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	09/10/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 5 of 6 residents (Residents #1, #2, #3, #8, and #9) reviewed for abuse. 1. The facility failed to ensure adequate supervision was provided to prevent a physical altercation between Residents #8 and #9 on the facility's memory care unit on 06/17/25 and failed to ensure the nurse on the unit, RN K, had visual access to the residents to be able to intervene timely. Resident #9 punched Resident #8 approximately eight times in the face/head resulting in Resident #8 having an abrasion and swelling on the left side of his face. 2. The facility failed to ensure Resident #1 was free from verbal abuse when he was verbally abused by CNA #1 on 09/04/25. 3. The facility failed to ensure Resident #3 were free from abuse on 05/13/25 when Resident #2 punched him in the face. The noncompliance was identified as a past non-compliance. The Immediate Jeopardy (IJ) began on 05/13/25 and ended on 09/05/25. The facility had corrected the noncompliance before the abbreviated survey began. These failures could place residents at risk of abuse, trauma, and psychological harm. Findings included:1. Record review of Resident #8's most recent Quarterly MDS Assessment, dated 04/06/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. Resident #8's cognition was moderately impaired with a BIMS score of 6. The resident's diagnoses included: non-Alzheimer's dementia (various types of dementia), unspecified dementia, unspecified severity, with other behavioral disturbances, coronary artery disease (general decline in cognitive abilities that affect a person's ability to perform everyday activities) and high blood pressure. Resident #8's MDS indicated he had shown no signs of behavior or mood swings. Record review of Resident #8's undated care plan reflected the following care plans that had been developed:- Resident #8 had a history of trauma that may have a negative impact related to physical aggression from another resident. The care plan goals included: maintain resident's safety and integrity during post trauma episode, using appropriate interventions. The care plan interventions included consult with family regarding the resident's condition as appropriate. Identify situation/event/images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. These triggers could include physical aggression from others. - Resident #8 had delirium or an acute confusional episode related to change in condition. The care plan goal reflected: Resident will be free of signs and symptoms of delirium (changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness. The care plan interventions included to consult with family and interdisciplinary team, review chart to establish baseline level of functioning. Educate resident/family/caregivers to observe for and report any signs or symptoms of delirium. Ensure fluid intake of at least 1500 cc /24 hours. - Resident #8's had potential to demonstrate physical behaviors Dementia, History of harm to other, poor impulse control. The care plan goals included: The resident will demonstrate effective coping skills. The care plan interventions included: analyze [sic] of key times, places, circumstances, triggers, and what deescalates behaviors and document. Assess and address for contributing sensory deficits. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain. If 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. Resident to be 1:1 for 24 hours, every 15minutes for 24 hours, every 30 minutes for 24 hours, every 1 hour for 24 hours, every 8 hours for 24 hours. When resident becomes agitated: intervene before agitation escalates; Guide away from the source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away; and approach later. - Resident #8 resided in the Secure Care Unit, related to diagnosis of dementia and risk for elopement. Disease Process, Disoriented to place, Memory loss. Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the Secure Care Unit. Interventions included: Admit to Secure Care unit per physician orders, Engage resident in group activities and provide them with individualized meaningful projects that they will accomplish throughout the day, Involve resident in daily activities designed for Secure Care Unit, Monitor for S/S of depression, withdrawal from usual activities, Notify MD of any changes, Psych services per MD orders. Record review of Resident #8's progress notes written by RN K on 06/17/25 at 12:00 PM reflected: Writer heard yelling, saw patients Resident #8 and Resident #9 hitting one another and rolling on the dry floor. RN K went out and grabbed Resident #8's arm to prevent him from hitting and telling him to let go of Resident #9's shirt. After he let go then I pulled him away. Resident #9 then sat on the couch. Resident #8 laid on the

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the Administrator of the facility for 1 of 3 residents (Resident #1) reviewed for reporting abuse and neglect. LVN B failed to report an allegation of verbal abuse to the Administrator, on 09/05/25 when CNA used profanity towards Resident #1. This failure could have resulted in psychological harm to residents. Findings included: Record review of resident #1's face sheet dated 09/09/25, revealed the resident was a [AGE] year-old male with an admission date of 09/04/21 and readmitted on [DATE]. Record review of Resident #1's Annual MDS, dated [DATE], reflected he had a BIMS score of 15, indicating no cognitive impairment. His diagnoses included Type 2 Diabetes Mellitus (A long-term condition in which the body has trouble controlling blood sugar), Chronic Pain Syndrome (Condition characterized by persistent pain lasting longer than 3-6 months, often accompanied by psychological and functional impairment), and Cognitive Communication Deficit (Impaired communication due to deficits in attention, memory, or executive function). The MDS reflected Resident #1 did not have any physical or verbal behaviors towards others. The MDS also reflected Resident #1 was dependent on staff to assist with ADLs. Record review of Resident #1's Care Plan Initiated 11/15/24 and revised on 09/05/25, reflected, Focus: Resident has a history of making false accusations, related to but not limited to: the staff, showers, activities of daily living, and preferences. Resident instigates staff by cursing at them and calling them derogatory names. Goal: Reductions or absence or false accusation. Interventions: Anticipate and meet the resident's needs. Assist the resident to develop more appropriate methods of coping and interacting with staff. Encourage the resident to express feelings appropriately. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Interview on 09/09/25 at 9:48 AM with Resident #1 revealed on 09/04/25, his roommate called CNA A to his room. Resident #1 said CNA A walked into the room asked who had called her, to which he responded with none ya. Resident #1 said he heard CNA A say fuck you to him and then immediately walk out of the room. Resident #1 said that CNA A saying that made him cry, feel put down, and uncomfortable. Resident #1 said that right after it happened, he told his nurse (LVN B). Resident #1 revealed LVN B removed CNA A from his hallway and provided Resident #1 with a different aide, so CNA A no longer cared for him. Interview on 09/09/25 at 2:23 PM with LVN B revealed Resident #1 came to her after the incident with CNA A on 09/04/25. LVN B stated that Resident #1 and CNA A used the F word to each other. LVN B said when Resident #1 reported it to her, he appeared visibly upset by it. LVN B said she switched the aides out, so CNA A was no longer caring for Resident #1. LVN B reported that she had to calm Resident #1 down and reported it to the administrator and DON because it was verbal abuse to Resident #1. Interview on 09/10/25 at 1:06 PM with LVN B revealed while she originally did say yesterday, she had reported the abuse allegation to the Administrator and DON, she remembered that she might not have because she thought CNA A had done that. LVN B stated she was expected to report the abuse immediately to the Administrator who was the Abuse Coordinator Interview on 09/10/25 at 11:31 AM with the DON revealed she was told about the incident between Resident #1 and CNA A on 09/05/25 by the Social Worker right after he reported it to her. The DON stated that it was reported to her that Resident #1 was bating CNA A and said Fuck you first, but then CNA A said it back. The DON stated that CNA A admitted it was wrong to say that to a resident. The DON revealed they suspended and terminated CNA A on 09/05/25. The DON reported that telling a resident Fuck you was considered verbal abuse. The DON stated she was unaware of LVN B being told about the situation on 09/04/25. The DON reported that all staff were expected to notify the Administrator immediately after the allegation was reported. The DON reported that residents have the right to be free from abuse and that if abuse is not reported immediately, problem resolution may be delayed, and residents may be harmed further. The DON stated her expectations were for staff to keep all residents safe and free from abuse. Interview on 09/10/25 at 11:56 AM with the Administrator revealed CNA A told Resident #1 Fuck you the previous night (09/04/25) around 6 pm. The Administrator said during her interview with Resident #1, he told her that CNA A cursing at him was unprovoked. The Administrator said Resident #1's roommate also confirmed that CNA A did say fuck you to Resident #1 on the night of 09/04/25. The Administrator stated that the Social Worker notified the Administrator on 09/05/25 of the abuse allegation after Resident #1 notified the Social Worker. The Administrator stated on 09/05/25 is when the facility had

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for 2 of 4 residents reviewed (Residents #2 and #5) for PASRR assessments.1.The facility failed to submit a NFSS form, used to request specialized services for residents, request within 20 from interdisciplinary team meeting dated 03/18/25 for Resident #2. 2. The facility failed to submit a completed a NFSS in the LTC Online Portal within 20 business days of Resident #5's IDT meeting. This failure could place residents at risk of not receiving or benefiting from recommendations for services they may require. Findings included:1. Record review of Resident #2's most recent Quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had moderate cognitive impairment with a BIMS score of 8. The resident's diagnoses included anxiety disorder (condition that cause significant and uncontrollable feelings of anxiety and fear), depression (persistent feeling of sadness and loss of interest), and schizophrenia (severe mental disorder), bipolar disorder (mental health condition with extreme mood swings), unspecified intellectual disabilities (condition that limits intelligence and disrupts abilities necessary for living independently). Resident #2's MDS indicated he received Speech Therapy 3 days beginning 12/22/24, Occupational Therapy 2 days beginning 12/10/24, and Physical Therapy 3 days beginning 12/09/24. Resident #2 had impairment on both side of his lower extremities and utilized a wheelchair. Supervision or touching assistance with lower body dressing, partial/moderate assistance with showers, oral, personal, and toileting hygiene, with set up assistance with eating. Record review of Resident #2's care plan, undated revealed he has been identified as having PASRR positive status related to Mental Illness and Intellectual Disabilities. Goal: Resident #2 will have the specialized services recommended by local authority according to PASRR Specialized Services program as needed. Interventions included the Local Authority would be invited annually to the care plan meeting for review of Specialized Services. Record review of Active Residents with PASRR Positive PE reflected Resident #2 on the list. The list indicated Resident #2 status date was 12/14/24 due to mental illness and developmental disabilities and had special services. Record review of Resident #2's PASRR Level 1 Screening completed 12/05/24 indicated Yes to Mental Illness and Intellectual Disability. Record review of Resident #2's PASRR Evaluation completed 12/13/24 indicated Yes to Intellectual Disability and Development Disability. Record review of Resident #2's PASRR Comprehensive Service Plan Form dated 03/18/25 revealed recommended Nursing Facility Specialized Services included new: Customized Manual Wheelchair, Specialized Assessment Occupational Therapy, Specialized Assessment Physical Therapy, Specialized Assessment Speech Therapy, Specialized Occupational Therapy, Specialized Physical Therapy, Specialized Speech Therapy, Day Habilitation, Habilitation Coordination, Independent Living Skills Training. The above services have been accepted by Resident #2. Record review of Resident #2's PASRR Comprehensive Service Plan Form dated 06/19/25 reflected the recommended Nursing Facility Specialized Services included ongoing: Customized Manual Wheelchair, Specialized Assessment Occupational Therapy, Specialized Assessment Physical Therapy, Specialized Assessment Speech Therapy, Specialized Occupational Therapy, Specialized Physical Therapy, Specialized Speech Therapy, Habilitation Coordination. The above services have been accepted by Resident #2 except CMWC. Interview on 09/09/25 at 9:30 AM with Resident #2 revealed he had a wheelchair which he used daily. Resident #2 stated he received physical therapy, but he did not know if he received occupational or speech therapy. Interview on 09/09/25 at 12:00 PM with PASRR representative revealed there was an interdisciplinary team meeting on 03/18/25. The facility was required to have uploaded documentation from the meeting into the portal within 20 business days from the meeting. According to the PASRR representative, she saw Resident #2 during his Occupational Therapy and he was doing fine, however when she looked in the portal for the documents, they had not been uploaded from the 03/18/25 meeting. The PASRR representative stated she spoke with the Social Worker about the missing documents in the hopes of having the documents uploaded. Interview on 09/09/25 at 3:32 PM with the Social Services Director revealed she was not an employee during the 03/18/25 visit and was not aware of missing documents for Resident #2 until she spoke with PASRR representative on 09/08/25. The Social Services Director stated she just recently started getting the invite to PASRR meetings, and would pass the invitation to the Director of Rehabilitation along with letting the

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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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 2 of 5 residents (Resident #8 and Resident #9) reviewed for supervision. The facility failed to ensure adequate supervision was provided to prevent a physical altercation between Residents #8 and #9 on the facility's memory care unit on 06/17/25 and failed to ensure the nurse on the unit, RN K, had visual access to the residents to be able to intervene timely. Resident #9 punched Resident #8 approximately eight times in the face/head resulting in Resident #8 having an abrasion and swelling on the left side of his face. The noncompliance was identified as a past non-compliance. The Immediate Jeopardy (IJ) began on 06/17/25 and ended on 06/19/25. The facility had corrected the noncompliance before the abbreviated survey began. This failure placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #8's most recent Quarterly MDS Assessment, dated 04/06/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. Resident #8's cognition was moderately impaired with a BIMS score of 6. The resident's diagnoses included: non-Alzheimer's dementia (various types of dementia), unspecified dementia, unspecified severity, with other behavioral disturbances, coronary artery disease (general decline in cognitive abilities that affect a person's ability to perform everyday activities) and high blood pressure. Resident #8's MDS indicated he had shown no signs of behavior or mood swings. Record review of Resident #8's undated care plan reflected the following care plans that had been developed:- Resident #8 had a history of trauma that may have a negative impact related to physical aggression from another resident. The care plan goals included: maintain resident's safety and integrity during post trauma episode, using appropriate interventions. The care plan interventions included consult with family regarding the resident's condition as appropriate. Identify situation/event/images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. These triggers could include physical aggression from others. - Resident #8 had delirium or an acute confusional episode related to change in condition. The care plan goal reflected: Resident will be free of signs and symptoms of delirium (changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness. The care plan interventions included to consult with family and interdisciplinary team, review chart to establish baseline level of functioning. Educate resident/family/caregivers to observe for and report any signs or symptoms of delirium. Ensure fluid intake of at least 1500 cc /24 hours. - Resident #8's had potential to demonstrate physical behaviors Dementia, History of harm to other, poor impulse control. The care plan goals included: The resident will demonstrate effective coping skills. The care plan interventions included: analyze [sic] of key times, places, circumstances, triggers, and what deescalates behaviors and document. Assess and address for contributing sensory deficits. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain. If 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. Resident to be 1:1 for 24 hours, every 15minutes for 24 hours, every 30 minutes for 24 hours, every 1 hour for 24 hours, every 8 hours for 24 hours. When resident becomes agitated: intervene before agitation escalates; Guide away from the source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away; and approach later. - Resident #8 resided in the Secure Care Unit, related to diagnosis of dementia and risk for elopement. Disease Process, Disoriented to place, Memory loss. Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the Secure Care Unit. Interventions included: Admit to Secure Care unit per physician orders, Engage resident in group activities and provide them with individualized meaningful projects that they will accomplish throughout the day, Involve resident in daily activities designed for Secure Care Unit, Monitor for S/S of depression, withdrawal from usual activities, Notify MD of any changes, Psych services per MD orders. Record review of Resident #8's progress notes written by RN K on 06/17/25 at 12:00 PM revealed Writer heard yelling, saw patients Resident #8 and Resident #9 hitting one another and rolling on the dry floor. RN K went out and grabbed Resident #8's arm to prevent him from hitting and telling him to let go of Resident #9's shirt. After he let go then I pulled him away. Resident #9 then sat on the couch. Resident #8 laid on the floor. Vitals were taken. Neuros taken. All withing normal limits. Resident #8 complaint of face hurting