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	06/17/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, 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 (Resident #1) reviewed for infection control practices. While providing Resident #1, who was on EBP due to having a feeding tube and urinary catheter, with incontinence care, CNA A failed to wear a gown and failed to secure her identification lanyard badge, which resulted in the badge touching the resident's perineal area, buttocks, and feces.These failures could place residents at risk of cross-contamination and infections. Findings included: Record review of Resident #1's Face Sheet, dated 06/17/26, revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed he had the following diagnoses: cerebral palsy (neurological disorder that affects movement and posture), neurogenic bladder (lack of bladder control caused by nerve damage), constipation, and contractures of bilateral elbows and knees (permanent shortening of muscles, tendons, or tissues that cause joints to stiffen and lock). The MDS also reflected Resident #1's cognitive skills were severely impaired, indicating he was unable to make decisions. In addition, the MDS reflected that Resident #1 was: dependent on staff for all care, incontinent of bowel, had an indwelling urinary catheter (tube inserted into the bladder to drain urine), and had a feeding tube for nutrition.Record review of Resident #1's Care Plan, revised on 01/20/26, revealed he required tube feeding, and had an indwelling catheter with interventions to monitor signs and symptoms of UTI. The care plan reflected Resident #1 had an ADL self-care performance deficit and was dependent on staff for incontinence care and transfers. The care plan also revealed Resident #1 was on enhanced barrier precautions with an intervention to wear gloves and gown with resident hygiene, toileting/incontinent care, bed mobility, etc. Observation at 06/17/26 at 11:17 AM revealed the enhanced barrier precautions sign outside of Resident #1's room. A second EBP sign was observed at the head of Resident #1's bed on the wall. The sign revealed the following: Enhanced Barrier precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene. Observation also revealed PPE was available inside the room. Observation on 06/17/26 at 11:20 AM revealed CNA A entered Resident #1's room, washed hands, and applied gloves. No gown was put on prior to care. Resident #1 was observed lying in bed. CNA A closed the door and pulled the privacy curtain. Resident #1's brief was unlatched and feces was observed. CNA A began cleaning Resident #1's perineal area and was observed wearing a lanyard identification badge. While CNA A was leaning over Resident #1 to clean the feces, the badge was in the perineal area. Resident #1 was turned on his left side and CNA A was wiping the buttocks. The badge was observed dangling on Resident #1's buttocks and in the feces. CNA A completed incontinence care on Resident #1 with no further concerns. After the care, CNA A removed his gloves and washed hands. CNA A did not apply a gown for EBP and did not secure his identification badge before providing incontinence care.During an interview on 06/17/26 at 1:51 PM, (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA A revealed he had worked at the facility for 2 years. CNA A stated when a resident was on EBP, he should wear a gown and gloves. CNA A stated he did not think he needed to wear a gown with Resident #1 because it was only a BM and not blood. CNA A stated Resident #1 did have a catheter and feeding tube but was unable to state what EBP was or the risk of not wearing a gown. CNA A stated he probably had been trained on enhanced barrier precautions but could not recall. CNA A stated his badge did get in the way of the incontinent care. He stated it was touching the feces. CNA A stated not securing his badge was an infection control risk. CNA A stated he does not usually wear this badge, but he forgot his normal one. During an interview on 06/17/26 at 2:00 PM, LVN B revealed she worked at the facility for 1.5 years. LVN A stated she was the nurse for Resident #1. LVN A stated she expected the aides to wear a gown and gloves for incontinent care if a resident was on EBP. She stated it was an extra barrier precaution for a resident with a catheter, wounds, or other tubes into the body. LVN A stated if aides were not following EBP, the risk was spreading infection. LVN A stated if a badge was hanging, it should be removed or secured before any care. LVN A stated the badge could fall into the BM or urine and spread infection or carry something onto clothes to the next resident. During an interview on 06/17/26 at 3:30 PM, ADON C revealed she had worked at the facility for 24 years. She stated the staff were supposed to gown up and put on gloves (PPE) for any resident on EBP. ADON C stated the PPE was for protecting the staff and the patient. ADON C stated Resident #1 was on EBP for his catheter and feeding tube. ADON C stated the risk of not wearing the gown was an infection risk. ADON C stated a dangly badge should be tucked inside or taken off during any care. She stated the badge could collect stuff and staff may not remember to wipe it off. ADON C stated if a badge was hanging down for Resident #1, it was an infection risk. She stated Resident #1 had a history of infections and it could affect him more. ADON C stated staff had been educated and trained on EBP. She stated they also have assignments to stock the EBP bins on the staffing schedule. ADON C stated there was a sign outside the door, and one by the headboard so staff knew what resident was on EBP. She stated the supplies were also in the room. During an interview on 06/17/26 at 4:02 PM, the DON revealed she had worked at the facility since May 2025. She stated she expected staff to wear proper PPE for residents on EBP. The DON stated any residents with a wound or tubes were on EBP. She stated Resident #1 was on EBP and that staff should be wearing a gown and gloves for incontinent care. The DON stated the risk of not wearing proper PPE was risk to the residents, that they could get sick. The DON stated the gown protected the residents from staff and prevented cross contamination. She stated staff know what residents were on EBP from the sign outside the door, the sign above the resident's bed, and the container with PPE inside the room. The DON stated it was an infection control risk if staff were wearing a badge on a lanyard. The DON stated she expected her staff to clean them and wear the gown for Resident #1 so it would have been out of the way. The DON stated they have started staff education on infection control and EBP. Record review of the facility's Enhanced Barrier Precautions Policy, dated 04/01/24, reflected the following: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient. EBP are indicated for residents with any of the following: .Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.Record review of the facility's Infection Control Plan: Overview policy, dated 2019, reflected the following: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.