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	12/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 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 the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 8 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 received appropriate monitoring of his condition after the resident refused three consecutive dialysis treatments on 10/04/25, 10/07/25, and 10/09/25. This failure placed residents at risk of a delay in medical evaluation and treatment, which could result in worsening of conditions. Findings included:Record review of Resident #1's face sheet, dated 10/10/25, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses that included: metabolic encephalopathy (change in brain function due to systemic illness), heart failure, candidiasis (fungal infection), chronic kidney disease, dependence on dialysis (treatment to remove waste and excess fluid from the body), diabetes mellitus (body's inability to control blood sugar levels), morbid obesity (body mass index of 40 or higher), COPD (lung disease), and major depressive disorder (mood disorder). Record review of Resident 1's OSA MDS assessment, dated 07/25/25, reflected the resident's BIMs score was 9, which indicated moderate cognitive impairment. The MDS Assessment under Section G-Functional Status, reflected Resident # 1 required extensive assistance with most ADLs. The MDS Assessment under Section O-Special Treatments, Procedures, and Programs, reflected Resident #1 received dialysis. Record review of Resident #1's care plan, dated 09/23/25, reflected the resident was non-compliant with ADL care with interventions that included: allowing resident to make decisions about treatment regime, educating the resident about possible outcomes of not complying with treatment or care, encouraging participation and interaction during care, giving clear explanation of care activities as they occur, and if possible, negotiating a time for ADLs. Further review of this documents reflected a new focus was added on 10/10/25, after surveyor entered the facility, that reflected Resident #1 had a history of non-compliance with dialysis with interventions that included: education the resident on importance of his dialysis regimen ad potential consequences, engaging in collaborative discussions with the resident and family to ensure shared decision-making regarding care, identifying barriers to adherence to dialysis, and providing support and resources to help resident overcome barriers. Record review of a document in Resident #1's EHR titled U.S Renal Care, undated, reflected in part the following: Dear [Resident #1],This letter is to confirm that we have reserved a place for you to receive dialysis at [dialysis provider]. Thank you for choosing [dialysis provider] as your dialysis provider where we provide best quality of care and exceptional service.Frequency: T, TH, STime: 3:20 PMStart Date: 4/8/2025. Record review of Resident #1's progress notes, dated 10/09/25 at 11:25 AM by LVN C, reflected the following: [LVN C] notified NP r/t [Resident #1] refusing Dialysis. Record review of Resident #1's progress notes, dated 10/09/25 at 11:40 AM by LVN C, reflected the following:[Resident #1] refused to go to Dialysis. [LVN C] educated [Resident #1] on the importance of keeping Dialysis appointment. Notified DON/MD/Family. Further record review of Resident #1's progress notes, from 10/04/25-10/10/25, reflected there was no documentation of Resident #1 missing dialysis treatments on 10/04/25 or 10/07/25 or attempts to send the resident to the hospital for evaluation after missing 3 dialysis treatments. Record review of Resident #1's Lab Results Report, dated 10/07/25, reflected in part the following: -Collection Date: 10/07/2025 at 6:17 AM-Received Date: 10/07/2025 at 11:36 AM-Reported Date: 10/09/2025 at 4:57 PM. CMPGlucose-298 mg/dL (range 74-100)- HighChloride- 108.3 mmol/L (range 98.0-107.0)- HighBUN- 46 mg/dL (range 8-26)- HighCreatinine- 4.54 mg/dL (range 0.72-1. 25)- HigheGFR (Non African-American)- 14 ml/min/1.73 (range >60)- LowA/G ration- 0.61 % (range 0.80-2. 00)- LowAlbumin- 2.00 g/dL (range 3.40-5.00)- LowTotal Protein- 5.3 g/dL (range 6.0-7.8)- LowAlkaline Phosphatase- 156 U/L (range 40-150)- High. In an interview and observation on 10/10/25 at 11:00 AM, Resident #1 was lying awake in bed with no obvious odors, marks, or bruises. Resident #1 was alert and oriented and able to participate in an interview. Resident #1 stated he received dialysis 3 times a week; however, he missed his last three treatments. Resident #1 stated he missed treatments on 10/04/25 and 10/07/25 because he had a cough and he did not want to wear a mask at the dialysis center, so he refused to go. Resident #1 stated he missed treatment on 10/09/25 because his transportation was late and he did not want the technicians at the dialysis center to be upset, so again, he refused to go. Resident #1 stated he would go to his treatment on 10/11/25 if he felt okay. Resident #1 stated he felt slightly bloated from possible

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 3 of 7 residents (Resident #1, Resident #2, and Resident #3) reviewed for infection control. The facility failed to ensure Residents #1, #2 and #3, who were on Enhanced Barrier Precautions, received proper care from staff donning and doffing personal protective equipment for infection control. This failure could place residents at risk for the spread of infections and decreased quality of life. Findings included:Resident #1 Record review of Resident #1's face sheet, dated 10/10/25, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses that included: metabolic encephalopathy (change in brain function due to systemic illness), heart failure, candidiasis (fungal infection), chronic kidney disease, dependence on dialysis (treatment to remove waste and excess fluid from the body), diabetes mellitus (body's inability to control blood sugar levels), morbid obesity (body mass index of 40 or higher), COPD (lung disease), and major depressive disorder (mood disorder). Record review of Resident #1's OSA MDS assessment, dated 07/25/25, reflected the resident's BIMS score was 9, which indicated moderate cognitive impairment. The MDS Assessment under Section G-Functional Status, reflected Resident # 1 required extensive assistance with most ADLs. The MDS Assessment under Section O-Special Treatments, Procedures, and Programs, reflected Resident #1 received dialysis. The MDS Assessment under Section M-Skin Conditions, reflected Resident #1 did not have any ulcers, wounds or skin problems; however, he received the following preventative treatments: pressure reducing device for bed, turning and repositioning program, nutrition or hydration intervention, and application of ointments/medications. Record review of Resident #1's care plan, dated 09/23/25, reflected the resident had a pressure ulcer or potential for pressure ulcer development with interventions that included: heels floated with the use of pillows, incontinent care after each episode and apply moisture barrier, assisting resident with repositioning every 2 hours, a cushion in wheelchair, and using a lifting device or draw sheet to reduce friction. Further review of this document reflected Resident #1 was on enhanced barrier precautions for Candida auris (yeast that can cause severe, invasive infections) with interventions that included: gloves and gowns donned (put on) during linen change, resident hygiene, transfers, dressing, incontinent care, bed mobility, wound care, etc., performing hand sanitation before entering the room and prior to leaving, and a posting of enhanced barrier precautions is to be placed on the door of the resident's room. Record review of Resident #1's hospital records, dated 09/27/25, reflected the resident was admitted to the hospital for observation for abdominal pain. Labs reflected a skin culture that was collected was positive for Candida auris (yeast that can cause severe, invasive infections). In an observation during the initial tour of the facility, there was no enhanced barrier precaution signage on the door of Resident #1's room. In an interview on 10/10/2025 at 11:00 AM, Resident #1 stated he received poor care from the staff regarding an open wound on his bottom due to him having to remind then to put cream on it. Resident #1 did not express any concerns with infection control. In an observation on 10/10/2025 at 11:45 AM, LVN A donned personal protection equipment with improper hand sanitizing prior to donning gloves. LVN A dropped one of her clean gloves on the floor, picked it up and put it back into her scrub pocket. A trash can was next to her feet. Observation of Resident #1's skin revealed his bilateral (both) buttocks had multiple scars from healed wounds. The skin area to the left lower buttock revealed an old scar that was slightly open as a newly formed wound. Measurements were noted to be 0.2 cm x 0.2cm x 0 cm. Redness with no drainage was observed with foul odor noted from the anal area. There was no fecal matter present. When asked how long that area had been open LVN A stated, It's NOT open. After skin examination concluded, CNA D who was assisting LVN A, was observed doffing her personal protective gown by touching the front of her gown and jerking it off without untying all ties after doffing her gloves. Neither LVN A nor CNA D properly cleaned their hands after doffing personal protective equipment Resident #2Record review of Resident #2's face sheet, dated 10/10/25, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses that included: cerebral palsy (brain damage that causes problems with movement, balance, and posture), contractures (permanent or temporary limitations in joint mobility), need for assistance with personal care, gastrostomy (surgical procedure that creates an opening in stomach for feeding and medication