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	03/24/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) facility reviewed for nutrition. The facility failed to immediately notify the physician when Resident #1's weight showed a 15.9% loss from 02/10/26-03/09/26. This failure could place residents at risk for malnutrition or mismanagement of underlying medical conditions.Findings include: Record review of Resident #1's Annual MDS Assessment, dated 03/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 9, which indicated moderate cognitive impairment. Section I-Active Diagnoses reflected Resident # 1's active diagnoses included non-Alzheimer's Dementia (brain disorder that affects memory, thinking, and behavior), Parkinson's Disease (progressive movement disorder of the nervous system), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), schizophrenia (chronic brain disorder characterized by hallucinations and delusions), history of alcohol abuse, cirrhosis (scarring and damage of the liver), metabolic encephalopathy (brain dysfunction that causes confusion), benign neoplasm of sigmoid colon (non-cancerous growth on inner wall of colon). Section K-Swallowing/Nutritional Status reflected Resident #1 was 66 inches in height and 145 pounds in weight, with no or unknown weight loss. Record review of Resident #1's Care Plan, dated 05/14/25, reflected the resident had dental health problems with interventions that included: coordinating and arranging for dental care and transportation, monitoring, documenting, and reporting to MD any s/sx of dental problems needing attention such as pain, abscesses, debris in mouth, and cracked or bleeding lips, missing or damaged teeth, and providing mouth care as per ADL personal hygiene. Further review of this document reflected Resident #1 did not have a focus or interventions regarding nutrition and weight loss. Record review of Resident #1's EHR under vitals reflected in part the following:-01/09/26-148.2 lbs.-02/10/26-145.5 lbs.-03/09/26-122.4 lbs.Further review reflected there were no documented re-weighs. Record review of Resident #1's lab work, dated 03/02/26, reflected in part the following:Glucose-68 (reference range 82-115)-the body's main energy source, derived from food and regulated by insulinAlbumin-3.3. (reference range 3.4-5.0)-vital protein produced by the liver that transports hormones, drugs, and nutrients throughout the body Record review of Resident #1's consolidated physician orders, dated 03/23/26, reflected in part the following: Dietary-Regular diet: mechanical soft texture, regular consistency; start date: 11/24/25Further review reflected there were no orders to address weight loss. Record review of Resident #1's weights and vitals summary, dated 03/24/26, reflected the following: 03/09/26 at 1:18 PM 122.4 lbs. ([mechanical lift scale]):-5.0% change [Comparison Weight 2/10/2026, 145.5 lbs., -15.9%, -23.1 lbs.] Record review of a document provided by the DON of the facility's weekly resident review on 03/12/26 reflected there were no triggers for weight loss in 30 days, and Resident #1 was not reviewed. In an observation on 3/23/26 at 12:45 PM, Resident #1 was observed being assisted with lunch. Resident #1 ate about 75% of his meal. In an observation on 03/23/26 at 3:45 PM, the mechanical lift scale reflected that Resident #1 (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weighed 132.0 lbs. An attempted interview with Resident #1's RP on 03/23/26 at 11:15 AM was unsuccessful due to no response to call. In an interview on 03/23/26 at 3:12 PM, CNA A stated she worked at the facility for 7 months. She stated she worked with Resident #1 sometimes and although he was able to physically feed himself, he required supervision. CNA A stated Resident #1 usually ate all his food but preferred food from outside or from his family. She stated she recently worked with Resident #1, and he appeared to have lost a little bit of weight and the nurses were aware. CNA A stated the aides were responsible for reporting any changes of condition to the nurses, which included any changes in a resident's appetite or weight. In an interview on 03/23/26 at 4:15 PM, the DON stated Resident #1 did not appear physically smaller nor had it been reported by any of the nurses. She stated Resident #1 had a good appetite and ate a lot. The DON stated she entered all weights into PCC and must have missed Resident #1's weight loss. She stated a weight loss of over 5% would have been immediately reported to the MD, RD and family. The DON stated the IDT had discussed seeking outside sources to assess Resident #1 for other health conditions such as a tumor to explain his increased behaviors and now weight loss. In an observation on 03/24/26 at 9:02 AM, Resident #1 was being assisted with eating a bowl of cereal. The Interim Administrator stated Resident #1 had already had breakfast and was eating seconds with the bowl of cereal. Resident #1 was observed to be dressed and well-groomed with no visible marks or bruises. Resident #1 did not appear to be malnourished or severely underweight. In an interview on 03/24/26 at 9:10 AM, Resident #1 stated he was well and did not feel like he was losing any weight. Resident #1 stated he ate enough food at the facility and was even provided with his cultural food from outside when he wanted it. In an interview on 03/24/26 at 9:52 AM, the MD stated his expectation was for the facility to notify him of any changes in weight over a 5% gain or loss and consult with the Dietitian. The MD stated he was aware Resident #1 was at risk of weight loss due to diagnosis of cirrhosis and due to his behaviors of constant moving and sliding down to the floor; however, it had not been reported that the resident had a significant weight loss. The MD stated the facility recently reported having issues with their mechanical lift scale and were advised to fix the issue and re-weigh any residents with discrepancies. The MD stated he recently ordered lab work for Resident #1, and he had no concerns because the abnormal lab values were related to the resident's cirrhosis and not from malnutrition. The MD stated it was reported very clearly that Resident #1 ate well and the facility even purchased outside food to satisfy the resident's preference, so there was no concern for the resident's appetite. The MD stated if Resident #1's documented weights were accurate, the fact he was eating well and still losing weight raised concerns for other issues. The MD stated he would order new labs to check Resident #1 for underlying conditions like cancer. The orders were submitted but had not been completed prior to surveyor's exit. An attempted interview with Resident #1's RP on 03/24/26 at 10:00 AM was unsuccessful due to no response to call. In an interview on 03/24/26 at 10:27 AM, the RD stated she was no longer the permanent Dietitian at the facility; however, she was covering until the new Dietitian was able to return to work. The RD stated the new Dietitian informed her she visited the facility on 03/11/26 and found not all residents had current weights entered in the system, so she was going to have to return on a later date as they had the entire month to address any issues. The RD stated during her time working with Resident #1, she did not recall the resident having any skin (wounds) or dietary concerns or signs of weight loss that needed to be addressed, and it was reported Resident #1 had a good appetite. The RD stated Resident #1's weight remained stable. The RD stated if a resident had a weigh loss of more than 5% within a month, she would expect the facility to notify her immediately. She stated she would advise the facility to re-weigh the resident for accuracy, then implement a fortified diet and/or supplements as needed with weekly weights for close monitoring. In an interview on 03/24/26 at 11:15 AM, the Compliance Nurse stated if a resident had significant weight loss the expectation would be for the nurse to re-weigh, then notify the MD, Dietitian, and family. The Compliance Nurse stated the care plan would be updated to include interventions such as weekly weights and the Red Glass nutrition program which would alert staff the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was at risk for weight loss. The Compliance Nurse stated staff would also need to be in-serviced regarding any new interventions implemented. She stated the facility reported having recent issues with their scale but received a new one last week The Compliance Nurse could not state if Resident #1's weight was accurate or why there was not a documented re-weigh for accuracy. She stated she had the facility to start an in-service on weight monitoring and audit all residents' weights. In an interview on 03/24/26 at 11:30 AM, the Activity Director stated she was also a medication aid and was responsible for taking weights of all residents. She stated the residents were weighed at least monthly unless their order or care plan said differently, and Resident #1 was weighed once a month. The Activity Director stated she would write down the weights and provide the weights to the DON. She stated she was not responsible for putting the weights in PCC or monitoring the numbers for significant changes; however, all staff were responsible for reporting any changes of physical condition to the DON. The Activity Director stated she had not noticed any changes in Resident #1's physical condition regarding his weight, and she was the one who weighed him on 02/10/26 and 03/09/26 using the mechanical lift scale. She stated she also assisted him with eating and he always ate most, if not all his food. In an interview on 03/24/26 at 1:08 PM, the DON stated they had weekly meetings to review residents who triggered alerts for ADL declines, which included weight loss, and the team would discuss implementing interventions. The DON stated Resident #1 did not trigger an alert for weight loss during the weekly meeting on 3/12/26 because she had not entered the resident's weight from 03/09/26. The DON stated she was busy with training that week and was behind on documentation. She stated the following week they had a QAPI meeting and Resident #1's current weight still had not been entered, so his weight loss was missed again. The DON stated the Activity Director was responsible for taking all weights and documenting them on paper. The DON stated the Activity Director would not notice any significant changes in weights based on the numbers because the facility did not keep a running log of weights on the paper document to prevent falsification. The DON stated it was her responsibility to record all weights from the paper document into PCC (the facility's electronic health record system), and the facility's policy stated weights, and documentation was supposed to be completed by the 10th of each month. She stated it was after the 15th before she recorded Resident #1's weight from 03/09/26, otherwise the weight loss would have been caught by the MDS Nurse when she updated the resident's annual MDS assessment on 03/15/26. The DON stated this caused the MDS assessment to be inaccurate and another missed opportunity to catch Resident #1's weight loss. The DON stated that missing significant weight loss could place the residents at risk of untreated serious health conditions. Record review of the facility's policy titled Notifying the Physician of Change in Status, undated, reflected the following: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. The facility utilizes the INTERACT tool, Change in condition -When to notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Work day notification of the physician.The nurse will notify the physician or their dckgated nurse practitioner or physician assistant with change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implt::mented in the resident's clinical record.Before the physician is contacted, the nurse will gather and organize resident information. Applicable information will include current medications, vital signs, signs and symptoms initiating call, currentlaboratory information, and interventions that have currently been implemented Record review of the facility's policy titled Resident Weight, revised 02/13/2007, reflected the following: All residents will be weighed by the 10th of the month and their weights documented correctly. The appropriate actions regarding significant changes will be carried out. Procedure: Weights shall be obtained and documented at admission, readmission, and monthly unless ordered otherwise by the physician, or unless dictated more frequently by the resident's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. Factors indicating the need for more frequent weights include significant weight loss, drastic decrease in food consumption, prolonged nausea, vomiting, or diarrhea, significant weight gain, swelling or edema, poor appetite during adjustment period to the facility, recent change from tube feeding to oral intake, or pressure ulcers that are not resolving as expected. Monthly weights will be obtained prior to the 10th of the month. The DON or designee will review all weights to determine the need for any re-weighs. Re-weighs will be completed within 24 hours of the first weight. Significant Weight LossThe facility reviews resident weights after monthly weights are obtained, to determine residents with significant weight changes. A significant weight change will be defined as 5% or greater in one month, 7.5% or greater in three months, or 10% or greater in six months. The weight change will be recorded on the appropriate weight watcher's form along with interventions, and follow-up will also be recorded the designated location. The physician and family will be notified. In addition, an acute care plan for weight loss will be initiated and the clinical record reviewed for possible need of a significant change of condition MDS assessment. Assess the resident for possible reason for weight loss.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 8 residents (Resident #1) reviewed for assessments. The MDS Nurse failed to ensure Resident #1's annual MDS assessment, updated on 03/15/26, was accurate and reflected the resident's recent significant weight loss. This failure could place residents at risk for missed care needs and continued decline in health.Findings include: Record review of Resident #1's Annual MDS Assessment, dated 03/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 9, which indicated moderate cognitive impairment. Section I-Active Diagnoses reflected Resident # 1's active diagnoses included non-Alzheimer's Dementia (brain disorder that affects memory, thinking, and behavior), Parkinson's Disease (progressive movement disorder of the nervous system), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), schizophrenia (chronic brain disorder characterized by hallucinations and delusions), history of alcohol abuse, cirrhosis (scarring and damage of the liver), metabolic encephalopathy (brain dysfunction that causes confusion), benign neoplasm of sigmoid colon (non-cancerous growth on inner wall of colon). Section K-Swallowing/Nutritional Status reflected Resident #1 was 66 inches in height and 145 pounds in weight, with no or unknown weight loss. Record review of Resident #1's Care Plan, dated 05/14/25, reflected the resident had dental health problems with interventions that included: coordinating and arranging for dental care and transportation, monitoring, documenting, and reporting to MD any s/sx of dental problems needing attention such as pain, abscesses, debris in mouth, and cracked or bleeding lips, missing or damaged teeth, and providing mouth care as per ADL personal hygiene. Further review of this document reflected Resident #1 did not have a focus or interventions regarding nutrition and weight loss. Record review of Resident #1's EHR under vitals reflected in part the following:-01/09/26-148.2 lbs.-02/10/26-145.5 lbs.-03/09/26-122.4 lbs. Further review revealed there were no documented re-weighs Record review of Resident #1's weights and vitals summary, dated 03/24/26, reflected the following:03/09/26 at 1:18 PM 122.4 lbs. ([mechanical lift]):-5.0% change [Comparison Weight 2/10/2026, 145.5 lbs., -15.9%, -23.1 lbs.] Record review of a document provided by the DON of the facility's weekly resident review on 03/12/26 reflected there were no triggers for weight loss in 30 days, and Resident #1 was not reviewed. In an interview on 03/24/26 at 9:45 AM, the MDS Nurse stated she had been the MDS nurse for about 11 months. She stated MDS assessments were completed quarterly, annually, and if there was a significant change. The MDS Nurse stated significant weight loss would be considered a change and would trigger an alert in the system for her to update the MDS Assessment. The MDS Nurse stated she completed Resident #1's annual MDS assessment on 03/15/26 and there was not an alert for weight loss. The MDS Nurse stated the current weights were not always entered immediately into the system, and she used the data for weight that was available. The MDS Nurse stated she was familiar with Resident #1 and knew that he ate well and would often ask for seconds, so it would not have been typical for him to have a significant weight loss. She stated interventions in the care plan were derived from information in the MDS assessment, so inaccurate information could place the resident at risk for missed interventions for a change in condition. In an interview on 03/24/26 at 1:08 PM, the DON stated they had weekly meetings to review residents who triggered alerts for ADL declines, which included weight loss, and the team would discuss implementing interventions. The DON stated Resident #1 did not trigger an alert for weight loss during the weekly meeting on 3/12/26, because she had not entered the resident's weight from 03/09/26. The DON stated she was busy with training that week and was behind on documentation. She stated the following week they had a QAPI meeting and Resident #1's current weight still had not been entered, so his weight loss was missed again. The DON stated the Activity Director was responsible for taking all weights and documenting them on paper. The DON (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the Activity Director would not notice any significant changes in weights based on the numbers because the facility did not keep a running log of weights on the paper document to prevent falsification. The DON stated it was her responsibility to record all weights from the paper document into PCC, and the facility's policy stated weights and documentation were supposed to be completed by the 10th of each month. She stated it was after the 15th before she recorded Resident #1's weight from 03/09/26, otherwise the weight loss would have been caught by the MDS Nurse when she updated the resident's annual MDS assessment on 03/15/26 to include interventions for weight loss on the resident's care plan. The DON stated this caused the MDS assessment to be inaccurate and another missed opportunity to catch Resident #1's weight loss. The DON stated missing significant weight loss could place the resident at risk of untreated serious health conditions. Record review of the facility's, undated, policy titled Comprehensive Care Planning, reflected in part the following: The facility will develop and implement a comprehensive person-centered care plan for each resident,consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and the right to refuse treatment.When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set(MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility'srationale for deciding whether or not to proceed with care planning for each area triggered will be recorded inthe medical record. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a comprehensive care plan for Resident #1 to address the resident's recent significant weight loss. This failure could place residents at risk for missed care needs and continued decline in health.Findings include: Record review of Resident #1's Annual MDS Assessment, dated 03/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 9, which indicated moderate cognitive impairment. Section I-Active Diagnoses reflected Resident # 1's active diagnoses included non-Alzheimer's Dementia (brain disorder that affects memory, thinking, and behavior), Parkinson's Disease (progressive movement disorder of the nervous system), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), schizophrenia (chronic brain disorder characterized by hallucinations and delusions), history of alcohol abuse, cirrhosis (scarring and damage of the liver), metabolic encephalopathy (brain dysfunction that causes confusion), benign neoplasm of sigmoid colon (non-cancerous growth on inner wall of colon). Section K-Swallowing/Nutritional Status reflected Resident #1 was 66 inches in height and 145 pounds in weight, with no or unknown weight loss. Record review of Resident #1's Care Plan, dated 05/14/25, reflected the resident had dental health problems with interventions that included: coordinating and arranging for dental care and transportation, monitoring, documenting, and reporting to MD any s/sx of dental problems needing attention such as pain, abscesses, debris in mouth, and cracked or bleeding lips, missing or damaged teeth, and providing mouth care as per ADL personal hygiene. Further review of this document reflected Resident #1 did not have a focus or interventions regarding nutrition and weight loss. Record review of Resident #1's EHR under vitals reflected in part the following:-01/09/26-148.2 lbs.-02/10/26-145.5 lbs.-03/09/26-122.4 lbs. Further review revealed there were no documented re-weighs Record review of Resident #1's weights and vitals summary, dated 03/24/26, reflected the following:03/09/26 at 1:18 PM 122.4 lbs. ([mechanical lift]):-5.0% change [Comparison Weight 2/10/2026, 145.5 lbs., -15.9%, -23.1 lbs.] Record review of a document provided by the DON of the facility's weekly resident review on 03/12/26 reflected there were no triggers for weight loss in 30 days, and Resident #1 was not reviewed. In an interview on 03/24/26 at 9:45 AM, the MDS Nurse stated she had been the MDS nurse for about 11 months. She stated MDS assessments were completed quarterly, annually, and if there was a significant change. The MDS Nurse stated significant weight loss would be considered a change and would trigger an alert in the system for her to update the MDS Assessment. The MDS Nurse stated she completed Resident #1's annual MDS assessment on 03/15/26 and there was not an alert for weight loss. The MDS Nurse stated the current weights were not always entered immediately into the system, and she used the data for weight that was available. The MDS Nurse stated she was familiar with Resident #1 and knew that he ate well and would often ask for seconds, so it would not have been typical for him to have a significant weight loss. She stated interventions in the care plan were derived from information in the MDS assessment, so inaccurate information could place the resident at risk for missed interventions for a change in condition. In an interview on 03/24/26 at 1:08 PM, the DON stated they had weekly meetings to review residents who triggered alerts for ADL declines, which included weight loss, and the team would discuss implementing interventions. The DON stated Resident #1 did not trigger an alert for weight loss during the weekly meeting on 3/12/26, because she had not entered the resident's weight from 03/09/26. The DON stated she was busy with training that week and was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behind on documentation. She stated the following week they had a QAPI meeting and Resident #1's current weight still had not been entered, so his weight loss was missed again. The DON stated the Activity Director was responsible for taking all weights and documenting them on paper. The DON stated the Activity Director would not notice any significant changes in weights based on the numbers because the facility did not keep a running log of weights on the paper document to prevent falsification. The DON stated it was her responsibility to record all weights from the paper document into PCC, and the facility's policy stated weights and documentation were supposed to be completed by the 10th of each month. She stated it was after the 15th before she recorded Resident #1's weight from 03/09/26, otherwise the weight loss would have been caught by the MDS Nurse when she updated the resident's annual MDS assessment on 03/15/26 to include interventions for weight loss on the resident's care plan. The DON stated this caused the MDS assessment to be inaccurate and another missed opportunity to catch Resident #1's weight loss. The DON stated missing significant weight loss could place the resident at risk of untreated serious health conditions. Record review of the facility's, undated, policy titled Comprehensive Care Planning, reflected in part the following: The facility will develop and implement a comprehensive person-centered care plan for each resident,consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and the right to refuse treatment.When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set(MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility'srationale for deciding whether or not to proceed with care planning for each area triggered will be recorded inthe medical record. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that 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 10 residents (Resident #2) reviewed for quality of care. The facility failed to treat Resident #2's constipation as ordered by the physician.This failure could place residents at risk of developing an obstruction, or a rupture of the intestines. Findings include:Record review of Resident #2's admission MDS assessment, dated 01/14/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included diabetes, amputation of both legs above the knees, heart failure, and constipation . His BIMS score was 15, which indicated he was cognitively intact. His Functional Ability assessment indicated he needed partial assistance with toileting. Record review of Resident #2's care plan, dated 01/15/26, reflected he had a self-care deficit, and was a fall risk related to his leg amputations. Record review of Resident #2's Bowel Continence flow sheet, from 03/11/26 to 03/24/26, reflected the resident had no bowel movement since 03/17/26. Record review of Resident #2's physician orders revealed an order written by RN B, dated 03/14/26, which reflected: Dulcolax Rectal Suppository 10 mg (Bisacodyl). Insert 1 suppository rectally every 12 hours as needed for Constipation BM x 48 hours.Record review of Resident #2's Nurse Administration Record reflected the suppository was given on 03/14/26 and 03/24/26. In an interview on 03/24/26 at 9:50 AM, Resident #2 stated he needed something for constipation. He stated he was having some abdominal discomfort, and he thought his last bowel movement was the previous week sometime. Resident #2 stated he asked RN-B for an enema, and the nurse stated he would have to contact the physician for that because he only had an order for a suppository. Resident #2 stated he could wait to see what the doctor said. In an interview on 03/24/26 at 12:05 PM, RN-B stated he contacted the physician about the Resident #2 wanting an enema. The physician advised him to administer the suppository first, and if there were no results call him back. RN-B stated he followed up with Resident #2, who agreed to try the suppository. RN B stated he administered the suppository around 11:15 AM on 3/24/26. RN-B stated the resident had a large bowel movement about 30 minutes after the suppository had been administered. RN-B stated he was not aware the resident had not had a bowel movement since last week. RN-B stated when he assessed the resident that morning, he had bowel sounds in all four quadrants of his abdomen and was educated on letting the nurse know if he had not had a bowel movement in more than 12 hours. RN-B stated the CNAs were responsible for documenting the resident bowel movements on the flow sheet and notifying the nurse if it had been more than 2 days since the resident had a bowel movement. In an interview on 03/24/26 at 12:50 PM, CNA-C stated Resident #2 had not complained to her about not having a bowel movement since the previous week. She stated the only way the CNA could see the resident's bowel movement pattern would be to go into the Kardex and review it. She stated the CNAs didn't normally have to do that because the nurse was notified by the computer somehow. In an interview on 03/24/26 at 1:25 PM, the DON stated the residents should not go more than 3 days without a bowel movement because of the risk of constipation and possibly having a rupture of their bowels in the extreme situation. She stated the CNAs documented bowel patterns via the flowsheet, and if no bowel movement was documented in 2 days the nurse received a Clinical Alert in the form of a message and a red bell symbol at the top of the resident's dashboard. The DON stated she did not know if the nurses had not seen the alert, or if one had acknowledged it and did not follow up on it. She stated she would have to interview the staff who cared for him and check with the IT department to see if the alert did not activate for some reason. The DON stated the facility did not have a policy addressing constipation specifically, just resident assessments. In a follow-up interview on 03/24/26 at 1:40 PM, Resident #2 stated he had results from the suppository and felt better. He stated he would still like to have an (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enema to make sure he was cleaned out, and he would talk to the nurse about that . Record review of the facility's policy Resident Assessment, dated 2003, reflected: 2. The assessment will include at least the following: a. Medically defined conditions and prior medical history

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 5 residents (Resident #1) facility reviewed for nutrition. The facility failed to recognize, evaluate and address Resident #1's weight loss when there was a documented 15.9 % loss from 02/10/26-03/09/26. This failure could place residents at risk for malnutrition or mismanagement of underlying medical conditions.Findings include: Record review of Resident #1's Annual MDS Assessment, dated 03/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS score of 9, which indicated moderate cognitive impairment. Section I-Active Diagnoses reflected Resident # 1's active diagnoses included non-Alzheimer's Dementia (brain disorder that affects memory, thinking, and behavior), Parkinson's Disease (progressive movement disorder of the nervous system), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), schizophrenia (chronic brain disorder characterized by hallucinations and delusions), history of alcohol abuse, cirrhosis (scarring and damage of the liver), metabolic encephalopathy (brain dysfunction that causes confusion), benign neoplasm of sigmoid colon (non-cancerous growth on inner wall of colon). Section K-Swallowing/Nutritional Status reflected Resident #1 was 66 inches in height and 145 pounds in weight, with no or unknown weight loss. Record review of Resident #1's Care Plan, dated 05/14/25, reflected the resident had dental health problems with interventions that included: coordinating and arranging for dental care and transportation, monitoring, documenting, and reporting to MD any s/sx of dental problems needing attention such as pain, abscesses, debris in mouth, and cracked or bleeding lips, missing or damaged teeth, and providing mouth care as per ADL personal hygiene. Further review of this document reflected Resident #1 did not have a focus or interventions regarding nutrition and weight loss. Record review of Resident #1's EHR under vitals reflected in part the following:-01/09/26-148.2 lbs.-02/10/26-145.5 lbs.-03/09/26-122.4 lbs.Further review reflected there were no documented re-weighs. Record review of Resident #1's lab work, dated 03/02/26, reflected in part the following:Glucose-68 (reference range 82-115)-the body's main energy source, derived from food and regulated by insulinAlbumin-3.3. (reference range 3.4-5.0)-vital protein produced by the liver that transports hormones, drugs, and nutrients throughout the body Record review of Resident #1's consolidated physician orders, dated 03/23/26, reflected in part the following: Dietary-Regular diet: mechanical soft texture, regular consistency; start date: 11/24/25Further review reflected there were no orders to address weight loss. Record review of Resident #1's weights and vitals summary, dated 03/24/26, reflected the following: 03/09/26 at 1:18 PM 122.4 lbs. ([mechanical lift scale]):-5.0% change [Comparison Weight 2/10/2026, 145.5 lbs., -15.9%, -23.1 lbs.] Record review of a document provided by the DON of the facility's weekly resident review on 03/12/26 reflected there were no triggers for weight loss in 30 days, and Resident #1 was not reviewed. In an observation on 3/23/26 at 12:45 PM, Resident #1 was observed being assisted with lunch. Resident #1 ate about 75% of his meal. In an observation on 03/23/26 at 3:45 PM, the mechanical lift scale reflected that Resident #1 weighed 132.0 lbs. An attempted interview with Resident #1's RP on 03/23/26 at 11:15 AM was unsuccessful due to no response to call. In an interview on 03/23/26 at 3:12 PM, CNA A stated she worked at the facility for 7 months. She stated she worked with Resident #1 sometimes and although he was able to physically feed himself, he required supervision. CNA A stated Resident #1 usually ate all his food but preferred food from outside or from his family. She stated she recently worked with Resident #1, and he appeared to have lost a little bit of weight and the nurses were aware. CNA A stated the aides were responsible for reporting any changes of condition to the nurses, which included any changes in a resident's appetite or weight. In an interview on 03/23/26 at 4:15 PM, the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated Resident #1 did not appear physically smaller nor had it been reported by any of the nurses. She stated Resident #1 had a good appetite and ate a lot. The DON stated she entered all weights into PCC and must have missed Resident #1's weight loss. She stated a weight loss of over 5% would have been immediately reported to the MD, RD and family. The DON stated the IDT had discussed seeking outside sources to assess Resident #1 for other health conditions such as a tumor to explain his increased behaviors and now weight loss. In an observation on 03/24/26 at 9:02 AM, Resident #1 was being assisted with eating a bowl of cereal. The Interim Administrator stated Resident #1 had already had breakfast and was eating seconds with the bowl of cereal. Resident #1 was observed to be dressed and well-groomed with no visible marks or bruises. Resident #1 did not appear to be malnourished or severely underweight. In an interview on 03/24/26 at 9:10 AM, Resident #1 stated he was well and did not feel like he was losing any weight. Resident #1 stated he ate enough food at the facility and was even provided with his cultural food from outside when he wanted it. In an interview on 03/24/26 at 9:52 AM, the MD stated his expectation was for the facility to notify him of any changes in weight over a 5% gain or loss and consult with the Dietitian. The MD stated he was aware Resident #1 was at risk of weight loss due to diagnosis of cirrhosis and due to his behaviors of constant moving and sliding down to the floor; however, it had not been reported that the resident had a significant weight loss. The MD stated the facility recently reported having issues with their mechanical lift scale and were advised to fix the issue and re-weigh any residents with discrepancies. The MD stated he recently ordered lab work for Resident #1, and he had no concerns because the abnormal lab values were related to the resident's cirrhosis and not from malnutrition. The MD stated it was reported very clearly that Resident #1 ate well and the facility even purchased outside food to satisfy the resident's preference, so there was no concern for the resident's appetite. The MD stated if Resident #1's documented weights were accurate, the fact he was eating well and still losing weight raised concerns for other issues. The MD stated he would order new labs to check Resident #1 for underlying conditions like cancer. The orders were submitted but had not been completed prior to surveyor's exit. An attempted interview with Resident #1's RP on 03/24/26 at 10:00 AM was unsuccessful due to no response to call. In an interview on 03/24/26 at 10:27 AM, the RD stated she was no longer the permanent Dietitian at the facility; however, she was covering until the new Dietitian was able to return to work. The RD stated the new Dietitian informed her she visited the facility on 03/11/26 and found not all residents had current weights entered in the system, so she was going to have to return on a later date as they had the entire month to address any issues. The RD stated during her time working with Resident #1, she did not recall the resident having any skin (wounds) or dietary concerns or signs of weight loss that needed to be addressed, and it was reported Resident #1 had a good appetite. The RD stated Resident #1's weight remained stable. The RD stated if a resident had a weigh loss of more than 5% within a month, she would expect the facility to notify her immediately. She stated she would advise the facility to re-weigh the resident for accuracy, then implement a fortified diet and/or supplements as needed with weekly weights for close monitoring. In an interview on 03/24/26 at 11:15 AM, the Compliance Nurse stated if a resident had significant weight loss the expectation would be for the nurse to re-weigh, then notify the MD, Dietitian, and family. The Compliance Nurse stated the care plan would be updated to include interventions such as weekly weights and the Red Glass nutrition program which would alert staff the resident was at risk for weight loss. The Compliance Nurse stated staff would also need to be in-serviced regarding any new interventions implemented. She stated the facility reported having recent issues with their scale but received a new one last week The Compliance Nurse could not state if Resident #1's weight was accurate or why there was not a documented re-weigh for accuracy. She stated she had the facility to start an in-service on weight monitoring and audit all residents' weights. In an interview on 03/24/26 at 11:30 AM, the Activity Director stated she was also a medication aid and was responsible for taking weights of all residents. She stated the residents were weighed at least monthly unless their order or care plan said differently, and Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 was weighed once a month. The Activity Director stated she would write down the weights and provide the weights to the DON. She stated she was not responsible for putting the weights in PCC or monitoring the numbers for significant changes; however, all staff were responsible for reporting any changes of physical condition to the DON. The Activity Director stated she had not noticed any changes in Resident #1's physical condition regarding his weight, and she was the one who weighed him on 02/10/26 and 03/09/26 using the mechanical lift scale. She stated she also assisted him with eating and he always ate most, if not all his food. In an interview on 03/24/26 at 1:08 PM, the DON stated they had weekly meetings to review residents who triggered alerts for ADL declines, which included weight loss, and the team would discuss implementing interventions. The DON stated Resident #1 did not trigger an alert for weight loss during the weekly meeting on 3/12/26 because she had not entered the resident's weight from 03/09/26. The DON stated she was busy with training that week and was behind on documentation. She stated the following week they had a QAPI meeting and Resident #1's current weight still had not been entered, so his weight loss was missed again. The DON stated the Activity Director was responsible for taking all weights and documenting them on paper. The DON stated the Activity Director would not notice any significant changes in weights based on the numbers because the facility did not keep a running log of weights on the paper document to prevent falsification. The DON stated it was her responsibility to record all weights from the paper document into PCC (the facility's electronic health record system), and the facility's policy stated weights and documentation was supposed to be completed by the 10th of each month. She stated it was after the 15th before she recorded Resident #1's weight from 03/09/26, otherwise the weight loss would have been caught by the MDS Nurse when she updated the resident's annual MDS assessment on 03/15/26. The DON stated this caused the MDS assessment to be inaccurate and another missed opportunity to catch Resident #1's weight loss. The DON stated that missing significant weight loss could place the residents at risk of untreated serious health conditions. Record review of the facility's policy titled Resident Weight, revised 02/13/2007, reflected the following: All residents will be weighed by the 10th of the month and their weights documented correctly. The appropriate actions regarding significant changes will be carried out. Procedure: Weights shall be obtained and documented at admission, readmission, and monthly unless ordered otherwise by the physician, or unless dictated more frequently by the resident's condition. Factors indicating the need for more frequent weights include significant weight loss, drastic decrease in food consumption, prolonged nausea, vomiting, or diarrhea, significant weight gain, swelling or edema, poor appetite during adjustment period to the facility, recent change from tube feeding to oral intake, or pressure ulcers that are not resolving as expected. Monthly weights will be obtained prior to the 10th of the month. The DON or designee will review all weights to determine the need for any re-weighs. Re-weighs will be completed within 24 hours of the first weight. Significant Weight LossThe facility reviews resident weights after monthly weights are obtained, to determine residents with significant weight changes. A significant weight change will be defined as 5% or greater in one month, 7.5% or greater in three months, or 10% or greater in six months. The weight change will be recorded on the appropriate weight watcher's form along with interventions, and follow-up will also be recorded the designated location. The physician and family will be notified. In addition, an acute care plan for weight loss will be initiated and the clinical record reviewed for possible need of a significant change of condition MDS assessment. Assess the resident for possible reason for weight loss.