STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 24 residents (Resident #17) reviewed for abuse. The facility failed to ensure CNA Z did not abuse Resident #17 on 04/30/2026 during incontinent care. An IJ (Immediate Jeopardy) was identified on 04/30/26. The IJ template was provided to the facility on [DATE] at 4:50 PM. While the IJ was removed on 05/01/26, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal. This failure could place residents at risk for abuse, physical harm, mental anguish and emotional distress.Findings included: Review of Resident #17's quarterly MDS dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart failure, hypertension (high blood pressure), end stage renal disease (the final permanent state of kidney failure), Alzheimer's disease, stroke, and non-Alzheimer's dementia. The resident had a BIMS of 0 which indicated his cognition was severely impaired. The MDS reflected Resident #17 did not have any behaviors. The MDS indicated the resident was dependent on ADLs. Review of Resident #17's care plan initiated on 04/14/25 reflected the resident had ADL self-care performance deficit. Interventions included the assistance of 1 staff member for ADLs. Review of Resident #17's event nurses' note dated 04/30/26 documented by RN D reflected the following: .Resident reported that the previous night a tall man slapped him on his cheeks. Resident denied pain at this time. Head to toe assessment completed, normal skin color, vital signs within normal limit. No visible signs of bruises or swelling/injury at this time.Review of Resident #17's skin assessment dated [DATE] documented by ADON J indicated there were no bruises, skin tears, abrasions, or lacerations. Observation of Resident #17's video footage the morning of 04/30/26 at 4:57 AM revealed CNA Z entered Resident #17's room, turned on the light and removed the resident's covers and did not speak to the resident. CNA Z raised the resident's bed. Resident #17 was lying on his back and CNA Z was seen grabbing the resident's wrists and forcefully and aggressively turning the resident on his left side and CNA Z put his right hand on the resident's shoulder and forcefully put all of his weight on his left shoulder while he removed the resident's brief all while the resident yelled out in distress. Resident #17 is then seen on his back again and is heard saying to CNA Z what did I do, what did I do and the CNA did not respond. CNA Z then got a clean brief and pushed the resident to his right side and with his left hand held on to the resident's knees and with his right hand grabbed Resident #17's right wrist and again forcefully and aggressively yanked the resident onto his left side and part of the resident's upper extremity is seen hitting the left repositioning side rail all while the resident continued to moan. As CNA Z attempted to put on Resident #17's clean brief, the CNA grabbed both of the resident's wrists, crossed them across his chest, pulled the resident's gown over his wrists and held the resident down with his right hand while his left hand adjusted the brief while the resident continued to moan. The resident's hand remained with the gown over them and CNA Z was seen grabbing the resident's ankles and slightly throwing them to the center of the bed. CNA Z then grabbed the blankets and covered the resident back up, lowered the bed and the resident is heard saying again, what did I do (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and continued to moan. During the entire incident, CNA Z did not speak. Observation and interview on 04/30/26 at 11:28 AM of Resident #17 revealed he was in his room sitting in his wheelchair while family visited. The resident was asked about the incident, and he said a man had entered his room last night and beat him as Resident #17 pointed to his right face. There did not appear to be any injuries noted to his face at the time. Resident #17 said it made him feel fearful of the man and during the incident, he kept asking the man why he was doing that to him because he did not know him. The resident said he continued to yell out and cry, but the man did not stop and he did not want that man in his room again. The Resident's family said they were called and told about the incident and were asked to review the camera and that is when they saw the aide (CNA Z) mistreat the resident during care. The family stated they often reviewed the camera and had never witnessed that type of abuse and the resident had never mentioned any type of mistreatment. Interview on 04/30/26 at 12:33 PM, CNA I stated that morning (04/30/26) as he got Resident #17 up to change him, MA AA was in the room with the resident when he said that a tall man had went into his room and held him down and hit him. CNA I said he did not see any injuries or bruises on the resident. CNA I said Resident #17 repeated his story and it remained consistent, so they reported the incident to the Administrator and the DON. CNA I said Resident #17 was not combative during care and allowed staff to provide care. He stated Resident #17 was alert and oriented and had never made that type of allegation.Interview on 04/30/26 at 12:51 PM, CNA Z stated he went in to change Resident #17 during his last round and the resident was a little combative during care. He said he did get a little rough and restrained the resident while he put on the resident's brief. CNA Z stated he forcefully and aggressively turned the resident on his side and put his weight on the resident and CNA Z also admitted he restrained the resident's hand to his chest and the aide said he did that because the resident had a history of resisting care. CNA Z said if a resident became combative, they were to stop providing care and report to the nurse. CNA Z said he probably should have stopped when the resident was yelling and asking him to stop but he was used to the resident being combative so that is why he did it. Surveyor observation on 04/30/26 at 1:30 PM of Resident #17 a full body assessment of Resident #17 performed by the DON and RN D revealed the resident did complain of pain. The resident did not have any bruising, redness, or deformity to his back, shoulders, chest, or wrists. Resident #17 did not display any aggression and was very cooperative and did not appear afraid of staff. Interview on 04/30/26 at 2:37 PM, RN D said he was told by CNA I and MA AA that Resident #17 said a tall man has hit him on the cheek. RN D said he went into the room to talk to Resident #17, and the resident told him that a tall man had beat him up last night and said he hit his cheek. RN D said he reported the incident to the Administrator and the DON. He said he performed a head-to-toe assessment of Resident #17 and he did not have any injuries. RN D said the resident was very cognitive and had never made any similar type of allegation. RN D stated Resident #17 was not combative during care. Interview on 04/30/26 at 3:29 PM, LVN BB stated she worked that morning (04/30/26) and she did not hear any resident yell or hear any resident that appeared to be in distress.Interview on 04/30/26 at 5:01 PM, with MA AA stated that morning (04/30/26) she went into Resident #17's room to take his vitals he refused and said mama I got to tell you something, the man beat me up last night and I was crying asking him what I had done to deserve that but he kept going and it didn't make him stop. MA AA said she thought the resident was dreaming when he made the comment, but the resident continued to repeat the story. She said at that time CNA I entered the room and heard what the resident said. MA AA said they reported what Resident #17 said to the Administrator and the DON. MA AA stated it was not normal for the resident to make that type of statement. She said she had never provided the resident with direct care other than giving him his medication, but he was always compliant and no one had mentioned the resident was combative during care. Interview on 04/30/26 at 5:28 PM, CNA CC stated she provided care for Resident #17 and he had never been combative during care. She said he was always compliant and never tried to reach out to grab anyone. Interview on 05/01/26 at 5:37 AM, CNA R stated she has worked that morning (04/30/26) and she did not hear (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	any resident yell or cry during her shift. She stated she did not see any resident that appeared to be in distress. Interview on 05/01/26 at 6:22 AM, the DON stated CNA I and MA AA made her aware the morning of 04/30/26 that Resident #17 had told them a tall man had hit him in the face during the night. The DON said she then let ADON J and the Administrator know and they both (ADON J and Administrator) went to speak with the resident and the resident's story remained consistent with what he had told everyone else. The DON said they called Resident #17's family and asked them to review the camera footage and the family showed them and they were able to see CNA Z being very aggressive while he provided care. The DON said CNA Z was suspended pending the investigation and immediately terminated once they were able to view the video. The DON said Resident #17 had never made that type of comment in the past and the resident was not combative during care. Interview on 05/01/26 at 8:05 AM, ADON J stated she was told Resident #17 had told CNA I and MA AA that a tall black man had beat him so she (ADON J) and the Administrator went to talk with the resident and his story remained consistent with what he had told everyone else. She said the family was then contacted so they could review the footage and they saw CNA Z was very rough, tugging the resident and forcibly holding Resident #17 down during care. ADON J said CNA Z was terminated after they watched the video while they continued with the investigation. ADON J said no one had ever reported to her that Resident #17 was combative during care. Interview on 05/01/26 at 8:27 AM, the Administrator said MA AA told her that Resident #17 told her someone had gone into his room during the night and beat him up and he described him as a tall black man. The Administrator said she and the DON went to speak with the resident and his story had remained consistent so the family was contacted so they could review the camera footage. The Administrator said the video showed CNA Z was abusive to Resident #17 during care and CNA Z was then terminated. The Administrator said CNA Z denied the allegations when she called to get his statement. Review of the facility's policy titled Abuse/Neglect revised 03/2018 reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property exploitation.This includes but Is not limited to freedom of corporal punishment, involuntary seclusion, and any physical or chemical restraint.Resident should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies.The facility will provide and ensure the promotion of resident rights.An Immediate Jeopardy/Immediate Threat was identified on 04/30/26. The Administrator, DON and the Regional Director of Operations were notified of the Immediate Jeopardy on 04/30/26 at 4:45 PM. The IJ template was provided to the facility on [DATE] at 4:50 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 04/30/26 at 8:52 PM and reflected the following: Interventions: CNA was suspended on 04/30/26 by the Administrator, terminated and reported to the nurse aide registry. Completed 04/30/26. Resident #1 had a head-to-toe assessment completed by the charge nurse. No injuries noted. Completed 04/30/26. Weekly skin assessment was completed on all residents by DON/ADON/Compliance Nurse. Completed 04/30/26. A Trauma informed care assessment was completed by charge nurse on resident #1 and documented in the chart. No new findings were assessed. Completed 04/30/26. On 04/30/26, safe surveys were completed for all residents who are able to be interviewed by the Social Worker. No additional allegations of abuse from residents were disclosed. Completed 04/30/26. On 04/30/26 staff interviews were conducted by the Department managers. No additional allegations of abuse towards residents were disclosed. Completed 04/30/26. The medical director was notified of the immediate jeopardy by the Administrator on 04/30/26. An ADHOC QAPI meeting was completed with the Administrator, Regional Compliance Nurse, IDT Team and Medical Director to discuss the immediate jeopardy and plan of removal. Completed 04/30/26.Monitoring Monitoring Tools for actual/alleged abuse will be completed by Admin/DON. Admin/DON will interview 15-20 staff members per week about situational questions related to abuse. Monitoring will be on-going to prevent further abuse. Social Worker will complete 5 resident interviews per week about how staff is (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	treating them. Monitoring will be on-going to prevent further abuse. Weekly skin assessments will completed on all residents to rule out abuse. The Administrator, DON, ADON were in-serviced 1:1 by the ADO on the following policy. Completed 04/30/26.Abuse and Neglect Policy - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology.Trauma Informed Care PolicyIn-services: The following in-services were initiated by Regional Compliance Nurse, Administrator, and ADON for all staff. Any staff member not present or in-serviced as of 04/30/26 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All PRN, agency staff, or staff on leave will in serviced prior to assuming their next assignment. Completion date 04/30/26.Abuse and Neglect Policy - Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Trauma Informed Care Policy Pain Management Notification of Change Customer Service and Bedside CareMonitoring of facility's Plan of Removal included the following:Review of the resident skin assessment completed on 04/30/26 of all the residents did not reflect any issues/concerns.Review of Resident #17's Trauma Informed Care assessment dated [DATE] reflected the following: No previously documented diagnosis of mental disorder, psychological adjustment difficulty, or trauma.Have a diagnosis of PTSD: NoExperiences:Reports no known negative experiences.Has the resident been in a situation that was extremely frightening: NoHas the resident witnessed any extremely frightening situations: NoDoes or has the resident have a close relationship with someone who experienced any extremely frightening situations: NoInterview from 04/30/26 to 05/01/26 with 10 alert and oriented residents revealed they felt safe and did not have any concerns of abuse from staff. Review of the in-services on 05/01/26 completed on 04/30/26 revealed all staff were re-educated on Trauma Informed Pain Management, Notification of Change, Customer Service and Bedside Care. Interviews on 04/30/26 at 12:33 PM to 05/01/26 at 8:29AM with staff from various shifts were Administrator, DON, ADON J, MDS Coordinator L, MDS Coordinator M, Treatment Nuse, Activities Director, RN D, MA E, MA F, CNA G, CNA H, CNA I, CNA N, LVN O, LVN P, LVN Q, CNA R, CNA S, Housekeeping T, CNA U, MA V, LVN W, CNA X, CNA Y, MA AA, LVN BB, CNA CC, RN DD, CNA EE, PTA FF, MA GG, Dietary Manager, CNA HH, HR Coordinator, Medical Records, Floor Maintenance, CNA JJ, and CNA KK All staff were able to identify the following:- The different types of abuse and who to immediate report to. They were to report to the Administrator and if she were not available, they were to report to the DON- Signs/symptoms of pain in residents and who report to.- Identify resident change in condition and who to immediately report to.- Customer service and proper bedside manner during care- Education on trauma informed care and ensure all residents who are trauma survivors receive competent trauma informed care and eliminate triggers that may cause re-traumatization of the residentAn IJ was identified on 04/30/26. The IJ template was provided to the facility on [DATE] at 4:50 PM. While the IJ was removed on 05/01/26, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the plan of removal.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide a private meeting space for the residents' monthly council meetings for 15 of 15 confidential residents reviewed for resident council. The facility failed to provide a private space for resident council meetings.This failure could place residents, who attended resident council meetings, at risk of not being able to voice concerns due to a lack of privacy. Findings included:Observation and interview on 04/29/26 at 9:30 AM during a confidential resident group meeting with 12 residents, revealed the resident council meetings were held once a month in the dining room. There were two entrances to the dining room, and both doors were closed and the Activity Director posted do not enter signs on each door. During the meeting three staff members entered the dining room even with the signs posted on the door. The residents stated being interrupted during their resident council meetings was a frequent occurrence and they felt like they could not speak freely with the staff interruptions. Interview on 04/30/26 at 6:25 PM, the Activity Director stated staff interrupted the resident council meetings by entering or attempting to enter the dining room and she would ask the staff to leave. She said the expectation was that no staff should enter during the meeting and the meetings should stay private, so residents had the opportunity to express their concerns without feeling intimidated that staff were listening to what the residents said. Interview on 05/01/26 at 8:22 AM with the Administrator revealed expectations were that facility staff respect the residents' privacy during the resident council meetings. The Administrator said it was important that staff do not enter the meetings because it was residents opportunity to express their concerns without feeling intimidated. Review of the facility's policy titled Resident Council revised on 12/2016 reflected the following: .The facility will provide the resident council with private space;.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 3 (Residents #7, #23, and #97) of 18 residents reviewed for smoking.The facility failed to follow their smoking policy when Residents #7, #23, and #97 were observed to be smoking on the patio without supervision.This failure placed residents at risk of harm and/or serious injury.Findings included: Review of Resident #7's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility 12/16/25. The resident's diagnoses included heart disease, heart failure, hypertension (high blood pressure), and depression. Resident #7 had a BIMS score of 11 which indicated her cognition was moderately impaired. Review of Resident #7's smoking assessment updated 05/01/26 reflected the resident was safe to smoke. The smoking assessment further reflected the resident required direct supervision while smoking, all smoking materials would be kept at nurse station, and the evaluation had been discussed with the resident. Review of Resident #23's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer's dementia, anxiety disorder, and schizophrenia. Resident #23 had a BIMS scoreof 9 which indicated her cognition was moderately impaired. Review of Resident #23's care plan revised on 09/29/25 reflected the resident smoked and was non-compliant with smoking policy at times. Interventions included to monitor as needed when smoking to assure resident safety and staff will re-educate resident on smoking policy. Review of Resident #23's smoking assessment dated [DATE] reflected the resident was safe to smoke but required direct supervision. Review of Resident #97's face sheet printed on 05/01/26 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included lumbar vertebra fracture (a break in one of the five vertebrae in the lower back), anxiety disorder, COPD (progressive lung disease causing chronic coughing, wheezing, and severe breathlessness due to damaged airways), and cerebral infarction (type of stroke caused by a blockage that reduces oxygen to the brain). Review of Resident #97's smoking assessment dated [DATE] reflected he was safe to smoke and required direct supervision while smoking. The smoking assessment further reflected that all smoking materials would be kept at the nurse station and the evaluation was discussed with the resident. Observation and interview on 04/29/26 at 8:38 AM revealed there were three residents (Resident #7, #23, and #97) smoking outside on the patio with no staff present. Resident #97 was sharing a cigarette with Resident #23. Resident #7 sat at another table smoking alone on the patio. Resident #7 was asked if he should be smoking unsupervised and he said he happened to find an extra cigarette in his walker bag and that guy (pointed at Resident #97) had let him borrow the lighter. At that time, CNA Y walked out to the patio with the smoking paraphernalia in a lock box. CNA Y said the residents (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should not have been smoking unsupervised and she did not know where they had gotten their cigarettes and lighter. At that time Resident #97 tucked 4 cigarettes and a lighter under his leg and CNA Y said she would take care of it. Interview on 04/29/26 at 1:59 PM with Resident #97 revealed he had recently been admitted to the facility and had been informed of the smoking policy. The resident denied he was smoking on the patio and said he would never keep cigarettes or lighter on his person. Resident #97 also denied he shared his cigarette with Resident #23. Interview on 04/30/26 at 6:27 PM with the DON revealed residents were not allowed to smoke unsupervised or have smoking paraphernalia on them. The DON said she was not aware the residents were smoking with no supervision and said all residents needed to be supervised for their safety and could be fire hazard. The DON further stated some residents would sign themselves out and go the store and purchase their own smoking paraphernalia. Interview on 05/01/26 at 8:00 AM with ADON J revealed residents were not allowed to smoke unsupervised or have cigarettes or lighters on them for safety reasons and a was a fire hazard. ADON J said she was not aware residents had paraphernalia on their person and said it was difficult to monitor because the residents would sign themselves out and buy more at the store. Interview on 05/01/26 at 8:18 PM with the Administrator revealed residents were not allowed to have cigarettes or lighters on them because it could be a danger to themselves or others around. The Administrator said they had gone over the smoking with the residents and somehow, they continued to get cigarettes and lighters, and they would take them away when the residents were seen with them. Review of the facility's undated policy titled Smoking Policy reflected the following: .1. Matches, lighters, or other ignition sources for smoking are not permitted to be kept or stored in a resident's room 2.The resident must be within direct view of the smoking supervisor, in reasonably close proximity of the supervisor, and the supervisor must be able to quickly respond in the event of an emergency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #10) of 8 residents reviewed for comprehensive care plans.The facility failed to ensure Resident #10's care plan addressed resident's behavior of picking at her face.This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. The findings include:Record review of Resident #10's admission MDS Assessment, dated 02/11/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #10's diagnoses included multiple sclerosis (autoimmune condition that affects your brain and spinal cord), chronic pulmonary edema (condition caused by too much fluid in the lungs), lymphedema (lymph builds up in tissues and causes swelling), essential hypertension (high blood pressure) and Non-Alzheimer's Dementia (brain condition that slowly damages your memory, thinking, learning and organizing skills). Resident #10's BIMS score was 10 which indicated moderate cognitive impairment. Record review of Resident #10's care plan, dated 02/13/26, did not address Resident #10's had a behavior of picking at her face, causing redness and skin-breakdown. Observation and interview on 04/28/26 at 7:18 a.m. revealed Resident #10 in her room, sitting in her wheelchair. Resident #10 was observed to have small red areas on her face. Resident #10 stated she was told by staff that the red areas on her face were caused by her scratching on herself. Resident #10 stated she washes her face every day and she picks at them because the scabbing itches. Resident #10 stated the staff put ointment on the red spots. Interview on 04/30/26 at 3:02 p.m., CNA N stated Resident #10 has had skin-breakdown around her face for a while. She stated the red spots come and go. She stated the red spots would start healing and scab up but then the scabs would come off. She stated she had not seen Resident #10 pick on her face, but it appeared like Resident #10 does pick on the scabs. Interview on 04/30/26 at 3:05 p.m., LVN O stated Resident #10 had the tendency of picking on her face causing skin-breakdown areas on her face. She stated they had physician orders to apply Bactrim. LVN O stated the red areas were looking better and healing but Resident #10 would start picking and removing the scabs on them. LVN O stated they try to redirect and educate Resident #10 to stop picking on her skin. LVN O stated it was a behavior that Resident #10 had and the behavior should be care plan. She stated she was not aware it was not care planned. She stated it was the responsibility of the MDS Coordinator to care plan behaviors. LVN O stated if it was not care plan staff would not know Resident #10's behavior picking on her face. Interview on 04/30/26 at 3:07 p.m., MDS Coordinator L stated the MDS Coordinators were responsible for the initial care plan, and updating the care plan. MDS Coordinator L stated each department was also responsible for updating care plans. She stated the care plans should address any diagnosis, medications and behaviors that the residents were exhibiting. MDS Coordinator L stated she was aware of Resident #10 having a behavior of picking on her face. She stated the Treatment Nurse would be responsible for care planning any skin issues. MDS Coordinator L reviewed Resident #10's care plan and stated the behavior was not care plan. She stated potential risk of not care planning the behavior would be staff not knowing what is going on with the resident. Interview on 04/30/26 at 5:28 p.m., the Treatment Nurse stated he was aware of Resident #10 picking on her face. He stated the nurses were responsible for applying medications. He stated he does not provide any wound care to Resident #10's face. The Treatment Nurse stated Resident #10 behavior of picking on her face should be care plan and it was the responsibility of the nurses to care plan. He stated he was only responsible for care planning wounds. Interview on 05/01/26 at 6:43 a.m., the DON stated Resident (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#10 face was being treated with antibiotics. She stated Resident #10 had a behavior of picking on her scabs. She stated the red open spot on Resident #10's face were healing but Resident #10 would scratch or pick on the scabs. The DON stated Resident #10 did not admit to the facility with that behavior, it was something that the resident started to do. She stated the behavior should be care plan and she was not aware it was not. She stated it was the responsibility of the MDS Coordinators and nursing to update care plans. She stated her main focus was the resident acute care. The DON stated the behavior should be care plan so that the staff would be aware, alert and know the resident's baseline. Interview on 05/01/26 at 8:19 a.m., ADON K stated she was the ADON assigned to the memory care unit. She stated Resident #10 had a behavior of picking on her skin and it was a behavior she had started at the facility. She stated the red spots on her face were healing but the resident would take the scabs off. ADON K stated they had been treating the skin breakdown, educating the resident to not mess with it. She stated the behavior should be care plan so that the staff were aware. She stated it was her and the DONs responsibility to care plan the behavior. She stated it was missed and she was not aware it was not care plan. ADON K stated the potential risk of not care plan Resident #10's behavior would be infection and staff not knowing that the resident had that behavior. Record review of facility Comprehensive Care Planning policy, undated, reflected the following: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for 1 of 4 residents (Resident #11) reviewed for feeding tubes.RN D failed to follow physician orders and added the wrong amount of water during the flush to Resident #11's formula g-tube (device inserted through the belly into the stomach to deliver nutrition, fluids, and medications) during the feeding on 04/30/26. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care.Findings included:Review of Resident #11's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included aphasia (language disorder caused by brain damage that impairs speaking, understanding, reading, writing), stroke, hemiplegia (paralysis of one side of the body), and cerebral infarction (blockage in blood vessels supplying the brain resulting in tissue death). Resident #11 had a BIMS score of 0 which indicated her cognition was severely impaired. The MDS further reflected the resident was on a feeding tube. Review of Resident #11's care plan revised on 02/11/25 reflected the resident required a tube feeding related to impaired swallowing. Interventions included follow MD order for current feeding orders. Review of Resident 11's Order Summary Report for May 2026 reflected the following: Enteral Feed Order every shift Flush tube with 60 ml water before and after medication and feedingsEvery 4 hours Flush enteral tube with 30ml water pre/post medication administration and 5-10 ml water between each medicationObservation on 04/30/26 at 9:03 AM, revealed RN D checked Resident #11's g-tube placement prior to the resident's feeding. RN D poured 30ml of water into the syringe attached to the g-tube and let it flow to gravity. RN D then poured the formula into the syringe. After the formula had run through the syringe via gravity, he proceeded to flush with 30 ml of water after the feeding. Interview and observation on 04/30/26 at 9:29 AM with RN D revealed he flushed Resident #11's g-tube with 30 ml of water before and after the feeding. RN D looked at the flush order and said he had read it wrong, and the order was 60 ml of water. RN D further stated it was important to flush with the right amount of water because that was the resident's hydration. Interview on 05/01/26 at 6:17 PM with the DON revealed if Resident #11's g-tube water flush was 60ml per the physician order, then it should have been followed. The DON said it was important, so the resident's g-tube lines stayed clear and free of clogs during the feedings. Interview on 05/01/26 at 7:53 AM with ADON J revealed Resident #11 had two orders, one of the orders read to flush with 30ml before and after medications and the other order was to flush the g-tube with 60ml before and after medications and feedings. ADON J said they called the hospice company and clarified the order and the correct flush before and after feedings should be 60ml. ADON J further stated it was important for physician orders to be followed because flushing with too much water could overload the resident and flushing with too little could dehydrate the resident. Review of the facility's policy titled Enteral Tube Medication Administration dated 2025 reflected the following: PolicyThe facility assures the safe and effective administration of enteral formulas and medications. Selection of enteral formulas, routes, and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident condition, in consultation with the physician.

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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. Based on observations, interviews and record reviews the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for 1 of 5 carts reviewed for medication storage. LVN-A failed to secure her medication cart prior to walking away from it on 04/28/26. This failure could place residents at risk of accessing medications not prescribed for them. Observation on 04/28/26 at 5:30 a.m. a medication cart located outside the only nurses' station was unlocked. All drawers were able to be opened, and multiple prescription and over the counter medications were in the drawers. In an interview on 04/28/26 at 5:33 a.m. LVN-A stated she had walked away for just a minute to talk with someone. She stated she knew her cart should have been locked prior to walking away but did not think she was going to be gone very long and most of the residents were still in bed. She stated the risk of leaving the cart unlocked was residents accessing medications not prescribed for them. In an interview on 04/30/26 at 9:39 a.m. the DON stated all medication carts were required to be locked if the nurse or medication aide was not directly in control of the cart. If they walked away from the cart, no matter how long they were going to be away, they must lock the cart. She stated the risk of leaving the cart unlocked was a resident gaining access to medications that were not prescribed for them. In an interview on 04/30/26 at 9:54 a.m. RN-B stated that anytime she walked away from her cart, she was supposed to lock it. She stated locking it prevented anyone not authorized from accessing the cart, or a resident from gaining access to medications they were not prescribed. In an interview on 04/30/26 at 9:58 a.m. LVN-C stated that anytime she was not directly at her cart, she had to lock it to prevent anyone else from gaining access to the medications inside. She stated residents could access medications not prescribed for them. In an interview on 04/30/262/6 at 9:58 a.m. RN-D stated he always locked his medication cart any time he was away from it. Failing to do so could allow residents to access medications that were not prescribed for them and possibly having a reaction to them. In an interview on 04/30/26 at 10:04 a.m. MA-E stated her cart had to be secured any time she walked away from it. She stated leaving it unlocked could allow another resident to get access to medications that might not be theirs. In an interview on 04/30/26 at 10:08 a.m. MA-F stated her cart had to be locked any time she was not directly in front of it. It was kept secured to prevent anyone from accessing the medications inside and taking a medication not prescribed for them. Review of the facility's policy Medication Storage in the Facility, dated 2025, reflected: Medications and biologicals are stored safely, securely, and properly. The medication supply is accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications

Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #4) of 8 residents reviewed for infection controlStaff left a graduated cylinder, used to measure urine output, on the resident's bedside table. This failure could cause cross contamination from an unclean item to the clean items on the bedside table. Findings included:Observation on 04/28/26 at 8:38 a.m. Resident #4's bedside table contained her water cup, hairbrush, her book, and a graduated cylinder with traces of a yellow liquid at the bottom.In an interview on 4/28/26 at 8:38 a.m. Resident #4 stated the cylinder was used to measure the urine from her urinary catheter collection bag. She stated it had been left on her bedside table a couple of other times in the past. She stated she had asked the CNAs not to put it there, but they forget and do it anyway. Resident #4 stated she could not access her bathroom with her wheelchair so she could not put the cylinder in the bathroom herself. Resident #4 stated the cylinder had been there since the night shift emptied her collection bag around 6:00 a.m. She stated she was concerned that the CNAs would do the same thing with a resident who might be confused, and that resident might drink from it. In an interview on 04/30/26 at 9:36 a.m. the DON stated the graduated cylinder should not have been left on the resident's bedside table. The bedside table was considered clean, and the cylinder was definitely not clean. She stated the risk of placing it there could be cross contamination with the resident's food and drink, and if the resident was confused, they may try to drink from it. She did not know who had left it on the bedside table. In an interview on 04/30/26 at 9:50 a.m. CNA-G stated the graduated cylinder could not be left on the bedside table due to the risk of cross contamination with other items on the table like the drink cup or food. In an interview on 04/30/26 at 9:53 a.m. RN-B stated the graduated cylinder could not be left on a bedside table due to the risk of cross contamination. Dirty items like the cylinder could not share the same space as clean items like a drink cup or food. In an interview on 04/30/26 at 9:56 a.m. LVN-C stated dirty items could not be kept with clean items because of the risk of cross contamination. A resident's bedside table was generally considered a clean environment, and dirty items like urine measuring cups could not be left there. In an interview on 04/30/26 at 10:00 a.m. CNA-H stated the cylinders used to empty urine bags should always be rinsed out and left in the bathroom, not put back on the bedside table. She stated it was unsanitary and gross. She stated the cylinder looked like something that could be drunk from, and a confused resident might try to drink from it. In an interview on 04/30/26 at 10:04 a.m. CNA-I stated dirty items like the cylinder should be kept off the bedside table where other clean items were. He stated there was a risk of cross contamination as well as it being unpleasant for the residents. Review of the facility's undated policy Fundamentals of Infection Control Precautions, reflected: Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.