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	02/14/2025

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 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** 44937 Based on interviews and record review, the facility failed to immediately consult with the physician of a significant change in the resident's health status; or a need to alter treatment significantly for 1 (Resident #67) of 3 residents reviewed for notification of change. RN C failed to immediately notify the physician that Resident #67 came to the nursing station and stated to RN C that he was not feeling well. RN C stated Resident #67 looked pale, he looked sick. This failure could place residents at risk for delay in treatment, a negative outcome to a resident's physical, mental, and psychosocial health, well-being, or decreased quality of life. Findings included: Record review of Resident #67's face sheet reflected the resident was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further revealed Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] has a pressure at multiple sites. Please see physician orders and [MAR] for wound and treatment. Goal: [Resident #67] Pressure ulcer will show signs of healing and remain free form infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressing PRN . Wound Vac ordered. Record review of Resident #67's February 2025 physician orders reflected: Clean the left hip and right ischial ulcer with normal saline, Tap Dry, apply granular foam into the ulcer, cover with a drape, connect to Wound Vaccum with 125 MM mercury pressure, change every Monday, Wednesday, Friday, and as Needed. In the morning every Mon, Wed, Fri for wound treatment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Record review of Resident #67's MAR, for the month of February 2025 (02/01/25 - 02/14/25) revealed Resident #67 was provided care to clean the left hip and right ischial ulcer with normal saline, tap dry, apply granular foam into the ulcer, cover with drape, connect to wound vac with 125MM mercury pressure, change every Monday, Wednesday, Friday, and as needed. In the morning every Monday, Wednesday, Friday for wound treatment on day 02/03/25, 02/05/25, 02/07/25 and did not indicate care was provided on 02/09/25, and care was not provided on 02/10/25. Record review of Resident #67's progress notes dated 2/9/25 at 1:48 PM written by RN C revealed patient had come to nursing desk and stated he did not feel well, and that wound vac was not working right on left hip. Lips were pale, sclera pale. Went to patient room and discussed going to hospital. Discussed with patient removal of wound vac dressing and placement of wet to dry dressing. Patient refused wet to dry and said he was going to wait until he spoke with his wife and stated that he would let this writer know of his decision. Record review of Resident #67's progress notes dated 2/9/25 at 1:55 PM written by RN C revealed This writer had went to patient room to ask what his decision was. He stated that he wanted left hip wound dressing to be changed. He was informed that dressing would be changed as soon as possible. Patient verbalized understanding. Record review of Resident #67's progress notes dated 2/9/25 at 7:58 PM written by RN C revealed wound vac dressing change had been done to left hip. patient then informed this writer that his right hip dressing needed to be changed. informed supplies would need to be gathered. Wife present at bedside and offered to change dressing. Wife changed dressing to demonstrate how [she] was taught to change dressing. Pt tolerated well. Interview on 02/11/25 at 11:37 AM with Resident #67 revealed the resident asked if he could include his Family Member and made a phone call. Resident #67 and his Family Member stated there had been a lot of issues in regard to his wound care. They stated that the facility staff were not properly trained in providing wound care. Resident #67 stated there had been several times he needed assistance with care with his wound vacuum or needed his dressing changed and he felt staff would ignore him because they did not want to provide wound care. Resident #67 stated he and his Family Member had been speaking with the Administrator and the DON to have consistent and timely wound care. According to the Family Member and Resident #67, nursing staff to include the LVN M, were rude and lacked customer service and bedside manner. The staff would not want to complete his wound care. Resident #67 stated when LVN M was not available or had a day off, wound care could not be completed, because other nurses lacked the proper training to assist him with administering the wound vacuum. Resident #67 stated he has a wound on each hip and one right below his right butt check. Resident #67 stated upon speaking with the Administrator, wound care and placement of the wound vacuum should be completed early in the mornings at the start of shift. Resident #67 stated on last Sunday (02/09/25) he alerted RN C about 7:30 - 7:45 AM that he did not feel well, and needed to have his wounds cleaned and vacuum replaced because the wounds were leaking all over his bed and wheelchair. Resident #67 stated RN C did not return to assess, clean, and connect the wound vacuum until 5:30 PM, just prior to the end of her shift. At that time, it was discovered RN C did not have enough supplies to complete care which resulted in a prolonged wait to get care. According to Resident #67 the vacuum machine was malfunctioning early in the morning hours. It was off and not working, and the bandages were coming off allowing the wound to drain and leak all day which was disgusting. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/12/25 at 5:38 PM with RN C revealed she worked with Resident #67 on 02/09/25. She stated Resident #67 came to the nursing station around 7:30 - 7:45 AM and he stated, I'm not feeling good, I had been laying in this, I am leaking all over my bed, myself, and now my wheelchair. RN C stated Resident #67 looked pale, he looked sick (lips were pale, sclera pale). The wound looked like his wound was leaking, and the dressing needed to be changed. RN C stated she then told Resident #67 to contact Family Member and discuss being sent out to the hospital because she did not want to complete the care with a new canister if he was going out. She stated, she needed to know which supplies to use. If he was going to the hospital, she would need to use wet to dry supplies. RN C stated she was waiting on Resident #67 to come back to her with a response from the Family Member, on what they had decided about him going to the hospital or if he would stay in the facility. RN C stated, I should not have waited so long; I should not have allowed him to be last to complete care. RN C stated when she got around to checking on Resident #67 it was after 5:00 PM. RN C stated, I had other things going on and could not prioritize him above other situations, I did not intently neglect him. RN C stated she never made rounds to check on Resident #67 throughout the shift. However, she was responsible for ensuring wound care for Resident #67 was completed in a timely manner. She stated, not doing so placed him at risk of him becoming septic and making wounds worst with no suction. RN C stated she did not reach out to anyone during her shift for assistance to provide care for Resident #67. She stated she did not report to the DON or the Physician, Resident #67's status throughout the shift. RN C stated she was aware she should have reported that Resident #67 was not feeling well and that he also looked like he was not feeling well. RN C stated she could not say when the last time she had been trained to notify the physician of change of condition. Interview on 02/13/25 at 12:28 PM with the DON revealed she received a call from RN C around 5:30 PM indicating there were no supplies available to complete wound care for Resident #67. She stated that she thought the wound vacuum was messed up. According to the DON, she instructed RN C to look at the vacuum and contact LVN M for supplies. The DON stated she got confirmation from RN C that the vacuum was changed and working properly. According to the DON, she was in communication with RN C throughout the day and RN C never reported Resident #67 was not feeling or did not look well. The DON stated she heard from the Family Member that Resident #67 had reported that he was not feeling well. The DON stated she would have expected RN C to address Resident #67's concerns with his wounds and wound care in a timely manner, not wait the entire shift to complete care. The DON stated she also would expect RN C to have reported any negative findings to her, for example Resident #67 not looking well. The DON stated him saying he was not feeling well and him not looking well was an indication that something was not right with him. The DON stated RN C should have also contacted the physician so that he would be aware of what was going on with Resident #67 and follow any new orders or instruction provided by the physician. The DON stated RN C was responsible for notifying the DON and the Physician with any changes in resident status , not doing so placed Resident #67 at risk for infection, sepsis and prolonging the care he required. Interview on 02/14/25 at 1:16 PM with the Physician revealed he was not made aware that Resident #67 had a change in condition. The Physician stated he expected to be notified by the facility if there was change in condition with residents. The Physician stated if the wound vacuum machine was beeping that indicated the wound vacuum needed to be checked. The Physician stated at that time the wound should be assessed by the wound care nurse or the nurse on duty with the possibility of the dressings to be changed . According to the Physician he would have like the wound dressing to have been changed within 24 hours. The Physician stated not doing so could place Resident #67 at risk for infection at the wound. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy revised 03/11/23 titled Notifying the Physician of Change in Status reflected The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptom of signification change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interviews, and record review the facility failed to ensure all alleged violations involving neglect were reported to the State Survey Agency in a timely manner for 1 (Resident #67) of three residents reviewed for abuse and neglect. The Administrator failed to report Resident #67 fell backwards in his wheelchair (which had not anti-tippers or brakes), hitting his head on the floor of the van during takeoff in the facility parking lot. Resident #67 was sent to hospital resulting in initial encounter with head injury and contusion of right hand. Resident #67 stated his wheelchair was not strapped down correctly and stated he blacked out. The failure could place residents at risk of serious harm or neglect. Findings included: Record review of Resident #67's face sheet reflected the resident was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included osteomyelitis (bone infection that causes inflammation and destruction of bone tissue), paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further revealed Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] at risk for falls paraplegia. Goal: The resident will be free of falls through the review date. [Resident#67] will not sustain serious injury through the review date. Interventions: Anticipate and meet the resident's needs. Staff x 1 to assist with transfers. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 1:41 PM reflected Resident had a fall. Location: while on leave . Fall information: Hit Head. Cognition/Behavior at Time of Event: Oriented/no problem, . Resident assisted to chair from the fall while in transport van, Resident stated hit his head, Resident stated blacked out, Physician Assistant on site, sent to emergency room for further evaluation. Appears and /or states to be in pain. Describes the pain as: continuous, chronic. Location of pain: head, right wrist pain relieving intervention used at this time: sent to emergency room for evaluation. Initial Treatment/New Orders: send to emergency room . Resident Statement: I hit my head and I want to go to the hospital. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 2:51 PM reflected Resident #67 was transferred to a hospital on 02/06/25 at 1:55 PM related to transport van patient had fallen backwards in wheelchair, hitting head. Sent to hospital for evaluation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #67's progress notes written by LVN G dated 02/06/25 at 10:58 PM reflected At 8:17 PM. Resident #67 come back from hospital on non-emergency transportation on diagnosis of fall encounter Head injury, contusion of right hand. Initial encounter. Blood pressure 121/69, pulse 67, respiratory 18 saturation 98 percent, Alert and oriented x 4, able to voice needs and concerns, did head to toe skin assessment. Change hip dressing to Wet to Dry dressing, ongoing care, call light in reach. Record review of Resident #67's after visit summary dated 02/06/25 reflected Reason for visit: Fall, Diagnoses: Fall, initial encounter, Head injury, initial encounter, Contusion of right hand, initial encounter, History of paraplegia. CT head without contrast, chest x ray, hand x ray. Medications given: Oxycodone-acetaminophen, Instructions: Follow up with provider in two weeks around 02/20/25 if symptoms worsen. Record review of Resident #67's incident report dated 02/10/25 reflected Conclusion: resident in 3rd party transport van, his chair has no anti tippers or brakes. Resident fell backward due to inertia upon the driver taking off. Intervention: parts have been ordered for resident chair, and resident to use transport chair vs personal wheelchair. Therapy to screen. Interview on 02/11/25 at 11:37 AM with Resident #67 revealed on 02/06/25 he had a urology appointment and after he was loaded on the van, he fell backwards hitting his head. According to Resident #67, he had a headache and pain in his right hand from the fall. Resident #67 stated it was not the facility van driver, but an outside provider that was taking him to his appointment. Resident #67 stated he took off like a race car driver in the parking lot and I fell backwards, hitting my head on the floor, and blacked out. Resident #67 stated the van driver did not strap me down correctly, so when he took off, I fell backwards and hit my head, and was sent to the hospital. Interview on 02/13/25 at 12:28 PM DON revealed she knew Resident #67 was scheduled for urology appointment on 02/06/25. She stated the facility van had other appointments, so he was to be transported by an outside transport provider. The Social Worker stated she did not see Resident #67 exit the building for his appointment. The DON stated she was alerted to come outside, when she got outside, she saw Resident #67 still in his wheelchair and the straps were still attached. According to the DON, she jumped in the van and removed 2 straps. She stated Resident #67 had to be removed from the chair so they could get the wheelchair out of the van. Once the wheelchair was removed from the van, Resident #67 was placed back in the wheelchair, assessed, and was one on one with the nurse until the emergency medical services arrived to take him to the hospital. The DON stated Resident #67 was delirious and was not able to support his body while sitting in the wheelchair, he was not his baseline, he complained of head pain, and stated that he lost consciousness. The DON stated she did not speak to the Van Driver. She did not recall if an incident report was completed. According to the DON, the Administrator was present and would have handled any reporting, she was busy with Resident #67 ensuring he was ok. According to the DON, drivers were responsible for entering the facility to transport residents out and back inside upon returning to the facility . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 2:47 PM with the Social Worker revealed when residents required an outside appointment, they would leave notification for the Facility Transportation Driver to schedule the appointment with the provider and arrange transportation. According to the Social Worker, she was alerted by the Van Driver coming to the door saying, your patient has flipped out here on the van. The Social Worker stated at that point she alerted either the Administrator or the DON. The Social Worker stated when she got outside, she saw Resident #67 laying on his back yelling at the Van Driver, you fucking dropped me, there was no way I was strapped in. According to the Social Worker, Resident #67 and the Van Driver were going back and forth indicating Resident #67 was upset. The Social Worker stated she saw he was strapped in however she could not tell if it was done correctly. She stated there was one strap on each front wheel but did not recall if the back wheels had any straps. She further stated there were straps caught in the wheels and it was a lot of trouble getting the straps out of the wheelbase . According to the Social Worker, she was responsible for alerting the Administrator. The Social Worker stated any reporting to the State would be the responsibility of the Administrator. Interview on 02/13/25 at 4:27 PM with The Administrator revealed he was alerted by Resident #67's family member that he fell in the van outside in the parking lot. The Administrator stated he went out front, saw Resident #67 laying on the floor of the van yelling and cursing, stating his head hurt. The Administrator stated the nursing staff assessed him and stayed with him until he was taken by emergency medical services to the hospital. The Administrator stated when he went outside, he observed all four points connected, he did not recall seeing the seat belt connected. The Administrator stated he contacted the transport company to provide a statement about the incident. The Administrator stated they were not contracted with the outsourced transportation company and was not responsible for residents once they were in the hands of the outside provider. The Administrator revealed when residents used an outsourced transportation company residents were picked up from the nursing station or the front door by the van driver. The Administrator stated the Van Driver of the transport company was responsible for ensuring residents were safely transported, not doing so placed residents at risk of injuries. The Administrator stated the Van Driver stated to him, he did not know what happened, had all four points secured. The Administrator stated he did not complete an investigation. He stated he did not report to Health and Human Services because the transportation company followed up with him, and advised they would be reporting the incident to Health and Human Services, so he did not feel like he needed to do so . The Administrator revealed he did not feel like he had to report this incident within 2 hours because Resident #67 was not within the care of the facility. According to the Administrator he had not planned to report the incident to Health and Human Services and not doing so place Resident #67 at risk of further accidents and injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled Event Reporting reflected: The facility will complete an Event report on variances that occur within the facility. Variances include falls, skin tears, bruises, lacerations, fractures, choking, burns, elopement, or behaviors that affect others. All Events beyond immediate first aid must be reported immediately by the supervisor of the shift to the Administrator/DON. All Events resulting in a change in status of a resident must be reported immediately to the attending physician and family member. Documentation of the notification and subsequent interventions and comments must be recorded. The Administrator and /or DON will be responsible for ensuring completion of documentation and notification of the physician and the family member as well as notification to the home office and to the State Survey Agency. The investigation should be completed by the DON/Administrator or designee. The investigation report documents a thorough investigation of the events of the reported Event including persons, equipment, and materials that were involved. The investigation report must include what actions were taken to prevent subsequent Events and signatures of the individuals as indicated on the form.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observations, interviews, and record review the facility failed to investigate and report allegation of neglect for 1 (Resident #67) of 3 residents reviewed for accidents and hazards. The Administrator failed to investigate and report the results of the investigation to the state agency when Resident #67 fell backwards in his wheelchair (which had not anti-tippers or brakes), hitting his head on the floor of the van during takeoff in the facility parking lot. Resident #67 was sent to hospital resulting in initial encounter with head injury and contusion of right hand. Resident #67 stated his wheelchair was not strapped down correctly and stated he blacked out. This failure could place residents at risk of harm and injuries related to neglect and a delay in investigating. Findings include: Record review of Resident #67's face sheet reflected the resident was [AGE] years old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included osteomyelitis (bone infection that causes inflammation and destruction of bone tissue), paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further revealed Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] at risk for falls paraplegia. Goal: The resident will be free of falls through the review date. [Resident#67] will not sustain serious injury through the review date. Interventions: Anticipate and meet the resident's needs. Staff x 1 to assist with transfers. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 1:41 PM reflected Resident had a fall. Location: while on leave . Fall information: Hit Head. Cognition/Behavior at Time of Event: Oriented/no problem, Resident assisted to chair from the fall while in transport van, Resident stated hit his head, Resident stated blacked out, Physician Assistant on site, sent to emergency room for further evaluation. Appears and /or states to be in pain. Describes the pain as: continuous, chronic. Location of pain: head, right wrist pain relieving intervention used at this time: sent to emergency room for evaluation. Initial Treatment/New Orders: send to emergency room . Resident Statement: I hit my head and I want to go to the hospital. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 2:51 PM reflected Resident #67 was transferred to a hospital on 02/06/25 at 1:55 PM related to transport van patient had fallen backwards in wheelchair, hitting head. Sent to hospital for evaluation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #67's progress notes written by LVN G dated 02/06/25 at 10:58 PM reflected At 8:17 PM. Resident #67 come back from hospital on non-emergency transportation on diagnosis of fall encounter Head injury, contusion of right hand. Initial encounter. Blood pressure 121/69, pulse 67, respiratory 18 saturation 98 percent, Alert, and oriented x 4, able to voice needs and concerns, did head to toe skin assessment. Change hip dressing to Wet to Dry dressing, ongoing care, call light in reach. Record review of Resident #67's after visit summary dated 02/06/25 reflected Reason for visit: Fall, Diagnoses: Fall, initial encounter, Head injury, initial encounter, Contusion of right hand, initial encounter, History of paraplegia. CT head without contrast, chest x ray, hand x ray. Medications given: Oxycodone-acetaminophen, Instructions: Follow up with provider in two weeks around 02/20/25 if symptoms worsen. Record review of Resident #67's incident report dated 02/10/25 reflected Conclusion: resident in 3rd party transport van, his chair has no anti tippers or brakes. Resident fell backward due to inertia upon the driver taking off. Intervention: parts have been ordered for resident chair, and resident to use transport chair vs personal wheelchair. Therapy to screen. Interview on 02/11/25 at 11:37 AM with Resident #67 revealed on 02/06/25 he had a urology appointment and after he was loaded on the van, he fell backwards hitting his head. According to Resident #67 he had a headache and pain in his right hand from the fall. Resident #67 stated it was not the facility van driver, but an outside provider that was taking him to his appointment. Resident #67 stated he took off like a race car driver in the parking lot and I fell backwards, hitting my head on the floor, and blacked out. Resident #67 stated the van driver did not strap me down correctly, so when he took off, I fell backwards and hit my head, and was sent to the hospital. Interview on 02/13/25 at 12:28 PM DON revealed she knew Resident #67 was scheduled for urology appointment on 02/06/25, she stated the facility van had other appointments, so he was to be transported by an outside transport provider. The Social Worker stated she did not see Resident #67 exit the building for his appointment. The DON stated she was alerted to come outside, when she got outside, she saw Resident #67 still in his wheelchair; straps were still attached. According to the DON she jumped in the van and removed 2 straps, she stated Resident #67 had to be removed from the chair so they could get the wheelchair out the van. Once the wheelchair was removed from the van, Resident #67 was placed back in the wheelchair, assessed and was one on one with nurse until the emergency medical services arrived to take him to the hospital. The DON stated Resident #67 was delirious and not holding good truck control he was not his baseline, he complained of head pain and stated that he lost consciousness. The DON stated she did not speak to the Van Driver; she did not recall if an incident report was completed. According to the DON, the Administrator was present and would have handled any reporting, she was busy with Resident #6 ensuring he was ok. According to the DON drivers were responsible for entering the facility to transport residents out and back inside upon returning to the facility. The DON stated the Administrator was responsible for reporting all incidents to Health and Human Services, not doing so could place residents at risk of further injuries. (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/13/25 at 2:47 PM with Social Worker revealed when residents require an outside appointment, they will leave notification for the Facility Transportation Driver to schedule the appointment with the provider and arrange transportation. According to the Social Worker, she was alerted by the Van Driver coming to the door saying, your patient has flipped out here on the van, the Social Worker stated at that point she alerted either the Administrator or the DON. The Social Worker stated when she got outside, she saw Resident #67 laying on his back yelling at the Van Driver you fucking dropped me, there was no way I was strapped in. According to the Social Worker Resident #67 and the Van Driver were going back and forth indicating Resident #67 was upset. The Social Worker stated she saw he was strapped in however could not tell if it was done correctly. She stated there was one strap on each front wheel but did not recall if the back wheels had any straps, she further stated there were straps caught in the wheels and it was a lot of trouble getting the straps out the wheelbase. According to the Social Worker she was responsible to alert the Administrator which was the Abuse Coordinator when there was an incident of neglect, not doing so placed residents at risk of further neglect and injury . According to the Social Worker, she was responsible for alerting the Administrator. The Social Worker stated any reporting to the state would be the responsibility of the Administrator. Not doing so placed residents at risk of possible harm. Interview on 02/13/25 at 4:27 PM with The Administrator revealed he was alerted by Resident #67's family member that he fell in the van outside in the parking lot. The Administrator stated he went out front, saw Resident #67 laying on the floor of the van yelling and cursing, stating his head hurt. The Administrator stated the nursing staff assessed him and stayed with him until he was taken by emergency medical services to the hospital. The Administrator stated when he went outside, he observed all four points connected, he did not recall seeing the seat belt connected. The Administrator stated he contacted the transport company to provide a statement about the incident. The Administrator stated they were not contracted with the outsourced transportation company and was not responsible for residents once they were in the hands of the outside provider. The Administrator revealed when residents used an outsourced transportation company residents are picked up from the nursing station or the front door by the van driver. The Administrator stated the Van Driver of the transport company was responsible for ensuring residents were safely transported, not doing so placed residents at risk of injuries. The Administrator stated the Van Driver stated to him, he did not know what happened, had all four points secured. The Administrator stated he did not complete an investigation. He stated he did not report to Health and Human Services because the transportation company followed up with him, and advised they would be reporting the incident to Health and Human Services, so he did not feel like he needed to do so . The Administrator revealed he did not feel like he had to report this incident within 2 hours because Resident #67 was not within the care of the facility. According to the Administrator he had not planned to report the incident to Health and Human Services and not doing so place Resident #67 at risk of further accidents and injury. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled Event Reporting reflected: The facility will complete an Event report on variances that occur within the facility. Variances include falls, skin tears, bruises, lacerations, fractures, choking, burns, elopement, or behaviors that affect others. All Events beyond immediate first aid must be reported immediately by the supervisor of the shift the Administrator/DON. All Events resulting in a change in status of a resident must be reported immediately to the attending physician and family member. Documentation of the notification and subsequent interventions and comments must be recorded. The Administrator and /or DON will be responsible for ensuring completion of documentation and notification of the physician and the family member as well as notification to the home office and to the State Survey Agency. The investigation should be completed by the DON/Administrator or designee. The investigation report documents a thorough investigation of the events of the reported Event including persons, equipment, and materials that were involved. The investigation report must include what actions were taken to prevent subsequent Events and signatures of the individuals as indicated on the form.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 44937 Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 4 residents (Resident #67) reviewed for quality of care. RN C failed to assess Resident #67 for a change in condition in a timely manner when he reported he was not feeling well on 02/09/25 at approximately 7:30 AM, and RN C noticed he did not look well and offered to send the resident to the hospital. An IJ was identified on 02/13/25. The IJ template was provided to the facility on [DATE] at 5:20 PM. While the IJ was removed on 02/14/25, the facility remained out of compliance at a scope of isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or the need for hospitalization and prolonged treatment. Findings included: Record review of Resident #67's face sheet reflected the resident was [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further reflected Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] has a pressure at multiple sites. Please see physician orders and [MAR] for wound and treatment. Goal: [Resident #67] Pressure ulcer will show signs of healing and remain free form infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressing PRN .Wound Vac ordered. Record review of Resident #67's February 2025 MAR physician orders, reflected: Clean the left hip and right ischial ulcer with N/S, Tap Dry, apply granular foam into the ulcer, cover with a drape, connect to Wound VAC with 125 MM mercury pressure, change Q Monday, Wednesday, Friday, and as Needed. In the morning every Mon, Wed, Fri for wound treatment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #67's February 2025 MAR physician orders, reflected: If Wound VAC is not available, clean bilateral hip ulcer and hip ischial ulcer with normal saline, tap with dry dressing, apply silver alginate rope into all the ulcer, cover with multiple layers of 4 x 4s ABD, secure with [medipore] (cloth) tape , change the dressing every other day and as needed for wound discharge. Every 12 hours as needed for wound treatment related to Pressure Ulcer of Unspecified Buttock, Unspecified state. Record review of Resident #67's physician orders reflected: If wound vac is not available, clean bilateral hip ulcer and hip ischial ulcer with normal saline, tap with dry dressing, apply silver alginate rope into all the ulcer, cover with multiple layers of 4 x 4 s abdominal pads, secure with medipore (cloth) tape, change the dressing every other day and as needed for wound discharge. Every 12 hours as needed for wound treatment related to pressure ulcer of unspecified buttock, unspecified stage 1/9/2025 Clean the left hip and right ischial ulcer with n/s, tap dry, apply granular foam into the ulcer, cover with a drape, connect to wound vac with 125 mm mercury pressure, change every Monday, Wednesday, Friday. and as needed. In the morning every Monday, Wednesday, Friday for wound treatment 01/09/25, Record review of Resident #67's February 2025 MAR reflected Resident #67 was provided care to clean the left hip and right ischial ulcer with normal saline, tap dry, apply granular foam into the ulcer, cover with drape, connect to wound vac with 125 mm mercury pressure, change every Monday, Wednesday, Friday, and as needed. In the morning every Monday, Wednesday, Friday for wound treatment on day 02/03/25, 02/05/25, 02/07/25 and did not indicate care was provided on 02/09/25, and care was not provided on 02/10/25. Record review of Resident #67's progress notes dated 02/09/25 at 1:48 PM written by RN C reflected patient had come to nursing desk and stated he did not feel well, and that wound vac was not working right on left hip. Lips were pale, sclera pale. Went to patient room and discussed going to hospital. Discussed with patient removal of wound vac dressing and placement of wet to dry dressing. Patient refused wet to dry and said he was going to wait until he spoke with his wife and stated that he would let this writer know of his decision. Record review of Resident #67's progress notes dated 02/9/25 at 1:55 PM written by RN C reflected This writer had went to patient room to ask what his decision was. He stated that he wanted left hip wound dressing to be changed. He was informed that dressing would be changed as soon as possible. patient verbalized understanding Record review of Resident #67's progress notes dated 2/9/25 at 7:58 PM written by RN C reflected wound vac dressing change had been done to left hip. patient then informed this writer that his right hip dressing needed to be changed. informed supplies would need to be gathered. Wife present at bedside and offered to change dressing. Wife changed dressing to demonstrate how was taught to change dressing. Pt tolerated well. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #67's progress notes dated 2/10/25 at 12:19 AM written by RN C reflected Patient tolerated MN medications, pt alert, able to answer questions writer asked. Pt held water, accepted snack at this time. Fluids at bedside Gatorade and ice water. Wound vac on, dressing intact upon observation. Pt declined any needs that need to be addressed at this time. Care ongoing. Interview on 02/11/25 11:37 AM with Resident #67 revealed the resident in bed, Resident #67 asked if he could include his Family Member and made a phone call. Resident #67 and Family Member stated there has been a lot of issues in regard to his wound care, stated that the facility staff were not properly trained in providing wound care. Resident #67 stated there had been several times he needed assistance with care with his wound vacuum or needed his dressing changed and he felt staff would ignore him because they did not want to provide wound care. Resident #67 stated he and his Family Member had been speaking with the Administrator and the DON to have consistent and timely wound care. According to the Family Member and Resident #67, nursing staff to include the LVN M were rude and lacked customer service and bedside manner, staff would not want to complete his wound care. Resident #67 stated when the LVN M was not available or had a day off wound care could not be completed because other nurses, they lack the proper training to assist him with administering the wound vacuum. Resident #67 stated he has a wound on each hip and one right below his right butt check. Resident #67 stated upon speaking with the Administrator, wound care and placement of the wound vacuum should be completed early in the mornings at the start of shift. Resident #67 stated on last Sunday (02/09/25) he alerted RN C about 7:30 AM-7:45 AM that he did not feel well, and needed to have his wounds cleaned and vacuum replaced because the wounds were leaking all over his bed and wheelchair. Resident #67 stated RN C did not return to assess, clean, and connect the wound vacuum until 5:30 PM just prior to the end of her shift, at that time it was discovered RN C did not have enough supplies to complete care which resulted in a prolonged wait to get care. According to Resident #67 the vacuum machine was malfunctioning early in the morning hours, it was off and not working, the bandages were coming off allowing the wound to drain and leak all day which was disgusting. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/12/25 at 5:38 PM with RN C revealed she worked with Resident #67 on 02/09/25, she stated Resident #67 came to the nursing station around 7:30 - 7:45 AM he stated I'm not feeling good, I had been laying in this, I am leaking all over my bed, myself, and now my wheelchair. RN C stated Resident #67 looked pale, he looked sick (lips were pale, sclera pale). The wound looked like his wound was leaking, and the dressing needed to be changed. RN C stated she then told Resident #67 to contact Family Member and discuss being sent out to the hospital because she did not want to complete the care with a new canister if he was going out. She stated, I needed to know which supplies to use, if he was going to the hospital, I would need to use wet to day supplies. RN C stated she was waiting on Resident #67 to come back to her with a response from Family Member, on what they had decided about him going to the hospital or if he would stay in the facility. RN C stated I should not have waited so long; I should not have allowed him to be last to complete care. RN C stated when she got around to checking on Resident #67 it was after 5:00 PM. RN C stated I completed care on the right hip, and I did not know if you did one side you needed to do the other side as well, there was not enough supplies to complete the left side. I reached out to the DON because I did not have enough supplies to complete wound care for the left side, she then gave me LVN M's number to contact her about obtaining supplies. After contacting LVN M, she came to the facility to provide me with supplies, this was around 6:00 PM. RN C stated, I had other things going on and could not prioritize him above other situations, I did not intently neglect him. RN C stated she never made rounds to check on Resident #67 throughout the shift however she was responsible for ensuring wound care for Resident #67 was completed in a timely manner, not doing so placed him at risk of him being in sepsis and making wounds worst with no suction. RN C stated she did not reach out to anyone during her shift for assistance to provide care for Resident #67, she stated she just thought she would get to him prior to the end of her shift. RN C stated the Family Member entered Resident #67's room upset about him not receiving timely care and completed the wound care with RN C observing. According to RN C she received a video in-service on 02/10/25 and she was also expected to do one on one training with the LVN M on how to use wound vacuum. According to RN C she was trained on wound vacuum in prior positions however, not the way it was requested by Resident #67 and Family Member . RN C stated not providing care to Resident #67 in a timely manner was neglect and she did not intend on neglecting him by not addressing his wounds, not assessing him when he stated he did not feel well and when Resident #67 did not look like he felt well, as well as when she did not follow up on him until the end of her shift which was 10 hours later. RN C stated she had been inserviced several times on neglect, which was what I had done to Resident #67. RN C stated when Resident #67 looked pale, he looked sick (lips were pale, sclera pale). The wound looked like his wound was leaking, and the dressing needed to be changed, she recognized he had a change in condition and should have reported this change to the DON and the Physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/13/25 at 12:28 PM with the DON revealed she received a call from RN C around 5:30 PM indicating there were no supplies available to complete wound care for Resident #67, that she thought the wound vacuum was messed up. According to the DON, she instructed RN C to look at the vacuum and contact the LVN M for supplies. The DON stated she called LVN M to bring supplies and was on the phone with the LVN M when she entered the facility to deliver supplies. According to the DON, only a limited number of supplies are put out on the wound cart or in the medication room, when additional supplies are needed, the LVN M was contacted so she can tell us where to get more or she will come to the facility to get them from her office. The DON stated she got confirmation from RN C that the vacuum was changed and working properly. According to the DON, she was in communication with RN C throughout the day and she never reported Resident #67 was not feeling well or did not look well. The DON stated she heard from Family Member that Resident #67 requested earlier in the day to have his wounds changed and machine inspected. The DON stated she would have expected RN C to address Resident #67's concerns with his wounds and wound care in a timely manner, not wait the entire shift to complete care. The DON stated she sent a video to RN C on Monday and had been having all nursing staff to shadow one on one wound care with LVN M, that started weeks ago. The DON stated she started this process, so nurses were comfortable changing the wound vacuum and the supplies, and what to do when wound vacuums were beeping. The DON stated the RN was responsible for addressing Resident #67's needs for his wounds, and reporting when residents have a change in condition to the physician, the DON, and the Administrator. The DON further stated, not completing care in a timely manner placed Resident #67 at risk of sepsis, wound breakdown, hospitalization , and septic shock and because of that we took disciplinary action . According to DON, RN C neglected Resident #67 when she did not provide care in a timely manner when she saw that his wound was leaking and she saw the he did not look as if he was feeling well. DON stated when you are not addressing these concerns you are basically neglect the resident. DON stated when his condition changed, him not looking at his baseline, RN C should have notified myself and the Physician, not providing care or notifying the physician of Resident #67's condition was neglectful and went against facility policy. Interview on 02/13/25 at 4:27 PM with the Administrator revealed he received a call from the Family Member on 02/09/25 that RN C was refusing to replace the wound vacuum for Resident #67 and she was trying to send him out to the hospital instead. According to the Administrator, the Family Member reported she saw supplies in the room. The Administrator stated, I don't know if the nurse knew what she was doing and he expected the nursing staff to address any wound changes or resident needs in a timely manner. The Administrator stated it was reported back to him the dressings and wound care was completed. The Administrator stated he expected nurses to ensure they were following doctor orders, not doing so placed Resident #67 at risk of having to be sent out to the hospital for not addressing his need for wound care. The Administrator stated he did not have the full story of events and he did not investigate the incident; he did not feel he needed to because the wound care was completed . According to the Administrator the DON and ADONs were responsible for ensuring the nurses were trained to complete wound care. The Administrator stated not providing wound care, when the wound is leaking and Resident #67 stated he did not feel well, and not checking on Resident #67 for the entire shift would be a form of neglect, placing Resident #67 at risk of infection or the need to be sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/14/25 at 1:16 PM with the Physician revealed he was not made aware that Resident #67 looked as if he was not feeling well by RN C, that he had a change in condition. The Physician stated he expected to be notified by the facility if there was change in condition with residents. The Physician stated if the wound vacuum machine was beeping that indicated the wound vacuum needed to be checked. The Physician stated at that time the wound should be assessed with the possibility of the dressings to be changed . According the Physician waiting to the end of the shift to address Resident #67's needs, change in condition and assess his wounds was a form of neglect, waiting 10 hours could place the resident at risk of several things and the need to be sent to the hospital. Record review of the facility policy revised 09/09/24 titled Abuse/Neglect Policy reflected The resident has the right to be free from Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of the facility's Skin Integrity Management policy, dated 10/05/16 reflected: Wound care should be performed as ordered by the physician. Skin should be cleansed at the time of soiling and the routine intervals. The frequency of skin cleansing should be individualized according to need/and or resident preference. Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage. Record review of the facility's Physician Orders policy, dated 2015, reflected: to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and activities of daily living order for each resident. Record review of the facility's Notifying the Physician of Change in Status policy, revised 03/11/23, reflected: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptom of signification change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. This was determined to be an Immediate Jeopardy (IJ) on 02/13/25 at 5:25 PM. The Administrator was notified. The Administrator was provided the IJ template on 02/13/25 at 5:26 PM and a plan of removal was requested. The following plan of removal submitted by the facility was accepted on 02/14/25 at 1:40 PM and included the following: Facility: The {facility} Date: 2/14/25 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan of Removal Problem: F600 Free from Abuse and Neglect Interventions: As of 2/13/25 [Resident #1] had a complete head to assessment performed by the Treatment Nurse On 2/14/25 [Resident #1] had a head-to-toe assessment completed by the Regional Compliance Nurse, DON, and Tx Nurse. The MD was notified of all wounds by the DON. Orders were received. Wound vac dressing changed on 2.14.25 by the Treatment Nurse. All residents in the facility will receive a head-to-toe skin assessment. Wound treatments including wound vacs will be verified as completed according to MD orders by the Regional Compliance Nurse, DON, ADON. Completion date 2/13/25. Treatment nurse was educated on checking daily, Monday-Friday, to ensure that all wound care supplies is readily available. Completion date 2/14/25. All nurses were educated on the location of wound care supplies. If not available, they need to notify the DON and Administrator immediately. Completion date 2/14/25. The DON and ADON were in-serviced 1:1 on following topics by the Regional Compliance Nurse. Completed 2/13/25. Dressing Change Procedure- procedure to include wound vac dressings . Abuse and Neglect: failure to complete a dressing change according to MD orders including wound vacs could be considered abuse and neglect. Notification of Change in Condition: including notifying a MD for a change in a resident's condition. Resident Rights: to respect a resident's right to request care including dressing changes. The medical director was notified of the immediate jeopardy on 2/13/25. An ADHOC QAPI meeting was completed on 2/13/25 with IDT team including the Medical Director to discuss the immediate jeopardy and plan of removal. In-services: All nursing staff will be in-serviced on 2/13/25 regarding the following topics below by the ADO, the Regional Compliance Nurse, the Administrator, the DON, and the ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date 2/14/25. (continued on next page)

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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dressing Change Procedure- procedure to include wound vac dressings. Dressing Supplies- all supplies needed for treatment services are in the medication room. Notify the DON and Administrator if not available. Abuse and Neglect: failure to complete a dressing change according to MD orders including wound vacs could be considered abuse and neglect. Notification of Change in Condition: including notifying a MD for a change in a resident's condition. Resident Rights: to respect a resident's right to request care including dressing changes. The following Plan of Removal monitoring was conducted: Inservice Training Topic: -Dressing Change Procedure - Procedure to include wound vac dressings. -Abuse and Neglect: Failure to complete a dressing change according to MD order including wound vacs could be considered abuse and neglect. -Notification of Change in Condition: including notifying MD for a change in a resident's condition. -Resident Rights: to respect a resident's right to request care including dressing changes. Date and Time Conducted: 2/13/24. Instructor: Regional DON Attendees: Administrator, ADON A, ADON B, DON Inservice Training Topic: Wound Care Supplies Being Readily Available The wound nurse will ensure that all necessary wound care supplies are readily accessible for nursing staff. If staff encounter any difficulties in finding the supplies, she will guide them on where to locate the required items. From Monday to Friday, the wound nurse will verify that supplies are adequately stocked in the medication room, and on Fridays, she will also confirm that the supplies are prepared for the weekend. Date Conducted: 02/13/25. Instructor: Regional DON Attendees: LVN M (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Inservice Training Topic: Notification of Changes - see attached policy regarding notification of changes. Date Conducted: 02/13/25. Instructor: Regional DON Attendees to include MA P, MA EE, CNA F, CNA K, CNA N, CNA Q, CNA V, CNA X, CNA BB, RN D, RN GG, LVN H, LVN M, ADON A, CNA HH, CNA II, CNA JJ, CNA KK, CNA LL, CNA DD Inservice Training Topic: Abuse and Neglect Resident Rights Date Conducted: 02/13/25. Instructor: DON Attendees to include: ADON B, LVN H, CNA X, LVN BB, MA CC, MA EE, RN GG, CNA F, CNA JJ, CNA HH, RN D, MA P, CNA K, CNA Q, Med Rec, LVN M, CNA LL Inservice Training Topic: Wound Dressing Care and Changes Date Conducted: 02/13/25. Instructor: Regional DON Attendees to include: ADON B, LVN H, LVN BB, MA CC, CNA LL, MA EE, RN GG, RN D, CNA N, CNA Q, CNA T, LVN M, ADON B, CNA AA, CNA DD Inservice Training Topic: A resident request a change to the wound vac, immediately address the resident, do NOT delay treatment. Call the DON and Wound Care Nurse if there are any issues in applying the wound vac. Monitor the wound vac for changes to suction, taping, leakage, tubing kinked and any other concerns. Operating Manual Revision Date: 2024-08-16 titled extriCARE 3000 Negative Pressure Wound Therapy System Date Conducted: 02/13/25. (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Instructor: DON Attendees to include: LVN I, LVN BB, ADON B, ADON A, LVN H, MA CC, MA EE, RN D, RN GG, CNA Q, CNA T Interviews conducted with the above staff indicated they had understanding to identify when a resident has a change of condition, signs of abuse/neglect, the need to honor resident rights. Nursing staff was able to reveal where wound care supplies were kept; how and who to notify to restock if items were low, and Nurses stated they understood how to complete wound care on residents with wound vacuums. The Administrator was informed the Immediate Jeopardy was removed on 02/14/2025 at 7:10 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interviews, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure ulcers for 1 (Resident #67) of 2 residents reviewed for pressure ulcers with use of a wound vacuum. RN C failed to provide Resident #67 with wound care when he reported to her on 02/09/25 at approximately 7:30 AM that he was not feeling well and needed his dressing changed because his wound vac was leaking. RN C did not follow-up with Resident #67 for care until 5:30 PM at which time she discovered she did not have enough supplies to complete wound care. The wound care was not provided for approximately 10 hours after the resident had asked to have the dressing changed, which resulted in resident discomfort and wound drainage getting on the resident, his wheelchair, and bed linens. An IJ was identified on 02/13/25. The IJ template was provided to the facility on [DATE] at 5:20 PM. While the IJ was removed on 02/14/25, the facility remained out of compliance at a scope of isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. These failures placed residents with wounds at risk of wound deterioration, wound development, and infection. Findings included: Record review of Resident #67's face sheet reflected the resident was [AGE] years old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further revealed Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] has a pressure at multiple sites. Please see physician orders and [MAR] for wound and treatment. Goal: [Resident #67] Pressure ulcer will show signs of healing and remain free form infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressing PRN . Wound Vac ordered. Record review of Resident #67's February 2025 MAR physician orders reflected: Clean the left hip and right ischial ulcer with N/S, Tap Dry, apply granular foam into the ulcer, cover with a drape, connect to Wound VAC with 125 MM mercury pressure, change Q Monday, Wednesday, Friday, and as Needed. In the morning every Mon, Wed, Fri for wound treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #67's February 2025 MAR physician orders reflected: If Wound VAC is not available, clean bilateral hip ulcer and hip ischial ulcer with normal saline, tap with dry dressing, apply silver alginate rope into all the ulcer, cover with multiple layers of 4 x 4s ABD, secure with medipore (cloth) tape, change the dressing every other day and as needed for wound discharge. Every 12 hours as needed for wound treatment related to Pressure Ulcer of Unspecified Buttock, Unspecified state. Record review of Resident #67's physician orders revealed: If wound vac is not available, clean bilateral hip ulcer and hip ischial ulcer with normal saline, tap with dry dressing, apply silver alginate rope into all the ulcer, cover with multiple layers of 4 x 4 s abdominal pads, secure with medipore (cloth) tape, change the dressing every other day and as needed for wound discharge. Every 12 hours as needed for wound treatment related to pressure ulcer of unspecified buttock, unspecified stage 1/9/2025 Clean the left hip and right ischial ulcer with n/s, tap dry, apply granular foam into the ulcer, cover with a drape, connect to wound vac with 125 mm mercury pressure, change every Monday, Wednesday, Friday. and as needed. In the morning every Monday, Wednesday, Friday for wound treatment 1/9/2025 Record review of Resident #67's MAR, for the month of February 2025 (02/01/25 - 02/14/25) revealed Resident #67 was provided care to clean the left hip and right ischial ulcer with normal saline, tap dry, apply granular foam into the ulcer, cover with drape, connect to wound vac with 125MM mercury pressure, change every Monday, Wednesday, Friday, and as needed. In the morning every Monday, Wednesday, Friday for wound treatment on day 02/03/25, 02/05/25, 02/07/25 and did not indicate care was provided on 02/09/25, and care was not provided on 02/10/25. Record review of Resident #67's Wound Evaluation and Management Summary dated 02/12/25 reflected: Chief Complaint - Patient has wounds on his right hip; left hip; left ischium. Focused Wound Exam (Site 1) Stage 4 Pressure Wound of the Left Ischium Full Thickness Etiology (quality) . Pressure MDS 3.0 Stage . 4 Duration . Greater than 395 days Objective . Healing/Maintain Healing Wound Size (LxWxD): . 2 x 1.5 x 1.5 cm Surface Area . 3.00 cm (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Undermining . 4.2 cm at 3 o'clock Exudate . Moderate Serous Granulation tissue . 100 % Wound progress . Improved evidenced by decrease in depth Focused Wound Exam (Site 2) Stage 4 Pressure Wound of the Left Ischium Full Thickness Etiology (quality) . Pressure MDS 3.0 Stage . 4 Duration . Greater than 345 days Objective . Healing/Maintain Healing Wound Size (LxWxD): . 4.5x 5 x 0.6 cm Surface Area . 22.50 cm Undermining . 3 cm at 9 o'clock Exudate . Moderate Serous Granulation tissue . 100 % Wound progress . Not at Goal Dressing Treatment Plan - Negative pressure wound therapy apply three times per week for 10 days; NPWT , Coarse (green) foam, 120 mmHg suction, continuous mode, change 3 x week and PRN; Irrigate and cleanse wound with 1/4 % Dakin's with wound vac dressing changes apply three times per week for 10 days Focused Wound Exam (Site 3) Stage 4 Pressure Wound of the Left Ischium Full Thickness Etiology (quality) . Pressure MDS 3.0 Stage . 4 Duration . Greater than 365 days Objective . Healing/Maintain Healing (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Size (LxWxD): . 6 x 5 x 1 cm Surface Area . 30.00 cm Undermining . 2 cm at 6 o'clock Exudate . Moderate Serous Granulation tissue . 30 % Wound progress . Improved evidenced by decrease in depth Dressing Treatment Plan - Negative pressure wound therapy apply three times per week for 10 days; Continuous suction at 120 mmHg. Bridge dressing onto left anterior thigh; irrigate and cleanse wound with 1/4 % Dakin's with wound vac dressing changes apply three times per week for 10 days Record review of Resident #67's progress notes dated 2/9/25 at 1:48 PM written by RN C revealed patient had come to nursing desk and stated he did not feel well, and that wound vac was not working right on left hip. Lips were pale, sclera pale. Went to patient room and discussed going to hospital. Discussed with patient removal of wound vac dressing and placement of wet to dry dressing. Patient refused wet to dry and said he was going to wait until he spoke with his wife and stated that he would let this writer know of his decision. Record review of Resident #67's progress notes dated 02/9/25 at 1:55 PM written by RN C revealed This writer had gone to patient room to ask what his decision was. He stated that he wanted left hip wound dressing to be changed. He was informed that dressing would be changed as soon as possible. patient verbalized understanding Record review of Resident #67's progress notes dated 2/9/25 at 7:58 PM written by RN C revealed wound vac dressing change had been done to left hip. patient then informed this writer that his right hip dressing needed to be changed. informed supplies would need to be gathered. Wife present at bedside and offered to change dressing. Wife changed dressing to demonstrate how was taught to change dressing. Pt tolerated well. Record review of Resident #67's progress notes dated 2/10/25 at 12:19 AM written by RN C revealed Patient tolerated MN medications, pt alert, able to answer questions writer asked. Pt held water, accepted snack at this time. Fluids at bedside Gatorade and ice water. Wound vac on, dressing intact upon observation. Pt declined any needs that need to be addressed at this time. Care ongoing. (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/11/25 11:37 AM with Resident #67 revealed the resident in bed, Resident #67 asked if he could include his Family Member and made a phone call. Resident #67 and Family Member stated there has been a lot of issues in regard to his wound care. Resident #67 stated he and his Family Member had been speaking with the Administrator and the DON to have consistent and timely wound care. According to the Family Member and Resident #67, nursing staff to include the LVN M were rude and lacked customer service and bedside manner, staff would not want to complete his wound care. Resident #67 stated when the LVN M was not available or had a day off wound care could not be completed because other nurses, they lack the proper training to assist him with administering the wound vacuum. Resident #67 stated he has a wound on each hip and one right below his right butt check. Resident #67 stated upon speaking with the Administrator, wound care and placement of the wound vacuum should be completed early in the mornings at the start of shift. Resident #67 stated on last Sunday (02/09/25) he alerted RN C about 7:30 - 7:45 AM that he did not feel well, and needed to have his wounds cleaned and vacuum replaced because the wounds were leaking all over his bed and wheelchair. Resident #67 stated RN C did not return to assess, clean, and connect the wound vacuum until 5:30 PM just prior to the end of her shift, at that time it was discovered RN C did not have enough supplies to complete care which resulted in a prolonged wait to get care. According to Resident #67 the vacuum machine was malfunctioning early in the morning hours, it was off and not working, the bandages were coming off allowing the wound to drain and leak all day which was disgusting. Observation on 02/12/25 at 10:55 AM of Resident #67's wound care for Resident #67 with LVN M she explained the procedure was to wash her hands and put all the supplies together then donn PPE. Resident #67 was positioned, and the wound vacuum was disconnected. She removed the old dressings on the left hip and ischium. The wound looks clean no signs of swelling, redness, or bleeding was observed. She cleansed the area with gauze soaked with solution inside out with each swipe. She patted dry. The wound doctor measured the wound. She cleansed again and patted dry. She sprayed the edges with skin prep and waited to dry. She applied xeroform on an open area on the hip. She then applied the film to cover the hip. She cut the film to the size of the wound and applied the black foam. She doffed and washed hands and repeated the same procedure for the ischium. She doffed gloves and washed her hands. She applied the film to cover both areas and a bridge sponge was applied. She applied the tubing and then covered with film, and she anchored the tubing not to touch the body. She washed hands and donned gloves. She removed the old dressing on the right hip. The wound was observed, no swelling, no odor, and no bleeding was observed or redness. The same procedure was applied to the right hip. LVN M then connected both tubes from both hips and connected to a new canister and put it on. The pressure was at 125 mm mercury pressure. The wound vac was left working properly. Observation and interview on 02/12/25 at 11:39 AM with the Wound Care Doctor revealed him stating both wounds are measuring about the same maybe a bit smaller in diameter (left ischium 2x1.5x1.5 cm, left hip 4. 5x5x.06 cm, and right hip 6x5x1 cm). According to the Wound Care Doctor, he was not notified about the wound vacuum malfunctioning on 02/09/25. He further stated, Resident #67 left the facility a lot and that may have to do with the reason for the vacuum disconnecting, and I don't think they have staff over the weekend that is able to address that issue. The Wound Care Doctor stated therefore it has to be addressed on the following business day and Resident #67 would usually inform me when I come on Wednesday. The Wound Care Doctor stated he would like the wound to be cared for in a timely manner, and there should be staff trained to address the issue. The Wound Care Doctor stated not caring for the wound or replacing the dressing could place Resident #67 at risk of infection and needing to be sent to the hospital for sepsis. He further stated, I have no concerns with his care and the wound treatments . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/12/25 at 1:15 PM with the LVN M revealed she had been working with Resident #67 on wound care. She stated she was notified on 02/09/25 by RN C there were no supplies to complete wound care for Resident #67. LVN M stated she came to the facility to replenish supplies and left some in Resident #67's room. LVN M stated supplies were normally kept on the wound cart and the medication room located behind the nursing station. She stated that she could be contacted, if needed, to gather supplies out of her office if needed. LVN M stated when she arrived at the facility RN C asked her to provide care to Resident #67's wound, she said she responded No, today is my off day and she left the facility. According to the LVN M, Central Supply was responsible to keep supplies stocked, not doing so could place the residents at risk of not receiving timely care as needed. Interview on 02/12/25 at 5:38 PM with RN C revealed she worked with Resident #67 on 02/09/25. She stated Resident #67 came to the nursing station around 7:30 - 7:45 AM. He stated, I'm not feeling good, I had been laying in this, I am leaking all over my bed, myself, and now my wheelchair. RN C stated Resident #67 looked pale, he looked sick (lips were pale, sclera pale). The wound looked like it was leaking, and it needed to be changed. RN C stated she then told Resident #67 to contact Family Member and discuss being sent out to the hospital because she did not want to complete the care with the new canister if he was going out. She stated, I needed to know which supplies to use, if he was going to the hospital, I would need to use wet to day supplies. RN C stated she was waiting on Resident #67 to come back to her with a response from Family Member, on what they had decided about going to the hospital. RN C stated when she got around to checking on Resident #67 it was after 5:00 PM, she stated I completed care on the right hip, and I did not know if you did one side you needed to do the other side as well, there was not enough supplies to complete the left side. I reached out to the DON, and she gave me the LVN M's number to contact her, she then came to the facility to bring me supplies, this was around 6:00 PM. RN C stated, I had other things going on and could not prioritize him, I did not intently neglect him. RN C stated she was responsible for ensuring wound care for Resident #67 was completed in a timely manner, not doing so placed him at risk of him being in sepsis and making wounds worst with no suction. RN C stated the Family Member entered Resident #67's room upset about him not receiving timely care and completed the wound care with RN C observing. According to RN C she received a video in-service on 02/10/25 and she was also expected to do one on one training with the LVN M on how to use wound vacuum. According to RN C she was trained on wound vacuum in prior positions however, not the way it was requested by Resident #67 and Family Member. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/13/25 at 12:28 PM with the DON revealed she received a call from RN C around 5:30 PM indicating there was no supplies available to complete wound care for Resident #67, that she thought the wound vacuum was messed up, According to the DON she instructed RN C to look at the vacuum and contact the LVN M for supplies. The DON stated she also called the LVN M to bring supplies and was on the phone with the LVN M when she entered the facility to deliver supplies. According to the DON only a limited number of supplies are put out on the wound cart or in the medication room, when additional supplies are needed, the LVN M was contacted so she can tell us where to get more or she will come to the facility to get them from her office. The DON stated she got confirmation from RN C that the vacuum was changed and working properly. According to the DON she was in communication with RN C throughout the day and she never reported Resident #67 was not feeling or did not look well. The DON stated she heard from Family Member that Resident #67 requested earlier in the day to have his wounds changed and machine inspected. The DON stated she would have expected RN C to address Resident #67's concerns with his wounds and wound care in a timely manner, not wait the entire shift to complete care. The DON stated she sent a you tube video to RN C on Monday and had been having all nursing staff to shadow one on one wound care with the LVN M that started weeks ago. The DON stated she started this process, so nurses were comfortable changing the wound vacuum and the supplies, and what to do when wound vacuums are beeping. The DON stated RN was responsible for addressing Resident #67's needs for his wounds, and reporting when residents have a change in condition to the physician, DON, and the Administrator. The DON further stated, not completing care in a timely manner placed Resident #67 at risk of sepsis, wound breakdown, hospitalization , and septic shock and because of that we took disciplinary action. Interview on 02/13/25 at 4:27 PM with the Administrator revealed he received a call from the Family Member on 02/09/25 that RN C was refusing to replace the wound vacuum for Resident #67, that she was trying to send him out to the hospital instead. According to the Administrator the Family Member reported she saw supplies in the room. The Administrator stated, I don't know if the nurse knew what she was doing and that he expected the nursing staff to address any wound changes or resident needs in a timely manner. According to the Administrator the DON and ADONs were responsible for ensuring the nurses were trained to complete wound care. The Administrator stated it was reported back to him the dressings and wound care was completed that day. The Administrator stated he expected nurses to ensure they are following doctor orders, not doing so placed Resident #67 at risk of infections and having to be sent out to the hospital for not addressing his need for wound care. The Administrator stated he did not have the full story of events and he did not investigate the incident; he did not feel he needed to because the wound care was completed . The Administrator stated that he expected Resident #67's wound care to have been completed in the mornings at the beginning of the 6:00 AM shift. The Administrator stated not providing wound care, when the wound is leaking and Resident #67 stated he did not feel well, and not checking on Resident #67 for the entire shift would be a form of neglect. Interview on 02/14/25 at 1:16 PM with the Physician revealed he was not made aware that Resident #67 had a change in condition, the Physician stated he expected to be notified by the facility if there was change in condition with residents. The Physician stated if the wound vacuum machine was beeping that indicated the wound vacuum needed to be checked. The Physician stated at that time the wound should be assessed with the possibility of the dressings to be changed . According the Physician waiting 10 hours could place the resident at risk of several things and the need to be sent to the hospital Record review of facility policy revised 10/05/16 titled Skin Integrity Management reflected: (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound care should be performed as ordered by the physician. Skin should be cleansed at the time of soiling and the routine intervals. The frequency of skin cleansing should be individualized according to need/and or resident preference. Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage. Record review of facility policy dated 2015 titled Physician Orders reflected to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and activities of daily living order for each resident. Record review of facility policy revised 03/11/23 titled Notifying the Physician of Change in Status reflected The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for immediate medical attention. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptom of signification change, time/date of call to physician, and intervention s that were implemented in the resident's clinical record. This was determined to be an Immediate Jeopardy (IJ) on 02/13/25 at 5:25 PM. The Administration was notified. The Administrator was provided the IJ template on 02/13/25 at 5:26 PM and a plan of removal was requested. The following plan of removal submitted by the facility was accepted on 02/14/25 at 1:40 PM and included the following: Plan of Removal Problem: F686 Failure to Prevent Pressure Ulcers Interventions: As of 2/13/25 resident #1 had a complete head to assessment performed by the Treatment Nurse As of 2/13/25 the wound MD was notified. The wound MD assessed and measured all of resident #1 wounds. No additional orders were received. All residents in the facility will receive a head-to-toe skin assessment. Wound treatments including wound vacs will be verified as completed according to MD orders by the Regional Compliance Nurse, DON, ADON. Completion date 2/13/25. Treatment nurse was educated on checking daily, Monday-Friday, to ensure that all wound care supplies is readily available. Completion date 2/14/25. All nurses were educated on the location of wound care supplies. If not available, they need to notify the DON and Administrator immediately. Completion date 2/14/25. The DON and ADON were in-serviced 1:1 on following topics by the Regional Compliance Nurse. Completed 2/13/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dressing Change Procedure- procedure to include wound vac dressings. Abuse and Neglect: failure to complete a dressing change according to MD orders including wound vacs could be considered abuse and neglect. Notification of Change in Condition: including notifying a MD for a change in a resident's condition. Resident Rights: to respect a resident's right to request care including dressing changes. The medical director was notified of the immediate jeopardy on 2/13/25. An ADHOC QAPI meeting was completed on 2/13/25 with IDT team including the Medical Director to discuss the immediate jeopardy and plan of removal. In-services: All nursing staff will be in-serviced on 2/13/25 regarding the following topics below by the and ADO, Regional Compliance Nurse, Administrator, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date 2/14/25. Dressing Change Procedure- procedure to include wound vac dressings. Dressing Supplies- all supplies needed for treatment services are in the medication room. Notify the DON and Administrator if not available. Abuse and Neglect: failure to complete a dressing change according to MD orders including wound vacs could be considered abuse and neglect. Notification of Change in Condition: including notifying a MD for a change in a resident's condition. Resident Rights: to respect a resident's right to request care including dressing changes. Monitoring of POR: Inservice Training Topic: Dressing Change Procedure - Procedure to include wound vac dressings. Abuse and Neglect: Failure to complete a dressing change according to MD order including wound vacs could be considered abuse and neglect. Notification of Change in Condition: including notifying MD for a change in a resident's condition. Resident Rights: to respect a resident's right to request care including dressing changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date and Time Conducted: 2/13/24. Instructor: Regional DON Attendees: Administrator, ADON A, ADON B, DON Inservice Training Topic: Wound Care Supplies Being Readily Available The wound nurse will ensure that all necessary wound care supplies are readily accessible for nursing staff. If staff encounter any difficulties in finding the supplies, she will guide them on where to locate the required items. From Monday to Friday, the wound nurse will verify that supplies are adequately stocked in the medication room, and on Fridays, she will also confirm that the supplies are prepared for the weekend. Date Conducted: 02/13/25. Instructor: Regional DON Attendees: LVN M Inservice Training Topic: Notification of Changes - see attached policy regarding notification of changes. Date Conducted: 02/13/25. Instructor: Regional DON Attendees to include MA P, MA EE, CNA F, CNA K, CNA N, CNA Q, CNA V, CNA X, CNA BB, RN D, RN GG, LVN H, LVN M, ADON A, CNA HH, CNA II, CNA JJ, CNA KK, CNA LL, CNA DD Inservice Training Topic: Abuse and Neglect Resident Rights Date Conducted: 02/13/25. Instructor: DON Attendees to include: ADON B, LVN H, CNA X, LVN BB, MA CC, MA EE, RN GG, CNA F, CNA JJ, CNA HH, RN D, MA P, CNA K, CNA Q, Med Rec, LVN M, CNA LL Inservice Training Topic: Wound Dressing Care and Changes (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date Conducted: 02/13/25. Instructor: Regional DON Attendees to include: ADON B, LVN H, LVN BB, MA CC, CNA LL, MA EE, RN GG, RN D, CNA N, CNA Q, CNA T, LVN M, ADON B, CNA AA, CNA DD Inservice Training Topic: A resident request a change to the wound vac, immediately address the resident, do NOT delay treatment. Call the DON and Wound Care Nurse if there are any issues in applying the wound vac. Monitor the wound vac for changes to suction, taping, leakage, tubing kinked and any other concerns. Operating Manual Revision Date: 2024-08-16 titled extriCARE 3000 Negative Pressure Wound Therapy System Date Conducted: 02/13/25. Instructor: DON Attendees to include: LVN I, LVN BB, ADON B, ADON A, LVN H, MA CC, MA EE, RN D, RN GG, CNA Q, CNA T Interviews conducted with the above staff indicated they had understanding to identify when a resident has a change of condition, signs of abuse/neglect, the need to honor resident rights. Nursing staff was able to reveal where wound care supplies were kept; how and who to notify to restock if items were low, and Nurses stated they understood how to complete wound care on residents with wound vacuums. The Administrator was informed the Immediate Jeopardy was removed on 02/14/2025 at 7:10 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two of six residents (Resident #67 and Resident #99) reviewed for accidents. 1. The facility failed to provide adequate supervision to prevent Resident #99, who had cognitive impairment and resided on the secure unit, from eloping from the facility on 02/03/25 when the resident pried open the window in his room and made it 0.9 miles away from the facility. An Immediate Jeopardy was identified on 02/12/25 at 3:50 PM. While the Immediate Jeopardy was removed on 02/14/25, the facility remained out of compliance at the severity level of Potential for more than minimal harm that was not immediate jeopardy and a scope of Isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. 2. The facility failed to provide adequate supervision and assistive devices to Resident #67 on 02/06/25 when he was not properly secured on the facility's van, which resulted in the resident falling backwards in his wheelchair and hitting his head on the floor of the van during takeoff in the facility's parking lot. Resident #67 was sent to hospital resulting where he was evaluated and treated for head injury and a contusion of the right hand . An IJ was identified on 02/13/25. The IJ template was provided to the facility on [DATE] at 5:20 PM. While the IJ was removed on 02/14/25, the facility remained out of compliance at a scope of Isolated and a severity level potential for more than minimal harm that was not Immediate Jeopardy, due to the facility's need to implement corrective systems. This failure could place residents at risk for severe injury or harm, decline in health, and decreased quality of life and death. Findings included: 1. Record review of Resident #99's Admission Record dated, 02/12/25, reflected the resident was a [AGE] year old male with an initial admitted [DATE] and readmitted [DATE]. Resident #99's diagnoses included: unspecified dementia, muscle wasting and atrophy, depression, and chronic kidney disease. Record review of Resident #99's Optional State Assessment MDS dated , 01/18/25, reflected the resident's original admitted [DATE] and readmitted [DATE]. Resident #99's MDS also reflected the resident was mildly impaired with a BIMS of 8. The MDS also reflected in Section E900 Wandering Frequency occurred 1 to 3 days per week. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #99's undated Care Plan reflected the resident was at risk for wandering and elopement as evidenced by dementia and previous elopement when the resident convinced the hospital to discharge him to home rather than the facility. The goal was for the resident to not leave the facility unattended using interventions such as distract resident from wandering by offering pleasant diversions, structed activities, food conversation, television, and book. The Care Plan also revealed if the resident was exit seeking, the staff were to stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc . Also, the care plan reflected that the staff were to use interventions such as supervise closely and make regular compliance rounds whenever Resident #99 was in his room. The Care Plan also reflected if the resident was using statements such as I'm leaving and I'm going home or attempted to elope from the facility or hospital, it was to be reported to the MD. Record review of Resident #99's progress notes dated 02/03/25 at 5:47 AM by the DON reflected Resident #99 left the facility through his room window and jumped the fence. Per the progress note, the resident was noted to not be in his room or in the secure unit at about 5:30 AM. Nurse was made the staff aware and they began looking for the resident. The resident was noted to have an open window, staff began looking outside. Resident #99 was discovered at the gas station down the road per the progress note. The progress notes also reflected the resident was missing 15 minutes. DON documented that Resident #99 gave no statement when he returned. Progress note reflected the RP was notified and the intervention would be one on one supervision. At 6:28 AM Progress Notes reflected LVN E attempted to redirect the resident, resident became aggressive and he stated he ready to leave. MD notified new order received, send to [hospital] ER emergency room for further evaluation. Resident put on one on one until EMS arrive. At 6:45 AM progress notes reflected that Resident #99 was transferred to a hospital initiated by an emergency transfer order per physician order documented by LVN E. Record review of progress notes 01/30/25 by PA reflected Dementia with elopement risk .requiring placement in a secure unit due to risk of elopement. Excessive seeking behavior noted. Continue placement in secure unit. Monitor behavior. Review of Resident #99's Elopement Evaluation dated 01/14/25 reflected Resident #99 was at risk for elopement. Interview on 02/11/25 at 10:04 AM with the Administrator revealed that immediately after the resident eloped, he in-serviced on elopement prevention, elopement, abuse/neglect, and resident rights with all staff. The Administrator stated that the CNA and nurse on the secured unit were responsible for making rounds on the residents every two hours. He stated that if a resident eloped from the facility, the resident had a risk of being hurt. The Administrator stated that since Resident #99's elopement, he daily made rounds in the secured unit and checked all the residents' windows to ensure they were properly secured. Administrator also stated that he checked the unit doors and ensured that they were alarmed and secured. The Administrator also stated that he checked the exit door's alarm to ensure that it worked correctly daily. The Administrator stated that he changed the door codes to the secured unit monthly also. The Administrator said that he conducted elopement drills on each shift as well. Interviews on 02/11/25 at 6:12 PM and 02/12/25 at 9:12 AM were attempted with Resident #99's RP but were unsuccessful because the RP did not return calls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview via phone on 02/11/25 at 6:33 PM with LVN G revealed that she was the nurse on the 200 and 300 halls when LVN E reported to her that Resident #99 was missing from the secured unit. LVN G stated the staff conducted a room-by-room head count, but they could not locate the resident. LVN G stated she then got into her personal car and drove the area and soon located the resident. Resident #99 was approximately . 9 miles away crossing the street in front of a local gas station. LVN E got out of her car and attempted to get the resident into her car. However, he became aggressive. LVN G revealed that Resident #99 had a dinner knife, a fork, and a shaving razor. Resident #99 began to swing at LVN G with his weapons and scratched LVN G on her arms and face. LVN G was not sure which item left the scratches on her. LVN G notified LVN E because she could not persuade Resident #99 to get inside her car. LVN E came immediately. Both nurses, LVN G and LVN E, stated that they were able to persuade Resident #99 to get inside LVN E's car, and she returned him to the facility. LVN G said that LVN E notified the Administrator, DON, and 911 that the resident was located. LVN G stated that if a resident eloped, they could fall. LVN G revealed that after this incident she was in-serviced on abuse/neglect, elopement procedures, and elopement response. Interview via phone on 02/11/25 at 6:49 PM with LVN E revealed that when she went in to give Resident #99 his medications at approximately 5:30 AM, he was not in his room. LVN E stated she checked his restroom, but he was not in it. LVN E said that she then asked CNA F where Resident #99 was located. CNA F told LVN E that she saw the resident in his room about 5:00 AM. LVN E said that she went to the room's window and raised the blinds. LVN E stated that she then observed the window screen lying on the ground. LVN E said at that point she came out and told the aide that the resident had jumped out the window. LVN E then alerted the staff and began a facility wide search for Resident #99. LVN E stated that she eventually found the Resident in the street near a local gas station walking. LVN E got Resident #99 into her car and took him back to the building where he remained on one-on-one supervision until transport arrived. LVN E stated that Resident #99's elopement was a surprise to her because she never heard him talk about leaving and had not seen him exit seeking. LVN E also said that Resident #99 was quiet and just enjoyed watching television in his room alone. LVN E stated that it was the nurse's and CNA's responsibility to make rounds in the secured unit. LVN E stated that if a resident eloped, they could be injured in the process of trying to elope, they could fall, or get run over. LVN E revealed that she was in-serviced after the elopement regarding elopement procedure, elopement precautions, and abuse/neglect. She stated that for an elopement, a code was called, and the facility participates in an all-staff search for the missing resident as well as conduct a head count for all residents to ensure safety of the remaining residents. LVN E concluded by stating that administration should be notified throughout the process. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview via phone on 02/11/25 at 7:23 PM with CNA F revealed that she heard a loud noise at approximately 4:40 AM that came from Resident #99' Room. CNA F stated that she thought it was Resident #99 coming out of his bathroom and the heavy door shutting. CNA F then said that she went into his room while making her rounds in the secured unit about 5:00 AM. Resident #99 was in his room in his bed. CNA F stated that the nurse went into Resident #99's room at about 5:30 AM to give him his medication. Then she was notified by the nurse that Resident #99 was not in his room or bathroom. CNA F stated that she stayed in the secure unit while the nurse left the unit to search for the resident. CNA F stated that she went into his room and observed his window up. CNA F stated she also observed his bedside table across the secured courtyard next to the privacy fence. CNA F revealed that the previous night when she arrived at the building and began her rounds, she spoke with Resident #99. CNA F said that Resident #99 was awake in bed and said that he was doing ok. CNA F said that it was all staff's responsibility to ensure that residents did not elope. CNA F said that she was in-serviced on abuse/neglect, elopement prevention, and elopement response beginning approximately 1 hour after the elopement. Interview via phone on 02/11/25 at 7:40 PM with LVN H revealed that Resident #99 was a quiet resident who isolated in his room. LVN H stated that she worked the night shift. LVN H said that she made rounds on the resident every two hours. LVN H also revealed that she never heard Resident #99 talk about eloping, and it was not passed down through report that he was exit seeking or talking about elopement. LVN H said that it was all the staff on the unit's responsibility to watch the residents to ensure that they do not elope. LVN H said that if residents elope, they could go missing. LVN H did not recall the elopement in-services following the resident's elopement. But she stated that staff was normally in-serviced following an elopement. Interview on 02/12/25 at 9:42 AM with CNA J revealed that Resident #99 was a quiet and pleasant resident who did not exit seek. CNA J also stated that Resident #99 did not discuss leaving the facility and did not pack his belongings. CNA J stated that she checked on Resident #99 every two hours and more often because the residents on the secure unit need more attention. CNA J also stated that the last time she showered the resident that she did not shave the resident. Therefore, she was unsure how he acquired a razor. CNA J said that she was unsure how Resident #99 had dining utensils because the CNAs and nurses check to ensure that utensils are with the trays when they pick them up from the residents. CNA said that Resident #99 did not have a Wonder guard on him that would signal if he eloped. CNA concluded by stating that there were no residents on the unit that were currently exit seeking. Interview on 02/12/25 at 9:43 AM with LVN I, who worked day shift, revealed that Resident #99 did not show signs of elopement. LVN, I stated that Resident #99 shaved himself. And therefore, Resident #99 could have placed the razor in his pocket. LVN I also revealed that because the Resident primarily stayed in his room and took all his meals in his room, he must have kept a dinner knife and fork from one of the trays. LVN, I stated that it was all staff's responsibility to keep staff safe and to ensure that utensils and razor are not kept by the residents. LVN, I said that residents could injure themselves or another resident if they kept utensils and razors. LVN I also stated that if residents eloped, they would risk not receiving their medications timely, being hurt, etc. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/12/25 at 11:36 AM with the DON revealed that Resident #99 usually stayed in his bed and watched television in his room in the secured unit. The DON stated the staff in the secured unit increased rounding on Resident #99 since his admission from the hospital to ensure he was comfortable, The DON stated that the windows in the secured unit are screwed in place so that the windows cannot be raised more than four inches. The DON stated that she did not think that Resident #99 would be capable of getting the screws out of the windows. The DON also said that the windows do not have alarms on them. Therefore, staff were not alerted when the window went up. The DON also stated that because the secured unit's door alarm systems was working correctly, there were no other measures in place to monitor the residents for elopements excluding the secured units entrance/exit door. The DON revealed that the risk to Resident #99's elopement was possible injury. The DON also stated that it was the nurse and the aide's responsibility on the unit to ensure that no elopement occurred, and residents were kept safe at all times. Interview on 02/13/25 at 10:17 AM with the Administrator revealed that he began to in-service all staff on 02/12/25 after the notification of the IJ at 4:00 PM on 02/12/25. The Administrator stated that he in-serviced all staff on elopement prevention, elopement response, and abuse/neglect. The Administrator revealed that the in-service was completed via a text service that went to all facility staff and copies were provided evidencing it. The Administrator also said that the DON and her staff spoke with the staff about the in-service topics before they began their shifts in addition to the text that went out to all facility staff. The Administrator said that as part of the elopement prevention, nurses were instructed to complete elopement assessments. The administrator stated that he made daily rounds and checked all the windows on the secured unit to ensure that they were secured and not tampered. The Administrator also stated that he tested the exit door alarm daily and will change the code monthly. The Administrator said that as part of his abuse/neglect in-service, he spoke with residents to ensure their needs were met. The Administrator revealed that as part of the elopement response in-service, the Administrator informed staff to immediately conduct a head count and then notify the staff in the building before beginning the search. The Administrator then said that the authorities were to be notified if the resident was not found in 30 minutes. The Administrator stated that the nurses were in-serviced to notify the family, the DON, Ombudsman, IDT , (Interdisciplinary Team) and the physician. Record review of the facility's revised January 2023 Elopement Response policy reflected: Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented. 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. 2. Determination of missing resident either by routine nursing rounds or door alarms: A. Note: A resident is determined to be missing when he/she leaves the facility without the staff's knowledge. C. A resident must demonstrate a free and willful intent to leave the facility without prior notification of staff or is a wandering, confused resident who leaves the facility unattended. 4. Should an employee discover the resident is missing from the facility (Code Orange), he/she should: Report to the charge Nurse .Make a thorough search of the building and premises. And if not located, contact the DON, RP, physician .Make and extensive search of the surrounding area. 6. If unable to located resident in the building, proceed as follows: B. Affected Area-Charge Nurse assigns staff to specific outside areas to ensure that all surrounding areas are searched. C. After 30 minutes, if the resident has not been found, the following calls must be made: .Report missing resident to the police . (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's revised January 2023 Elopement Prevention policy reflected: Every effort will be made to prevent elopement episodes while maintain the lease restrictive environment for resident who are at risk for elopement. 1. The Elopement Risk will be completed upon admission . Physical Plant 1. All facility exits what resident have access to will have a device in place to alert staff of elopement attempts. Examples include- Wanderguard Wander management Ssystem Placement of the residents' device to alarm the system will be verified each shift and documented on a treatment or other flow record Keypad exit magnetic locks. Keyed alarms Secured Unit Or a combination of the above .Staff Training. Staff will receive training during their orientation process and then annually regarding: Elopement prevention. Operation of all exit devices. Actions to take if elopement occurs . Record review of the facility's revised 05/09/17 Abuse/Neglect Policy reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Record review of in-services reflected: Elopement Response completed on 02/12/25, Elopement Prevention completed on 02/12/25, and Abuse/Neglect completed on 02/12/25. Record review of in-services completed prior to survey entry reflected: Elopement completed on 02/03/25, Elopement Prevention completed on 02/03/25, Abuse/Neglect completed on 02/03/25, and Resident Rights completed on 02/03/25. This was determined to be an Immediate Jeopardy (IJ) on 02/12/25 at 3:50 PM. The Administrator was notified of the IJ and was provided the IJ template on 02/12/25 at 4:00 PM and a plan of removal was requested. The following plan of removal submitted by the facility was accepted on 02/13/25 at 9:51 AM and included the following: Plan of Removal Problem: F689 Free from Accidents/Hazards/Supervision Interventions: Record review of elopement drills completed 02/03/25, 02/05/25, 02/07/25, and 02/10/25 reviewed on 02/19/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Administrator, DON, and/or designee will initiate an in-service regarding: a. Elopement Response b. Elopement Prevention c. Abuse/Neglect All staff scheduled to work through 02/12/25 will be in-serviced by end of day and prior to next shift worked. Completed. 2. The Administrator will conduct 3 elopement drills per week. Administrator began. 3. The Administrator, DON, and ADON were in-serviced by the ADO and Regional Compliance Nurse and completed as of 02/12/25 on Elopement Prevention Policy to include implementing interventions for residents at risk for elopement, Elopement Response Policy, and Abuse/Neglect. Completed on 02/10/25 at 0900, 02/03/25 at 0545, 02/05/25 at 1000, and 02/07/25 at 1600. By Administrator 4. Elopement Risks will be completed for all residents on the secured unit. Completed and provided. 5. AD Hoc QAPI Contributors will meet and review the elopement risk for all residents residing on the secured unit. Completed on 02/12/25. 6. All elopement events were reviewed by the facility QAPI committee members and are completed as of 02/12/25. 7. All elopement risk care plan interventions will be reviewed and have been completed/updated as of 02/12/25 by the Regional Compliance Nurse, DON, and ADON. All interventions are in place and care planned. 8. Administrator will monitor the locking mechanism on all the exit doors and windows in the secured unit (This question was confirmed as Question #1 by administrator on the Missing Resident/Elopement Monitoring form Week 2) on 02/13/25. 02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/10/25, 02/11/25, 02/12/25, 02/13/25, 02/14/25 - By Administrator 9. Administrator will review for 1:1 monitoring in the secured unit. Completed. 02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/10/25, 02/11/25, 02/12/25, 02/13/25, 02/14/25- By Administrator Only 02/03/25 had1:1 monitoring. 10. Through daily rounds and duties at least five times per week, observe for visitors allowing residents to exit the facility unsupervised. Completed. No issues noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/10/25, 02/11/25, 02/12/25, 02/13/25, 02/14/25- By Administrator 11. Change the door code monthly. Completed. Did not provide the date the code was changed. Only that it was changed. - By Administrator 12. The medical directed was notified of the IJ situation. Identified Residents at Risk: Only 1 resident was affected regarding this incident. The resident was not harmed as a result of this elopement. Systemic Changes: 1. The Administrator will monitor the residents' windows in the secured unit for signs of tampering. 2. The Administrator will also monitor the facility entrance and secured unit doors to ensure their locks are functioning properly as well as their alarms. 3. Elopement drills will be continued so that all shifts are prepared for elopements. Responsibility: It is the Administrator, or designee, and the Director of Nursing, or designee's responsibility to follow the actions and the systematic changes listed above. The Administrator, or designee, and the Director of Nursing, or designee, will report their findings of the above actions and systematic changes through their QAPI [Quality Assessment Performance Improvement] Process. Monitoring the Plan of Removal: The Administrator and DON in-serviced all staff on the following: 1. Elopement Response completed on 02/12/25. 2. Elopement Prevention completed on 02/12/25. 3. Abuse/Neglect completed on 02/12/25. Monitoring interviews for the Immediate Jeopardy were started on 02/13/25 at 10:00 AM and continued through 02/14/25 at 12:00 PM with 40 staff across all three shifts, including weekdays and weekends, including all departments. The staff were interviewed about elopement response, elopement prevention, and abuse/neglect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following staff's in-service logs were reviewed, and they were interviewed during the monitoring time frame. The were able to articulate what they were taught including the correct protocols and procedures related to elopement prevention, elopement response, and abuse/neglect: RN D, LVN E, CNA F, LVN G, LVN H, LVN I, CNA J, CNA K, MA L, LVN M, CNA N, CNA O, MA P, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, CNA W, CNA X, CNA Y, CNA Z, CNA AA, LVN BB, MA CC, CNA DD, MA EE, RN FF, Administrator, DON, ADON A, HR, Laundry Aide, Social Services, Housekeeping Aide, Activities Director, COTA, and Medical Records. 2. Record review of Resident #67's face sheet reflected the resident was [AGE] years old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #67's quarterly MDS assessment, dated 11/28/24, reflected a BIMS score of 14, which indicated his cognition was intact. His diagnoses included osteomyelitis (bone infection that causes inflammation and destruction of bone tissue), paraplegia (the inability to voluntarily move the lower parts of the body), neurogenic bladder (the bladder muscles and nerves do not function properly), anxiety disorder, pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) of unspecified buttock, unspecified stage and need for assistance with personal care. The MDS further revealed Section M - Skin Conditions - Skin and Ulcer/Injury Treatment indicated the resident's required pressure ulcer/injury care and surgical wound care. Record review of Resident #67's Care plan, revised date 01/29/25, reflected: Focus: [Resident #67] at risk for falls paraplegia. Goal: The resident will be free of falls through the review date. [Resident#67] will not sustain serious injury through the review date. Interventions: Anticipate and meet the resident's needs. Staff x 1 to assist with transfers. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 1:41 PM reflected Resident had a fall. Location: while on leave . Fall information: Hit Head. Cognition/Behavior at Time of Event: Oriented/no problem, Resident assisted to chair from the fall while in transport van, Resident stated hit his head, Resident stated blacked out, Physician Assistant on site, sent to emergency room for further evaluation. Appears and /or states to be in pain. Describes the pain as: continuous, chronic. Location of pain: head, right wrist pain relieving intervention used at this time: sent to emergency room for evaluation. Initial Treatment/New Orders: send to emergency room . Resident Statement: I hit my head and I want to go to the hospital. Record review of Resident #67's progress notes written by RN GG dated 02/06/25 at 2:51 PM reflected Resident #67 was transferred to a hospital on 02/06/25 at 1:55 PM related to transport van patient had fallen backwards in wheelchair, hitting head. Sent to hospital for evaluation. Record review of Resident #67's progress notes written by LVN G, dated 02/06/25 at 10:58 PM reflected At 8:17 PM. Resident #67 come back from hospital on non-emergency transportation on diagnosis of fall encounter Head injury, contusion of right hand. Initial encounter. Blood pressure 121/69, pulse 67, respiratory 18 saturation 98 percent, Alert, and oriented x 4, able to voice needs and concerns, did head to toe skin assessment. Change both hip dressing to Wet to Dry dressing, ongoing care, call light in reach. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #67's after visit summary dated 02/06/25 reflected Reason for visit: Fall, Diagnoses: Fall, initial encounter, Head injury, initial encounter, Contusion of right hand, initial encounter, History of paraplegia. CT head without contrast, chest x ray, hand x ray. Medications given: Oxycodone-acetaminophen, Instructions: Follow up with provider in two weeks around 02/20/25 if symptoms worsen. Record review of Resident #67's incident report dated 02/10/25 reflected Conclusion: resident in 3rd party transport van, his chair has no anti tippers or brakes. Resident fell backward due to inertia upon the driver taking off. Intervention: parts have been ordered for resident chair, and resident to use transport chair vs personal wheelchair. Therapy to screen. Interview on 02/11/25 at 11:37 AM with Resident #67 revealed on 02/06/25 he had a urology appointment and after he was loaded on the van, he fell backwards hitting his head. According to Resident #67 he had a headache and pain in his right hand from the fall. Resident #67 stated it was not the facility van driver, but an outside provider that was taking him to his appointment. Resident #67 stated he took off like a race car driver in the parking lot and I fell backwards, hitting my head on the floor, and blacked out. Resident #67 stated the van driver did not strap me down correctly, so when he took off, I fell backwards and hit my head, and was sent to the hospital. Interview on 02/13/25 at 12:28 PM the DON revealed she knew Resident #67 was scheduled for urology appointment on 02/06/25, she stated the facility van had other appointments, so he was to be transported by an outside transport provider. The Social Worker stated she did not see Resident #67 exit the building for his appointment. The DON stated she was alerted to come outside. When she got outside, she saw Resident #67 still in his wheelchair; straps were still attached. According to the DON she jumped in the van and removed 2 straps, she stated Resident #67 had to be removed from the chair so they could get the wheelchair out the van. Once the wheelchair was removed from the van, Resident #67 was placed back in the wheelchair, assessed and was one on one with nurse until the emergency medical services arrived to take him to the hospital. The DON stated Resident #67 was delirious and was not able to support his body while sitting in the wheelchair, he was not at his baseline , he complained of head pain and stated that he lost consciousness. The DON stated she did not speak to the Van Driver; she did not recall if an incident report was completed. According to the DON drivers were responsible for entering the facility to transport residents out and back inside upon returning to the facility. Interview on 02/13/25 at 2:47 PM with Social Worker revealed when residents require an outside appointment, they will leave notification for the Facility Transportation Driver to schedule the appointment with the provider and arrange transportation. According to the Social Worker, she was alerted by the Van Driver coming to the door saying, your patient has flipped out here in the van, the Social Worker stated at that point she alerted either the Administrator or the DON. The Social Worker stated when she got outside, she saw Resident #67 laying on his back yelling at the Van Driver you fucking dropped me, there was no way I was strapped in. According to the Social Worker Resident #67 and the Van Driver was going back and forth indicating Resident #67 was upset. The Social Worker stated she saw he was strapped in however could not tell if it was done correctly. She stated there was one strap on each front wheel but did not recall if the back wheels had any straps, she further stated there were straps caught in the wheels and it was a lot of trouble getting the straps out the wheelbase. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/13/25 at 3:07 PM with Facility Transportation Driver revealed she was responsible for scheduling appointments and transportation for residents who have appointments outside the facility. The Facility Transportation Driver stated when appointment times conflict it would become a need to outsource the transportation. The Facility Transportation Driver stated on 02/06/25 the facility van was booked with resident appointments, therefore she needed to outsource transportation for Resident #67's urology appointment. The Facility Transportation Driver stated she contacted Resident #67's insuran [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 2 residents (Residents #9 and #63) reviewed for dialysis. The facility failed to ensure dialysis communication forms for Residents #9 and Resident #63 were received back from dialysis center after returning from dialysis treatment on the dates mentioned below. The missing communication forms for Resident #9 totaling to 10 days on the following dates: 01/01/25, 01/03/25, 01/06/25, 01/08/25, 01/10/25, and 01/17/25, 02/03/25, 02/05/25, 02/07/25 and 02/10/25. Resident #63 was missing communication forms totaling to 12 days on the following dates: 01/01/25, 01/03/25, 01/06/25, 01/08/25, 01/10/25, 1/20/25,1/24/25, 01/29/25, 02/03/25, 02/05/25, 02/07/25 and 02/10/25. This failure could place residents at risk of inadequate communication between the facility and dialysis center. Findings included: 1. Record review of Resident #9's quarterly MDS assessment, dated 11/13/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #9 had a diagnosis of end stage renal disease (a chronic condition that occurs when the kidneys can no longer filter waste from the blood and requires long-term dialysis). She had a BIMS score of 15, which indicated her cognition was intact. The MDS reflected Resident #9 received dialysis. Record review of Resident #9's care plan, dated 01/25/25, reflected Resident #9 needed hemodialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly). The care plan reflected the following goals: [Resident #9] would have immediate intervention should any signs and symptoms of complications from dialysis occur through the review date. The care plan interventions reflected: Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis. Monitor/document/report PRN any signs and symptoms of infection to access site: Redness, Swelling, warmth or drainage. Record review of Resident #9's February 2025 physician's order reflected to monitor Arteriovenous shunt/fistula (a surgical procedure that creates a new pathway for fluid to flow) to (site) for thrill & bruit (A bruit is a sound and a thrill is a vibration that indicate a fistula is working properly) every shift notifies medical doctor/Nurse practitioner for any unusual/unexpected findings. Record review of Resident #9's EHR on 02/13/24 reflected nursing documentation regarding Resident #9's pre- and post-dialysis vital signs but missed any communication from dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's dialysis communication forms for 01/01/25 to 01/31/25 reflected dialysis communication form dated 01/13/25, 01/15/25, 01/20/25, 01/22/25, 01/24/25, 01/27/25, 01/29/25 and 01/31/25, all the other dialysis dates of the month of January 2025 were missing communication forms totaling to 6 days in January 2025 on the following days: 01/01/25, 01/03/25, 01/06/25, 01/08/25, 01/10/25, and 01/17/25. Record review of Resident #9's dialysis communication forms for 02/01/25 to 02/14/25 reflected dialysis communication form dated 02/12/25. All the other dialysis dates of the month of February 2025 were missing communication forms totaling to 4 days in February 2025 on the following days: 02/03/25, 02/05/25, 02/07/25 and 02/10/25. 2. Record review of Resident #63's admission MDS assessment, dated, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and a readmission of 01/18/2025. Resident #63 had a diagnosis of end stage renal disease (a chronic condition that occurs when the kidneys can no longer filter waste from the blood and requires long-term dialysis). He had a BIMS score of 05, which indicated his cognition was severely impaired. The MDS reflected Resident #63 received dialysis. Record review of Resident #63's care plan, dated 08/30/24, reflected Resident #63 needed dialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly) rule out renal failure. The goals reflected Resident #63 would have immediate intervention should any signs and symptoms of complications from dialysis occur through the review date. The resident will have no s/s of complications from dialysis through the review date. The care plan interventions included: Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis. Check and change dressing daily at access site. Monitor/document/report to MD PRN any signs and symptoms of infection to access site: Redness, Swelling, warmth or drainage. Record review of Resident #63's February 2025 physician's order reflected to monitor Arteriovenous shunt/fistula (a surgical procedure that creates a new pathway for fluid to flow) to (site) for thrill & bruit (A bruit is a sound and a thrill is a vibration that indicate a fistula is working properly) every shift notifies medical doctor/Nurse practitioner for any unusual/unexpected findings. Record review of Resident #63's EHR on 02/13/25 reflected nursing documentation regarding Resident #63's pre- and post-dialysis vital signs but missed any communication from dialysis center. Record review of Resident #63's dialysis communication forms for 01/01/25 to 01/31/25 reflected dialysis communication form dated 1/22/25,1/27/25, and 01/31/25, all the other dialysis dates of the month of January 2025 were missing communication forms totaling to 8 days in January 2025 on the following days: 01/01/25, 01/03/25, 01/06/25, 01/08/25, 01/10/25, 1/20/25,1/24/25 and 01/29/25. Record review of Resident #63's dialysis communication forms for 02/01/25 to 02/14/25 reflected dialysis communication form dated 02/12/25. All the other dialysis dates of the month of February 2025 were missing communication forms totaling to 4 days in February 2025 on the following days: 02/03/25, 02/05/25, 02/07/25 and 02/10/25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/11/25 at 02:18 PM with Resident #9 revealed she went for dialysis Monday, Wednesday, and Friday. She stated she got a form that she took to dialysis and brought back to the facility. She stated she got checked for her vital signs when she left for dialysis and when she came back from dialysis. Interview on 02/11/25 at 01:26 PM with Resident #63 revealed he went for dialysis Monday, Wednesday, and Friday. He stated he got a form that he took to dialysis and brought back to the facility. He stated his vital signs were checked when he left for dialysis and when he came back from dialysis. Interview on 02/14/25 at 09:41 AM with RN D revealed she was aware Resident #9 and Resident#63 went for dialysis Monday, Wednesday, and Friday. She stated she was supposed to send Resident #9 and Resident #63 with the dialysis communication form when they left for dialysis and then collect the form when the resident's returned from dialysis. RN D stated she knew she was supposed to monitor the dialysis access site for the bruit thrill (a vibration caused by blood flowing through the fistula and can be felt by placing fingers just above incision line), dressing for bleeding and vital signs when Residents #9 and Resident #63 were back from dialysis which she does and document in the progress notes. She stated it was nurse's responsibility to collect the dialysis communication forms when Resident #9 and Resident #63 came back and filed them. RN D stated they were supposed to call the dialysis clinic and follow up if communication forms were not sent back with residents. She stated the importance of the dialysis communication forms was continuation of care between the dialysis and facility. Failure to follow up on the communication form after dialysis was completed could cause them to miss the orders and recommendations and treatments from dialysis center. She stated she had done trainings on dialysis communication form. Interview on 02/14/25 at 9:54 AM with the ADON A revealed her expectation was, nurses were supposed to fill out the forms with the residents' pre-dialysis vitals, and the form would be taken to dialysis by Resident #9 and Resident #63. She stated she expected the nurses to collect the form after dialysis, perform vital signs, and document on communication forms and put the communication forms on the binders to be uploaded. She stated the importance of the communication form was communication between the facility and dialysis center on new orders, treatment given, and any change of condition. She stated she had checked on the binders and had noticed the communication forms were missing after the surveyor brought it to her attention. She stated she was responsible of ensuring nurses were completing the forms, monitoring vitals pre and post dialysis. She stated the last time she checked the binders, was on 02/14/25 after she was notified the communication forms were missing. She stated the risk of not having the communication form brought back from dialysis was omission of orders and not knowing what medications were administered at the dialysis center. Interview on 02/14/25 at 2:27 PM with the DON revealed her expectation was for the nurses to check vitals before and after dialysis and document on the communication form. She stated she expected nurses to send Resident #9 and Resident #63 with a communication form and get it when back from dialysis and if forms are not sent back with Resident nurse should follow up with dialysis center. She stated the failure to collect the forms back from dialysis where they could miss important orders from dialysis and the treatment given at dialysis. She stated the ADON's were responsible of following up to ensure the staff were getting the communication forms back from dialysis. She stated the facility had done training with staff and provided a record dated 02/13/25 on dialysis policy that addressed dialysis monitoring of vitals before and after dialysis and documentation. Record review of the facility's Dialysis policy, dated November 2023, reflected the following: (continued on next page)

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	675028	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates Healthcare and Rehabilitation Center	201 Sycamore School Rd Fort Worth, TX 76134

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.19.This facility will monitor departures and returns from the dialysis center. The facility will document the resident vital signs, general appearance, orientation, and additional baseline data as needed. The resident's clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of three medication carts (300) and 3 of 3 residents (Residents #7,#147, and #178) reviewed for pharmacy services. 1. The facility failed to ensure the 300 Hall nurses' medication cart contained accurate narcotic logs for Resident #7, #147 and #178 on 02/12/25. 2. The facility failed to ensure expired medications , 1 bottles of atropine 0.1% with expiration dates of August 2024 was removed and destroyed form 300 hall nurses cart on 02/12/25. These failures could place residents at risk for medication errors, drug diversion, and ineffective drug therapy. Findings included: 1. Record review of Resident# 7's Quarterly MDS Assessment, dated 12/10/24, reflected the resident was [AGE] year-old female readmitted to the facility on [DATE] with original admission on 06/16/2011, with diagnoses that included anxiety (common mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life). The resident had mild impaired cognition with a BIMS score of 11. Record review of Resident #7's physician's orders dated 11/15/24 reflected an order for the resident to receive Lorazepam Oral Tablet 1 MG. Give 1/2 tablet to 2 tablets by mouth every 2 hours as needed related to anxiety disorder. Record review of Resident # 47's Quarterly MDS assessment, dated 01/01/25, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome (a condition characterized by persistent pain that lasts for at least 3-6 months and significantly impacts a person's life). The resident had intact cognition with a BIMS score of 15. Record review of Resident #47's physician orders dated 12/12/24 reflected an order for the resident to receive Hydrocodone-Acetaminophen oral tablet 10-325 mg. Give 1 tablet by mouth every 8 hours, as needed for pain. Record review of Resident# 178's entry MDS assessment, dated 02/07/25, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included pain. The resident BIMS score not completed Resident #178 was newly admitted . Record review of Resident #178's physician orders dated 02/08/25 reflected an order for the resident to receive Hydrocodone-Acetaminophen oral tablet 10-325 mg. Give 2 tablet by mouth every 4 hours, as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and record review on 02/12/25 at 2:12 PM of 300 Hall nurses' medication cart and the Narcotic Administration Record, with RN C, revealed Resident #7's Narcotic Administration Record for lorazepam 1 mg reflected a total of 13 pills remaining, while the blister pack count was 12 pills. It was last administered on 01/20/25 at 9:30 PM. It also revealed Resident#47's Narcotic Administration record Hydrocodone-Acetaminophen oral tablet 10-325 mg reflected a total of 7 pills remaining, while the blister pack count was 6 pills. Last administered on 02/10/25 at 07:41 AM. It also revealed Resident#178's Narcotic Administration record Hydrocodone-Acetaminophen oral tablet 10-325 mg reflected a total of 38 pills remaining, while the blister pack count was 36 pills. Last administered on 02/11/25 at 8:00 AM.RN C was observed to remove lorazepam 1mg 1/2 tablet in a cup covered with another cup that was not labelled in her pocket. 2. Observation on 02/12/25 at 2:45 PM of the 300 Hall medication cart with the RN C revealed 1 bottle of atropine 1 % with expiration date of 8/8/24 . Interview with RN C on 02/12/25 at 2:45 PM revealed she popped Lorazepam 1mg 1/2 tablet put in a cup and she had not administered to Resident #7 before lunch because she had realized she had popped, and it was not meant for her. RN C stated she forgot to notify the other nurse for destruction. She took residents to dining for lunch and she forgot. She stated when she saw this surveyor checking the carts that was the time she removed from the cart and put it in her pocket. She stated she had administered Hydrocodone-Acetaminophen oral tablet 10-325 mg I (one) tablet, to Resident #47 as needed every 8 hours, and she had not signed off on the narcotic administration record log. She had also administered Hydrocodone-Acetaminophen oral tablet 10-325 mg 2 tablets to Resident #178 as needed every 8 hours, and she had not signed off on the narcotic administration record log. She stated she knew she was supposed to sign-out on the narcotic count sheet after administration and on the Medication Administration Record, but she did not. RN C stated the failure to log off could lead to overdose since the person that came after her would not be able to tell when the narcotic was administered. She stated failure to label the cup and keeping the medication in a cup could lead to missing a dose and administering to wrong resident leading to medication error. RN C also stated she was responsible of checking her cart every shift for the expired medications, but she forgot to check. She stated the risk of having expired medication in her cart was adverse effect if administered. She stated she had completed an in-service on Medication administration. Interview on 02/13/25 at 9:44 AM, the ADON B stated her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log. She stated she also expected RN C to assess the Resident #7 before she popped Lorazepam 1mg 1/2 tablet and if she had made a mistake to call her or any other nurse they destroy and not to put in cup in her pocket. She stated it was her responsibility to audit the carts weekly and if there was an issue she audited daily. She stated she had last checked the cart on 02/4/25. The ADON stated failure to document after administration and destroying after refusal or popping by mistake could lead to drug diversion, missing of a dose, overdose and residents not getting therapeutic effects. She stated facility had done trainings on medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/13/25 at 1:34 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log. She stated nurses should not be pulling medications if the resident had not asked for it. She stated she asked RN C why she had not destroyed the medication that she had accidentally popped, and she did not give her a varied answer. She stated she expected RN C to label the cup, repull the right medication and then destroy the other one with a witness but not keeping in her pocket. DON stated failure to document could lead to overdose and effect on resident management. She stated ADONs were responsible for auditing the medication carts. She stated the facility had done training on medication administration and trainings dated 10/4/24 and 01/08/24 and RN C was not in attendance. Record review of facility policy entitled Medication Administration procedures , dated 10/25/17, reflected the following: 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. 17.If a controlled medication removed from its packaging and is not to be administered (resident refusal or contamination) the dose needs to be wasted to where the drug is unable to be used and /or destroyed and disposed of. If controlled medication is wasted, it must be documented on the controlled accountability sheet for the medication and witnessed by a nurse. Both staff members must sign on the accountability sheet verifying the drug was wasted. Record review of the facility's Storage of Medications policy, dated 2003, reflected the following: Did not address expired medications removal from the carts .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42859 Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored securely and had acceptable labeling for one (Halls 200 nurses Medication Cart) of three medication carts reviewed for labeling and storage. The facility failed on 02/12/25 to ensure insulin vials were dated after they were opened and were not dated with wrong dates located on the medication cart for the 200 hall. This failure could place residents at risk of not receiving the therapy needed. Findings included: Observation on 02/12/25 at 1:55 PM of the nurses' medication cart used for Hall 200 back with RN C revealed one insulin vial of Humalog 100 unit/ml which was opened, partially used, and not labeled with the open date. There was also one vial of Levemir dated 5/11/25 that had been opened and partially used on the cart. Interview on 02/12/25 at 2:38 PM with RN C, who was the charge nurse for Halls 200 , revealed she knew insulin pens/vials were supposed to be dated once they were opened or after they were removed from the refrigerator and placed on the cart with an opening date. She stated she knew she was supposed to check the cart every time she reported to work to ensure insulins pens were labeled and dated and those that were expired to be discarded, but she did not check her cart that morning. She also stated failure to label and date insulin with opened dates would not allow staff to notice when it expired, and they could continue to administer expired medications and the blood sugar levels would not be controlled. She stated she had been trained on labeling, storage and putting the open date but she could not tell when. Interview on 02/13/25 at 9:50 AM with ADON B revealed, her expectation was all nurses to check their cart for labelling and expired medications. She stated she expected the nurse to date insulin when opened. She stated it was her responsibility to check the carts and ensure insulins were dated and labeled weekly. She stated she last checked the carts on 02/4/2025. She stated the risk of not putting the opening date and putting wrong dates on insulin vials/pens was that they cannot tell when they expire and if administered, they might not meet the therapeutic effects as expected. She stated she had done in-service on labelling and storage, but she did not provide any training records. Interview on 02/13/25 at 1:34 PM with the DON revealed it was her expectation that staff dated the insulin pens once they pulled them from the refrigerator, but it was all nurses responsibility to check the carts and ensure insulins were dated and labeled. She stated it was the responsibility of ADON to monitor and ensure the nurses were labelling and discarding the expired medications weekly. She stated if the staff were not putting the opening dates on the insulin pens and vials, it placed residents at risk of having reactions like the medication being ineffective since they could not tell of the potency. She could not provide any documentation on trainings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled Medication that must be dated when opened or storage condition changed, dated 2003, reflected: All the medications below should have date opened written on the medication and /or container it arrived in. Insulins (vials, cartridge, pens) keep refrigerated until needed for use. Expiration is based on manufactures recommendations after opening and /or stored at room temperature.recommendations after opening and /or stored at room temperature.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview, and record review the facility failed to provide specialized rehabilitative services for 1 (Resident #2) of 3 residents reviewed for specialized rehabilitative services. The facility failed to ensure Resident #2 received a speech therapy evaluation as per physician orders dated 01/28/25. This failure could place residents with orders for therapy at risk of not meeting their highest practicable well-being. Findings included: Record review of Resident #2's Nursing Home Comprehensive Item Set MDS dated [DATE] reflected Resident #2's initial admitted [DATE] and readmitted [DATE]. Resident #2's diagnoses were non-traumatic brain dysfunction, non-Alzheimer's dementia (common type of dementia), malnutrition, and aphasia (rare type of dementia where language is heavily affected). Resident #2's MDS also reflected that Resident #2 had severe cognitive impairment. MDS reflected that Resident #2 began receiving occupational therapy in 10/17/24 with no end date. MDS did not reflect that she received speech therapy or physical therapy. Record review Resident #2's Care plan dated 02/14/25 reflect: Focus: Potential Risk for Malnutrition. Goals: Maintain Stable weight and nutritional parameters. Interventions: Monitor and document meal intake, monitor resident weights, Monitormonitor resident's labs, Notify the physician for any negative findings, abnormal labs, or resident non-compliance, Offer diet as ordered by the physician, Update food preferences as needed. Record Review of Resident #2's Progress Note dated 01/24/25 by the Registered Dietician reflected Recommend speech evaluation. Record Review of Resident #2's Physician's orders documented the following order: On 01/28/25 ST eval and treat as indicated. Dietician Recommended. Interview on 02/14/25 at 3:26 PM with facility Speech Therapist revealed that she did not receive a referral from the facility for Resident #2. The Speech Therapist stated that the director of rehabilitation normally received the order for rehabilitation and passed it to her so that she could complete the initial screening after the facility's morning meeting. The Speech Therapist stated that normally if there was a conversation in the daily meeting, the director of rehab would inform her so that she could retrieve the facility communication form that the facility administration completes on a resident that would be receiving speech therapy. However, the Speech Therapist stated that she never received a communication form. And she was never informed by the director of rehabilitation that the resident had an order for speech therapy. The facility Speech Therapist stated that the resident's lost time in speech therapy could lead to a larger weight loss. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/14/25 at 4:27 PM with the DON revealed that the dietician would complete a communication order and send it to the DON with their recommendation. Then the DON would forward the recommendation to the doctor who would then approve (or not approve) the order. However, the DON stated that she never received the dietician's recommendation for Resident #2. The DON said that the regional compliance nurse put the doctor's order in the EHR on 01/28/25. The DON stated that she was unsure how the regional nurse received Resident #2's dietary order. The DON stated that it was possible for the resident to have continued poor nutrition, choking, etc. if she did not receive the speech screening as ordered by the doctor. Interview on 02/14/25 at 5:52 PM with the Registered Dietician revealed that she wrote the dietary recommendation for Resident #2 on 01/24/25. The Registered Dietician stated that she emailed a copy of the recommendation to the Administrator, DON, ADON, Dietary Manager and MDS Coordinator. The Registered Dietician stated that without the recommended screening the resident was at risk for further weight loss. The Administrator revealed there was no facility policy regarding therapists following physicians' orders. The Administrator stated in an email on 02/18/25 at 2:58 PM that the facility follows physician orders as the physician signs the orders for evaluation, clarification orders for frequency, as well as evaluations and recertifications.