers were not on his wheelchair when he came out of the dialysis center. The Van Driver said she noticed his anti-tippers were in his personal bag that he carried to the dialysis center each time he went. The Van Driver said she made sure that Resident #5's anti-tippers were on his wheelchair when she dropped him off for dialysis. The Van Driver said she was in-serviced after the incident occurred and knew to always check to ensure Resident #5's anti-tippers were on his wheelchair at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Phone interview on 04/30/25 at 2:55 PM with the Dialysis Center's Receptionist revealed the nurse for Resident #5 had left for the day but would be back tomorrow to discuss what happened on 04/01/25. The Dialysis Center's Receptionist said she saw what happened that day (04/01/25) from the inside of the building after Resident #5 had already fallen. The Dialysis Center's Receptionist said she noticed there was a commotion outside the center, saw the van was parked, and saw Resident #5 was tipped backwards on the ground with his head on the ground. The Dialysis Center's Receptionist said Resident #5's head was towards the van near the bumper area and his feet were in the air. The Dialysis Center's Receptionist said once the resident passed the door of the lobby to go outside they do not monitor them or have anything to do with them. The Dialysis Center's Receptionist said Resident #5 liked to wait outside for the facility van, although they preferred the resident to wait inside the lobby area. The Dialysis Center's Receptionist said typically, the center would not take off a resident's anti-tippers and she was not sure who would have done that. Phone interview on 05/01/25 at 9:44 AM with Resident #5's Dialysis Nurse revealed he did not remove any parts from Resident #5's wheelchair. Resident #5's Dialysis Nurse said he never touched anything on Resident #5's wheelchair and the only thing he would touch would be the brakes to unlock/lock the wheelchair. Resident #5's Dialysis Nurse said he would not modify or take off a resident's anti-tippers from his wheelchair. Resident #5's Dialysis Nurse said he did not know what anti-tippers were. Interview on 05/01/25 at 9:52 AM with the DOR revealed Resident #5 had anti-tippers on his wheelchair for as long as he's had a wheelchair that she knew of. The DOR said she started working at the facility in October and he had them since then at least. The DOR said she took Resident #5's anti-tippers off the van when he returned to the facility from dialysis on 04/01/25. The DOR said she talked to Resident #5 and he seemed upset that day but he told her that he had the dialysis staff take off his anti-tippers. The DOR said she was not sure why Resident #5 would have someone remove them from his wheelchair. The DOR said Resident #5's anti-tippers were easy to take off but the resident would not have been able to do it himself. The DOR said it was not a normal thing for dialysis staff to take off Resident #5's anti-tippers. The DOR said the purpose of the anti-tippers was to keep the resident from tipping backwards. The DOR said Resident #5 had them on his wheelchair because he was a high fall risk and since he was a double amputee his balance could be off at any time. The DOR said if the anti-tippers were removed, then Resident #5 would be able to flip his wheelchair fully backwards. The DOR said Resident #5's wheelchair was still in the facility and had the anti-tippers still on them. Observation on 05/01/25 at 10:00 AM with the DOR of four random residents in the facility revealed they all had anti-tip devices on the backs of their wheelchairs. Observation on 05/01/25 at 10:05 AM with the DOR of Resident #5's wheelchair in his empty room revealed his wheelchair had both anti-tip devices on the back of it. Interview on 05/01/25 at 11:20 AM with CNA V revealed she cared for Resident #5 every day and he used anti-tippers on his wheelchair. CNA V said she was not there the day the incident happened (04/01/25) but heard that Resident #5 fell back and hit his head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/01/25 at 11:52 AM with ADON U revealed she heard that Resident #5's fall happened outside of the dialysis center and when he returned to the facility she looked at his head but did not know how he fell . ADON U said Resident #5 refused to go to the hospital so they started neuro checks on him. ADON U said she saw he had 2 abrasions to the back of his head, so they watched him for four days and they resolved on their own. ADON U said she was newer to the facility and was not sure if Resident #5 used anti-tippers prior to this incident. Phone interview on 05/01/25 at 1:01 PM with the previous Interim DON revealed she received a call from the Van Driver saying Resident #5 had a fall on 04/01/25. The previous Interim DON said they initiated a video call so she could see the resident. The previous Interim DON said the Van Driver told her that Resident #5 was upset when he came out of the dialysis center and he was trying to put himself on the van lift improperly when she told him multiple times to let her assist him but he refused. The previous Interim DON said the Van Driver said Resident #5 was able to get his wheelchair over the ramp on the van lift that was flushed with the ground, and he flipped backwards sustaining an abrasion to the back of his head. The previous Interim DON said the Van Driver called 911 but Resident #5 refused any treatment from the EMT's and refused to go to the hospital. The previous Interim DON said Resident #5 returned to the facility and a head-to-toe assessment was done and his wounds were dressed. The previous Interim DON said the facility notified Resident #5's Family Member and they also tried to convince him to go to the hospital but he still refused. The previous Interim DON said the x-ray company was currently in the facility at the time and they were asked to complete the skull series x-rays on Resident #5. The previous Interim DON said the results came back and were negative. The previous Interim DON said when he talked to Resident #5, he told her it was his fault and that the Van Driver told him not to get on the van that way but he was mad and he did it anyway and fell . The previous Interim DON said Resident #5 was supposed to have anti-tippers on his wheelchair as an intervention and he reported that he requested the dialysis center staff to take them off. The previous Interim DON said when she found that out, the facility immediately went to put them back on Resident #5's wheelchair. The previous Interim DON said the Maintenance Director also checked Resident #5's wheelchair to make sure that it was functioning properly and it was. The previous Interim DON said someone reached out to the dialysis center to request they not alter any resident's wheelchair and if they do, they need to communicate with the facility about it. Interview on 05/01/25 at 1:50 PM with ADON Y revealed she understood that the dialysis center removed Resident #5's anti-tippers from his wheelchair. ADON Y said Resident #5 was getting into the van in his wheelchair and according to the Van Driver, he tilted himself on purpose because he wanted attention and fell backwards. ADON Y said Resident #5 refused to go to the hospital to be checked out further. ADON Y said Resident #5 sustained a laceration to the back of his head. ADON Y said Resident #5 always had anti-tippers on his wheelchair and she was not sure why the dialysis center would take them off. ADON Y said she was not sure if that was normal for the dialysis center staff to take off a resident's anti-tippers. ADON Y said since Resident #5 was a double amputee it was easy for him to fall back in his wheelchair. ADON Y said when Resident #5 got back to the facility, staff complete neuro checks and monitored him for three days. ADON Y said a skull series was ordered and everything was negative. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 05/01/25 at 2:35 PM with the Administrator revealed Resident #5 went to dialysis and was upset because they made him wait for something while he was there. The Administrator said he was told when Resident #5 came out of the dialysis center, he wheeled himself backwards onto the van lift and when he rolled back his chair tilted back and he fell . The Administrator said Resident #5 had tilt assists on his wheelchair but he asked the dialysis staff to take them off because he did not want them. The Administrator said when Resident #5 came back to the facility, trauma and skin assessments were completed and staff had encouraged him to go to the hospital but he kept refusing. The Administrator said staff monitored him, completed neuro checks, and ordered for a skull series to be done which was negative. The Administrator said Resident #5 did have an abrasion to his head which was treated while at the facility. The Administrator said he also called Resident #5's dialysis center to talk to the staff about not touching their resident's equipment because all of it was there for a reason. The Administrator said in theory if Resident #5 had the anti-tippers on his wheelchair on 04/01/25 he would not have fallen because they would have prevented him from being able to lean all the way back. The Administrator said the Van Driver would have been responsible for making sure Resident #5's anti-tippers were on his wheelchair before she dropped him off, which she did. The Administrator said afterwards, the Van Driver completed trainings and in-services about safe transfers in the van. The Administrator said the Van Driver would have been responsible for assisting Resident #5 to get on and off the van and for keeping him safe. The Administrator said he did not document any communication with the dialysis center staff about removing the anti-tippers from his wheelchair. Record review of an abuse and neglect in-service, dated 04/01/25, reflected 24 staff had been in-serviced. Record review of a resident rights in-service, dated 04/01/25, reflected 24 staff had been in-serviced. Record review of a fall prevention in-service, dated 04/01/25, reflected 24 staff had been in-serviced. Record review of an Employee Auto Training Handbook reflected the Van Driver had a road test completed on 04/01/25. An acknowledgement form was signed by the Van Driver on 04/02/25 regarding the Employee Auto Training Handbook. Record review of the facility's policy, revised 10/05/16, and titled Preventive Strategies to Reduce Fall Risk reflected: Procedure: 3. Residents at risk will be care planned for fall prevention. 4. After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of the medication side effects.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs, to meet the needs of each resident for 2 of 3 residents (Residents #2 and #3) reviewed for pharmacy services. The facility failed to maintain accurate documentation regarding the administration of Resident #2 and Resident #3's PRN pain medication and failed to ensure LVN C checked the current physician's orders before administering the PRN pain medication, Hydrocodone/acetaminophen 10/325 mg, to Resident #2 on 01/06/25 when the resident had opioid restrictions. The failure placed residents at risk for possible drug overdose and complications. Findings included: Record review of Resident #2's Quarterly MDS Assessment, dated 03/25/25, reflected the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmission on 01/02/25 with a BIMS score of 09 revealing her cognation was moderately impaired. Her active diagnoses included metabolic encephalopathy (a progressive brain disorder that slowly destroys memory and thinking skills), other toxic encephalopathy (a neurological disorder caused by exposure to toxic substances, leading to brain dysfunction) and she received as needed pain medication. Record review of Resident #2's care plan, initiated on 03/04/25, did not reflect her use of as needed pain medication. Record review of Resident #2's Order Summary Report, dated 05/01/25, reflected the following: Norco Oral Tablet 10-325 mg (Hydrocodone-Acetaminophen) by mouth every 6 hours as needed with a start date of 04/10/24. Record review of the January 2025 MAR and NAR reflected the NAR had one dose of hydrocodone signed off, and the MAR had no documentation indicating when the Norco 10/325 mg was administered to Resident #2. An interview was attempted with Resident #2's family member on 05/01/25 and 11:19 AM via telephone; however, the attempt was not successful. A voicemail message was left, but the family did not return the call. Record review of Resident #2's Order Summary Report, dated 05/01/25, reflected the following: Record review of Resident #2's hospital discharge orders dated 01/03/25 reflected: Please do not give patient an opioid's medication she was just discharged from the hospital for opioid overdose. This includes hydrocodone. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on Resident #2's hospital discharge orders dated 01/03/25 reflected an order for Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen). Record review of a physician's verbal order dated 05/01/25 reflected: Norco oral tablet 10/325 mg (hydrocodone-acetaminophen). Give 1 tablet by mouth every 6 hours as needed for chronic pain. Hold 01/05/2025 -01/06/2025. Hold reason: medicine intoxication Record review of Resident #2's January 2025 MAR reflected there was no documentation she received Norco Oral Tablet 10-325 mg (Hydrocodone-Acetaminophen) on 01/06/25. Record review of Resident #2's Progress Notes from 01/03/25 to 01/06/25 did not reflect any information related to her receiving the Norco Oral Tablet10-325 mg (Hydrocodone-Acetaminophen) on 1/6/25. Record review of Resident #2's NAR reflected: Norco Oral Tablet 10-325 mg (Hydrocodone-Acetaminophen) Date: 1/6/25 ; Time: [07:00PM]; Amount Given: 1; Amount Left: 42; Signature: [LVN C] Interview on 04/30/25 at 07:43 PM with LVN C revealed she normally worked with Resident #2. LVN C revealed Resident#2 was only supposed to take Tylenol for pain.LVN C stated she could recall she was on Norco Oral Tablet10-325 MG(Hydrocodone-Acetaminophen), but she could not recall giving her after discharge form hospital. She stated she was off, and she was not in a position to go through the record to clarify why she administered Resident#2 pain pill. She stated she had done training once she administer narcotic she was supposed to document on the medication administration record and also on the narcotic administration record She stated the risk of administering Norco oral tablet 10-325 MG(Hydrocodone-Acetaminophen) would be medication error since they were not supposed to administer any opioids. Interview with responsible party for resident #2 on 05/01/25 and 11:19AM via phone was not successful voice mail was left. Interview on 05/01/25 at 12:47 PM with LVN G revealed she was the one that admitted the resident back from hospital . She revealed the hospital orders were not to administer opioids due to a diagnosis of opioid overdose . She stated she reconciled the medication list with doctor on admission and she put down on progress notes not to administer Resident#2 any opioid medication. She denied knowing Resident#2 was administered Norco 10/325mg. She stated failure to follow doctor's orders would lead to medication error and medication overdose. Interview with ADON Y on 05/01/25 at 1:15PM revealed her expectation was staff were not supposed to administer residnet#2 any opioids after being diagnosed with opioids overdose on 1/2/25. She stated when the surveyor brought the issue to her Attention she noticed Norco 10/325mg was administered ,while the hospital discharge order was Norco 5/325mgs.She stated she was responsible of following up the discharge orders and she missed the Norco 5/325mg order and also Norco 10/325mg was not discontinued after she came with new orders . She stated if she could have caught it she could have clarified with the doctor since they had specific orders from hospital not to administer opioids. She stated facility had done in-service on medication administration. In-service record given dated 01/08/24 revealed LVN C was not in attendance. (continued on next page)

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	05/01/2025

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/01/25 at 01:53 PM with the Corporate compliance RN revealed, she noted when it was brought to her attention by the ADON that Resident#2 received Norco 10/325 mgs on 1/6/25.She stated her expectation was the staff to follow up with the doctor after resident was discharged with restriction of opioid use before administering. She said LVN C should have confirmed the PRN Norco 10/325mgs order before she administered it to Resident #2. The Corporate Compliance RN said she was not sure why LVN C did not check her orders first and she was trying to call her, but she had not succeeded. She said as far as she knew, Resident #2 did not have any adverse effects from the medication. The corporate compliance RN said this situation was considered a medication error. She stated the risk was Resident#2 would have had side effects and be sent back to hospital. Interview on 05/01/25 at 3:42PM via phone with Physician Z it was revealed his expectation was nurses to follow the orders . He stated he was called, when Resident#2 was readmitted , and medication list was reconciled. He said he was far from his computer he could not recall the orders for Resident#2.He stated he was aware of opioids overdose but he could not recall her discharge orders and stated sometimes the hospital orders are contradicting, and that was why the nurses should always call for clarification because he is always available. He stated giving the wrong dose could lead to medication error and readmission to hospital .He stated he will check the orders and call back, but he did not. Record review of the facility's policy medication administration procedures , revised 10/25/17, reflected: .7. All PRN medication orders must specify the reason and frequency for use . PRN medications are to be Charted on the medication administration record. Explanation as to symptoms prior to administration and results are to be documented. Complete documentation of prn administration is to be noted in nurse's notes , or in the area provided for prn documentation on the medication administration record. Record review of Resident #3's Quarterly MDS Assessment, dated 03/14/25, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmission on 03/08/25 with a BIMS score of 15 revealing his cognation was intact .His active diagnoses included pain and pressure ulcer of unspecified Buttocks. Record review of Resident #3's care plan, initiated on 04/01/24, reflected: Focus: [Resident #19] has a potential for uncontrolled pain. Goal: Resident#3 will not have an interruption in normal activities due to pain through the review date. Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions . Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition Identify, record, and treat the resident's existing conditions which may increase pain and or discomfort. Record review of Resident #3's Order Summary Report, dated 05/01/25, reflected the following: Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain with a start date of 03/08/25. Review of Resident#3 NAR revealed on the month of April 2025 Resident #3 received pain medications on 4/3/25, 4/4/25, 4/5/25,4/6/25,4/7/25,4/10/25,4/11/25,4/12/25,4/15/25,4/17/25,4/18/25 ,4/19/25 ,4/20/25, 4/21/25,4/23/25 ,4/25/25 and 4/26/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the of Resident #3 Medication administration record revealed nurses only documented him receiving prn medication on 3/4/25, 4/4/25 ,4/19/25 ,4/20/25 and 4/21/25 had no documentation for 4/5/25, 4/6/25,4/7/25,4/10/25,4/11/25,4/12/25,4/15/25,4/17,25,4/18/25,4/23/25 ,4/25/25 and 4/26/25 on when the Norco 10/325mgs was administered to Resident#3 as indicated on the narcotic administration log. Interview with the family member for Resident#3 on 4/30/25 at 11:08 AM, it was revealed the staff were documenting as giving norco 10/325mgs as needed while he was not getting the medication. She stated Resident # 3 pain was being managed he had other scheduled pain medication and he only neeeded the norco 10/325 mgs as needed. Interview on 04/30/25 at 07:43 PM, LVN C stated when nurses administer as needed medication they supposed to ensure they document on both the NAR and the MAR. LVN C stated failure to document accurately it could lead to medication errors. Interview on 05/01/23 at 09:28 AM, ADON U who worked as a floor nurse for Resident#3 stated the NAR and the MAR should always match up. Failing to document what had been given could lead to medication errors and double dosing. She stated it could also indicate a possible drug diversion. Interview on 05/01/25 at 12:47 PM, LVN G stated both the NAR and the MAR should match up. She stated nurses are supposed to log off on NAR, document on MAR, and follow up for on MAR for effectiveness. LVN G stated failure to document accurately it could lead to medication errors. Interview on 05/01/25 at 1:15 PM, the ADON Y she stated her expectation was for nurses to document medication administered on the NAR and MAR. The ADON Y stated she had noticed the nurses were administering as needed medication and were not documenting on the MAR. She stated failing to accurately document medications given could lead to medication errors, double dosing of residents, or lack of properly medicating residents. She stated it was her responsibility to check after nurse on electronic health records and ensure Residents are getting their medications. She stated they had done training on medication administration. Interview on 05/01/25 at 01:53 PM, with Corporate Compliance RN said she had noticed nurses were not documenting as needed pain medication on MAR. She stated both the NAR, and the MAR should match up. She is at the facility weekly to check they were signing the MAR, but she does not check the PRN she only checks the routine medication. She stated it was ADONs responsibility to check the MAR. She stated failure to document accurately it could lead to overdose. She stated she will in-service staffs on PRN medication administration. Record review of the facility's policy medication administration procedures , revised 10/25/17, reflected: .7. All PRN medication orders must specify the reason and frequency for use . PRN medications are to be Charted on the medication administration record. Explanation as to symptoms prior to administration and results are to be documented. Complete documentation of prn administration is to be noted in nurse's notes , or in the area provided for prn documentation on the medication administration record 2. Record review of Resident #2's Order Summary Report, dated 05/01/25, reflected the following: (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Norco Oral Tablet10-325 MG(Hydrocodone-Acetaminophen) by mouth every 6 hours as needed with a start date of 04/10/24. Record review of Resident #2's hospital discharge orders dated 01/03/25 reflected Please do not give patient an opioid's medication she was just discharged from the hospital for opioid overdose. This includes hydrocodone. Record review on Resident#2 hospital discharge orders dated 01/3/25 revealed Norco Oral Tablet 5-325 MG(Hydrocodone-Acetaminophen). Record review on physical verbal order dated 05/01/25 revealed :Norco oral tablet 10/325mg(hydrocodone-Acetaminophen).Give 1 tablet by mouth every 6 hours as needed for chronic pain. Hold 01/05/2025 -01/06/2025.Hold reason: medicine intoxication Record review of Resident #2's January 2025 MAR reflected there was no documentation she received Norco Oral Tablet 10-325 MG(Hydrocodone-Acetaminophen) on 1/6/25 Record review of Resident #2's Progress Notes from 01/03/25 to 01/06/25 did not reflect any information related to her receiving the Norco Oral Tablet10-325 MG(Hydrocodone-Acetaminophen) on 1/6/25. Record review of Resident #2's Narcotic administration record reflected: Norco Oral Tablet 10-325 MG(Hydrocodone-Acetaminophen) - Date: 1/6/25 ; Time: [07:00PM]; Amount Given: 1; Amount Left: 42; Signature: [LVNC] Interview on 04/30/25 at 07:43 PM with LVN C revealed she normally worked with Resident #2. LVN C revealed Resident#2 was only supposed to take Tylenol for pain.LVN C stated she could recall she was on Norco Oral Tablet10-325 MG(Hydrocodone-Acetaminophen), but she could not recall giving her after discharge form hospital. She stated she was off, and she was not in a position to go through the record to clarify why she administered Resident#2 pain pill. She stated she had done training once she administer narcotic she was supposed to document on the medication administration record and also on the narcotic administration record She stated the risk of administering Norco oral tablet 10-325 MG(Hydrocodone-Acetaminophen) would be medication error since they were not supposed to administer any opioids. Interview with responsible party for resident #2 on 05/01/25 and 11:19AM via phone was not successful voice mail was left. Interview on 05/01/25 at 12:47 PM with LVN G revealed she was the one that admitted the resident back from hospital . She revealed the hospital orders were not to administer opioids due to a diagnosis of opioid overdose . She stated she reconciled the medication list with doctor on admission and she put down on progress notes not to administer Resident#2 any opioid medication. She denied knowing Resident#2 was administered Norco 10/325mg. She stated failure to follow doctor's orders would lead to medication error and medication overdose. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADON Y on 05/01/25 at 1:15PM revealed her expectation was staff were not supposed to administer residnet#2 any opioids after being diagnosed with opioids overdose on 1/2/25. She stated when the surveyor brought the issue to her Attention she noticed Norco 10/325mg was administered ,while the hospital discharge order was Norco 5/325mgs.She stated she was responsible of following up the discharge orders and she missed the Norco 5/325mg order and also Norco 10/325mg was not discontinued after she came with new orders . She stated if she could have caught it she could have clarified with the doctor since they had specific orders from hospital not to administer opioids. She stated facility had done in-service on medication administration. In-service record given dated 01/08/24 revealed LVN C was not in attendance. Interview on 05/01/25 at 01:53 PM with the Corporate compliance RN revealed, she noted when it was brought to her attention by the ADON that Resident#2 received Norco 10/325 mgs on 1/6/25.She stated her expectation was the staff to follow up with the doctor after resident was discharged with restriction of opioid use before administering. She said LVN C should have confirmed the PRN Norco 10/325mgs order before she administered it to Resident #2. The Corporate Compliance RN said she was not sure why LVN C did not check her orders first and she was trying to call her, but she had not succeeded. She said as far as she knew, Resident #2 did not have any adverse effects from the medication. The corporate compliance RN said this situation was considered a medication error. She stated the risk was Resident#2 would have had side effects and be sent back to hospital. Interview on 05/01/25 at 3:42PM via phone with Physician Z it was revealed his expectation was nurses to follow the orders . He stated he was called, when Resident#2 was readmitted , and medication list was reconciled. He said he was far from his computer he could not recall the orders for Residnet#2.He stated he was aware of opioids overdose but he could not recall her discharge orders and stated sometimes the hospital orders are contradicting and that is why nurses should always call for clarification because he is always available .He stated giving the wrong dose could lead to medication error and readmission to hospital .He stated he will check the orders and call back but he did not . Record review of the facility's policy medication administration procedures , revised 10/25/17, reflected: .7. All PRN medication orders must specify the reason and frequency for use . PRN medications are to be Charted on the medication administration record. Explanation as to symptoms prior to administration and results are to be documented. Complete documentation of prn administration is to be noted in nurse's notes , or in the area provided for prn documentation on the medication administration record.