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	12/11/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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 0641 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 interviews and record reviews, the facility failed to ensure the assessments accurately reflected the resident's status for 2 of 4 residents (Residents #1 and #2) reviewed for accuracy of assessments. The facility failed to ensure Resident #1 and Resident #2's MDS assessments were accurate and coded for behavior and mood. This failure could place residents at risk for receiving inadequate care and services based on an inaccurate assessment. Findings included:Record review of Resident #1's face sheet dated 09/19/2025 reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. The face sheet reflected he was discharged on 09/17/2025 to the hospital. The resident's current diagnoses included: Chronic Respiratory Failure, Unspecified Whether with Hypoxia or Hypercapnia (a condition where the lungs fail to adequately exchange oxygen and carbon dioxide over a prolonged period) Need for Assistance with Personal Care (staff assistance with ADL's); Anxiety (fear and worrying) disorder due to known physiological condition, non-compliance with Medical Treatment and regimens, generalized Anxiety (fear and worrying). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating he was cognitively intact. Sections D Mood score 0 and listed no moods. Section E score 0 Behaviors did not address behaviors. Resident required partial and moderate assistance from staff for ADL's, treatments included oxygen treatment for asthma, congestive heart, and Respiratory failure.Record review of Resident # 1's quarterly care plan dated 09/03/2025 reflected Resident has Emphysema/COPD report to nurse if observed with difficulty breathing.[Resident #1] has oxygen therapy Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry (measure oxygen saturation levels), Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis (collapsed lung), Hemoptysis (coughing up blood or bloody mucus, Cough, Pleuritic pain (sharp pains in the checklist), Accessory muscle usage, Skin color. [Resident #1] has behavior problems as evidenced by making false accusations towards staff, refusing care and medications.[Resident #1] has attention-seeking behavior. Assist residents to develop more appropriate methods of coping with and interacting with staff. Encourage residents to express their feelings appropriately. Monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, persons involved and situations. Document all behaviors and potential causes. Staff will encourage residents to make choices that are consistent with goals of care. Staff will provide education re: medications to ensure resident adheres to medication regimen. The resident has an ADL Self Care Performance Deficit. The residents will maintain or improve their current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Encourage the resident to participate to the fullest extent possible with each interaction.Encourage the resident to use bell to call for assistance. The resident has a behavior of calling 911. Record review of Resident #1's physician orders reflected the following orders:- 08/28/2025 - Bumetanide oral tablet 2 mg (Bumex) give 1 tablet by mouth two times a day for edema related to chronic systolic (congestive) heart failure - 08/30/2025 - Duloxetine HCl Capsule Delayed Release Particles 30 MG Give 1 capsule by mouth one time a day for depression related to anxiety disorder due to known physiological condition.Psychiatric referral dated 09/17/2025 Record review of Resident #1's progress notes written by LVN M, dated 09/17/2025 12:00 PM, reflected: [Resident #1] was transferred to the hospital related to complaints of incorrect medication. This is intended to serve as notice of an emergency transfer. This notice was provided to emergency transportation EMT. Record review of Resident #1's progress notes written by the DON, dated 09/17/2025 2:59 PM, reflected: Resident has called facility numerous times today, threatening to call 911. He believes that the Bumex is not the correct pill, but instead a medication for schizophrenia. Later he reported Bumex pill was for his heart, and he did not have any heart issues. Resident has not been able to be effectively redirected. He raises his voice and will talk over staff when they attempt to explain.he believes the Bumex is causing s/sx of pain and aching. Record review of Resident #1's progress notes written by the DON, dated 09/17/2025 at 3:15 PM , reflected: [MD-J] was made aware of resident behaviors today, verbal order for psych referral per [MD J]. Interview on 09/19/2025 at 10:04 PM with the SW revealed Resident #1 had anxiety and refused care and treatment often. She stated she had met with the resident on numerous occasions along with the DON to address his concerns of being administered wrong treatment and medications. She stated she had made a psychiatric referral; however

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 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 observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 4 residents (Residents #4 and #8) reviewed for respiratory care. 1. The facility failed to ensure Resident #4's nasal cannula and tubing were bagged when not in use. 2. The facility failed to ensure Resident #8's CPAP mask was bagged when not in use. These failures could place residents at risk for respiratory infection. Findings included:Record review of Resident #4's face sheet dated 09/19/2025 reflected the resident was a [AGE] year-old-female, who admitted to the facility on [DATE] and initially on 04/10/2025. The resident's diagnoses included: Heart Failure, asthma (chronic lung condition that causes inflammation in the airway) and COPD (an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways.) respiratory failure (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide). Record review of Resident #4's MDS dated [DATE] reflected the resident's cognition was intact with a BIMS score of 15. The resident required total assistance for all ADLs, and she required oxygen therapy.Record review of Resident #4's quarterly care plan dated 06/20/2025 reflected: Adverse medication effect and behavior.The resident will be free from adverse medication effects Date Initiated: 06/20/2025 Target Date: 09/18/2025.Continually monitor for behaviors and medication adverse effects and notify the MD, LVN or NP as required. In addition, note any behaviors and adverse effects on the Weekly RN .Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Monitor for escalating anxiety, depression or suicidal thought and report . immediately to the nurse Date Initiated: 06/20/2025 Monitor for escalating anxiety, depression, sleep disturbance, substance abuse, or suicidal thoughts and report immediately to the physician and to the mental health provider.Resident refuses to utilize CPAP. 2.Staff will monitor changes in health. Staff will explain the risk and consequences of her refusing to utilize CPAP. Staff will listen to residents' concerns. The resident has altered respiratory status/Difficulty Breathing / Shortness of Breath.The resident has oxygen therapy, notify the nurse if the oxygen is off the resident.Record review of Resident #4's physician orders dated 09/19/2025 reflected an order Oxygen LPM: 3 Via: NC @HS at bedtime for Oxygen Usage at HS, Assessment every shift related to chronic obstructive pulmonary disease, unspecified (J44.9) Assess 02 Sat, Resp. Rate, Pulse, Breath sounds. Total time to assess. Observation 0n 09/19/2025 at 1:25 PM revealed Resident #4 lying in her bed on her back with the head of bed partially raised. The NC tubing was stored in a blue emesis bag (a disposable container used to collect and contain vomit) attached to her concentrator dated 09/15/2025. The nasal cannula tubing was not appropriately stored and dated in a bag to prevent exposure to the environment and bacteria. Observation and interview on 09/19/2025 at 1:25 PM with Resident #4 revealed she used oxygen at night. Resident #4 stated she did not recall when the tubing was last changed. She stated the staff usually stored the tubing in a plastic bag.2. Record review of Resident #8's face sheet dated 09/19/2025reflected reflected the resident was a [AGE] year-old-male, who admitted to the facility on [DATE]. The resident's diagnoses included: Acute respiratory Failure with Hypoxia (is a serious medical condition where the body doesn't get enough oxygen), Shortness of Breath, Obstructive Sleep Disorder (is a condition where your airway becomes blocked, causing breathing to pause during sleep.) Record review of Resident #8's entry MDS dated [DATE] reflected he has a BIMS score of 15, indicating he was cognitively intact. He was a short-term general hospital resident. Record review of Resident #8's Care Plan dated 09/12/2025 reflected: Resident requires the use of CPAP/BIPAP (to assist with breathing for people with certain respiratory conditions by delivering higher air pressure on inhalation and lower pressure on exhalation, making it easier to breathe.) r/t sleep apnea resident will maintain oxygen saturations 90% or greater over the next90 days.CPAP settings: Resident will use device as ordered.Staff to monitor saturation as ordered. Record review of Resident #8's physician orders reflected 09/19/2025 reflected: BiPAP-BiPAP-RATE 10 @ 30% at bedtime related to obstructive sleep Apnea (a disorder where breathing repeatedly stops and starts during sleep.) Asses 02 Sat, Resp. rate, pulse, and breath sounds and total time to assess. Record review of Resident #8's progress note written by the SW dated 09/16/2025 at 11:58 AM reflected: admission Care Plan: admission care plan held to discuss

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, 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 1 of 5 residents (Residents #9) reviewed for environment. 1. LVN-W, CNA-R, and MA failed to ensure the linen cart located on the 100 hall was covered when not in use. 2. LVN-W and CNA-U failed to properly discard a red biohazard bag, after providing care when the bag was left in the hallway of Hall 300 outside Resident #9's room. This deficient practice placed staff and residents at risk for infections and human body fluids.Findings included:During an observation and interview on 09/01/2025 at 1:15 PM revealed the clean linen cart located on Hall 100 had the cover up and over the top of the cart, which left the linen exposed to the environment and contamination. LVN-W and MA were observed working on the hall and passing the linen cart. The MA stated the cart was left by CNA-R, who was caring for a resident. The MA stated CNA-R was the last staff accessing the linen cart. The MA then she closed the cart. There were no residents in the hallway at the time of the observation. During an observation on 09/19/2025 at 1:20 PM of Hall 300 revealed a small sealed red biohazard plastic bag on the floor midway on the left side of the hall outside Resident #9's room. There were no residents in the hallway at the time of the observation. During an interview on 09/19/2025 at 1:35 PM with CNA-R revealed he pulled linen from the linen cart to change resident linen. CNA-R said he was not sure who left the cart exposed. CNA-R said linen carts must remain covered when not in use to prevent resident and visitor access and maintain sanitary conditions for linen. During an interview on 09/19/2025 at 1:59 PM with the MA revealed CNA-R was the last observed accessing the linen cart. The MA revealed the protocol for maintaining clean linen was to ensure the linen cart was properly covered to prevent exposure and cross-contamination. She stated it was all staff's responsibility to ensure the environment and tools for care were sanitary. During an interview on 09/19/2025 at 2:02 PM with CNA-U revealed she was working on Hall 300. She stated she saw the red bag lying on the floor outside of Resident #9's room. CNA-U said she did not pick the bag up when she initially saw it. CNA-U said LVN-W dropped the bag in the hallway after wound care. CNA-U stated she did not notify the charge nurse or LVN W that she dropped the bio-hazard bag. CNA-U said while walking down the hall for the interview with surveyor, she picked the red bag up with gloves and discarded it in the biohazard room. CNA-U said all staff were responsible for maintaining sanitary conditions in the environment, to prevent contamination or resident access. During an interview on 09/19/2025 at 2:15 PM with LVN-W revealed she had completed wound care on the hall earlier and dropped the biohazard bag upon leaving the resident's room to discard. She stated she returned to look for the bag, and it was gone. LVN-W stated all staff were responsible for maintaining sanitary conditions in the environment, to prevent contamination or resident access. She said leaving the bag could result in a resident accessing and touching contents from wound cleaning. During an interview on 09/19/2025 at 2:35 PM with the Administrator revealed it was her expectation for the staff to ensure the environment and equipment were sanitary and properly stored to prevent contamination. During an interview on 09/19/2025 at 3:32 PM with the DON. She stated it was her expectation for the staff to discard the biohazard bag in the appropriate placement immediately after completing care. DON stated that failing to discard the bio-hazard bags could lead to unsanitary conditions and resident infection. The DON stated that the nursing staff are trained to ensure the linen carts was covered to maintain sanitation. The DON said failing to properly secure the linen cart to prevent environment contamination. DON stated that it was all staff's responsibility to maintain a sanitary environment for residents. Record review of the facility's Infection Control Policy and Procedure Manual revealed an undated Communication of Hazards to Employees policy which reflected: All labels and signs will reflect the biohazard legend and international sign.All biohazard labels will be affixed to containers of regulated waste, refrigerators used to store biohazard materials, freezers containing blood or blood components, containers used to store, transport, or ship blood or other potentially infectious materials.All biohazard labels will be fluorescent orange or orange-red with the lettering or symbols in a contrasting color. Red bags or containers lined with red bags may be substituted for labels.Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from labeling requirements.Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipments, or disposal are exempted from the labeling requirement.Soiled Linen from a resident on isolation will be placed