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	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Road 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews the facility failed to ensure resident records were accurately documented for 17 of 86 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17) reviewed for resident records. The facility failed to ensure on 06/03/26 CNA A did not use CNA B's log in credentials when she documented care provided for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17.This failure could place residents at risk of inaccurate reporting of their care. Findings included:Record review of Resident #1's EHR revealed CNA care for 06/03/26 documented by CNA-B. Record review of the facility's staffing for 06/03/26 revealed CNA-B was not working. CNA-A was working the 100 Hall where Resident #1 resided. Record review of Resident #2's EHR also reflected CNA care for 06/03/26 documented by CNA-BRecord review for the 15 remaining residents, Residents #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17, who resided on 100 Hall revealed the same documentation as being completed by CNA-B. The care documented consisted of ADL assistance, bathing, turning, incontinence care, and amount of meal tray consumed. In an interview on 06/03/26 at 1:50 PM, CNA-A stated she had used CNA-B's log in credentials for her documentation because her log in credentials were not working. CNA-A stated this was her second shift at the facility and on her first shift her credentials did not work when she tried to log in and CNA-B had given her log in so she could document her care for the shift. CNA-A stated she had not asked the charge nurse of anyone else about fixing her log in credentials before going home. On 06/03/26 she did not ask the ADON, HR, DON, or anyone in administration about fixing her log-in credentials, she just continued to work. CNA-A stated she knew she was not supposed to use anyone else's log in to document. She stated as part of her orientation training last week she knew log ins were not to be shared with anyone else. She did not see the risk of documenting as another CNA. In a phone interview on 06/03/26 at 2:00 PM, CNA-B stated she had given her credentials to CNA-A on her first shift, which was a 2 PM- 10 PM shift, because there was no one from administration around to fix her credentials. She stated CNAs cannot leave their shift until all their cares have been documented. CNA-B stated CNA-A was only supposed to use her log in for that shift and then see about someone fixing her log in before her next shift. CNA-B stated she was aware she was not supposed to share her credentials with anyone else. She stated documenting as someone else would be creating a false record, and she could be responsible for any errors made by CNA-A.In an interview on 06/03/26 at 2:05 PM the DON stated CNA-B was not working, she had called in sick. She stated she was not aware there was documentation by CNA-B in the EHR of all the residents of the 100 Hall. The DON stated she asked CNA-A if she had documented using CNA-B's log-in credentials, CNA-A stated she had. The DON stated she asked CNA-A if she was aware she was not supposed to use someone else's log in, and CNA-A stated she was aware of that. The DON stated it could be considered false documentation if CNA-A used CNA-B's log-in credentials. She stated the EHR was supposed to be accurate, which included accuracy of who completed what care was provided. She stated her expectation would have been that CNA-A to notify the ADON or herself that her credentials were not working. If it was after hours, the DON stated the CNA should have called the ADON. The DON stated she was unable to locate a policy that addressed log in credential confidentiality or accuracy of documentation.

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