STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel's Healthcare	4515 Village Creek Rd Fort Worth, TX 76119

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for one (Resident #1) of three residents reviewed for abuse. The facility failed to implement their abuse policy and procedure after an allegation of abuse was made regarding Resident #1. After making an allegation of verbal abuse by the Administrator, the Administrator confronted Resident #1 regarding the allegation. This failure could place residents at risk of abuse due to facility failure to follow their policy and procedures for abuse.Findings included: Record review of the facility policy, Abuse/Neglect, not dated, reflected:F. ProtectionThe facility will take necessary measures to protect residents .from harm during and following an abuse investigation.Allegations of abuse.will remain confidential.3. Harassment and interfering with an investigation will result in disciplinary action up to and including termination. Record review of Resident #1's Annual MDS, dated [DATE], reflected he was a [AGE] year-old admitted to the facility on [DATE]. His cognitive skills for daily decision making were intact. His diagnoses included stroke, seizures, and Non-Alzheimer's dementia. Record review of Resident #1's Care Plan, dated 09/05/24, reflected:Resident #1 had a PASARR positive status (indicating that Resident #1 had been screened and found to have a serious mental illness or intellectual/developmental disability) related to intellectual disability. An interview on 01/06/26 at 11:30 am with Resident #1 revealed in October 2025 (10/15/25) during a fall festival, the Administrator and Activity Director told him to shut up, mind your business and don't say anything. Resident #1 said he was told this because he said it was not fair that the festival was not just for the residents. Other people came to the facility for the festival. He said the Activity Director was just joking with him when she said it, but the Administrator meant it. He said the Administrator took it to a whole new level. Resident #1 said he had a PASSAR meeting in December 2025 (12/02/25) and he told the staff present that the Administrator told him to shut up, mind your business and don't say anything during a festival in October 2025. He said he did not report the allegation before the meeting in December but did not say why. Resident #1 said the MDS Nurse went to get the Administrator. The Administrator came to the meeting. Resident #1 said he told the Administrator that she told him to shut up, and she told the resident, No I did not. The resident said he tried to argue with her, but every time he tried to say something, the Administrator would put her hand up to make him stop talking. Resident #1 said if the Administrator said something to him, then he had the right to speak up. Resident #1 said the Administrator was trying to talk to the people in the room and clear it up and he let her speak. He said he felt upset at the time of the meeting but did not hold any grudges and did not feel bad anymore. Resident #1 said the Administrator stayed in the room and argued with him about what she said to him, then left the room right before the other staff did. Resident #1 said he did not know if the Administrator left for the day but did tell him that she would not speak to him without a (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witness. The resident said he did not speak to the Activity Director about the statement, because she was just joking. An interview on 01/06/26 at 10:55 am with the Administrator revealed she entered the conference room and reported she wanted to give information about the self-reports the facility made. The Administrator said the facility had a fall festival on 10/15/25 and vendors came to the facility. She said there was a cake walk and a grilling station. The Administrator said she was working at the grill station. The Administrator said there was a self-report regarding Resident #1. She said Resident #1 accused her and the Activity Director of verbally abusing him during his PASSAR meeting in December 2025 (12/02/25). She said she was not in the meeting. She said the MDS Nurse came and got her because Resident #1 reported concerns during the meeting. The Administrator said she went to the meeting and the resident said he was told residents could not go to the festival and that she said to shut up, mind your business. The resident was never at my grill station. She stated she told him that she did not interact with him at that time of the party and that she doesn't use the word shut up. The Administrator said the Activity Director was not at the meeting. The Administrator said it was not facility policy to allow the alleged perpetrator to question the resident, but at the time it was just a conversation between the resident and her. She said in hindsight she should not have talked to the resident if he made a verbal allegation of abuse against her, but she thought Resident #1 wanted to [NAME] the [NAME]. The Administrator said the resident made the allegation of verbal abuse before the MDS Nurse went to get her to go to the meeting. The Administrator said she did not know who else was in the meeting other than the MDS nurse. The Administrator said after she spoke to Resident #1 in the meeting she suspended herself for one day and notified the Owner of the facility. The Administrator said the DON completed the self-report investigation. An interview on 01/06/26 at 12:00 pm with the MDS Nurse revealed she was at the PASSAR meeting for Resident #1 on 12/02/25. She said the meeting was held in her office and the Therapy Director and PASSAR staff were there. The MDS Nurse said Resident #1 made an allegation of verbal abuse against the Administrator and Activity Director that occurred during the Fall Festival. The MDS Nurse said she felt the accused had the right to face their accuser. She said she left the meeting to get the Administrator because she was the Abuse Coordinator. The MDS Nurse said she did not know what else to do. The MDS Nurse said the Administrator asked Resident #1 what his concerns were. Resident #1 told the Administrator that she told him to shut up and mind his own business. The Administrator said she explained to everyone in the room how the set-up was for the Fall Festival and then she left the room. The MDS Nurse said if a resident had to face their alleged perpetrator they could have a fear of retaliation and feel it was not a safe place to report their concerns. An interview on 01/06/26 at 1:00 PM with the ECC Service Coordinator revealed she was at the PASSAR meeting for Resident #1 on 12/02/25. She said Resident #1 made an allegation of verbal abuse against the Administrator. Resident #1 said the Administrator told him to shut-up. Resident #1 said he had not reported the allegation prior to the meeting. She said the MDS Nurse left the room to get the Administrator and address the allegation. The ECC Service Coordinator said the Administrator came to the meeting and negated Resident #1's claim of verbal abuse. She said the Administrator said he was fabricating the allegation due to retaliation. She said the Administrator argued back and forth with the resident about the allegation and she denied the allegation. She said the Administrator did not leave the room after the resident made the allegation. An interview on 01/07/26 at 11:40 AM with the Activity Director revealed she said she did not verbally abuse Resident #1. An interview on 01/06/26 at 2:45 PM with the Administrator revealed she said facility staff were supposed to contact the DON or Corporate Staff if she was named as the alleged perpetrator. She said since the summer of 2025, Resident #1 had made 4-5 calls to the state and (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that he would say his rights were affected. She said Resident #1 was upset because he could not sell stuff out of his room. The Administrator said after he made the verbal allegation against her she told him that she would make the appropriate phone calls. She said later that night she was suspended pending the investigation.

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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	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to, in response to allegations of abuse, have evidence that all alleged violations were thoroughly investigated for one (Resident #1) of three residents reviewed for abuse. The facility failed to thoroughly investigate an allegation of verbal abuse reported by Resident #1. This failure could place residents at risk of abuse due to facility failure to fully investigate allegations for abuse. Findings included: Record review of Resident #1's Annual MDS, dated [DATE], reflected he was a [AGE] year-old admitted to the facility on [DATE]. His cognitive skills for daily decision making were intact. His diagnoses included stroke, seizures, and non-Alzheimer's dementia. Record review of Resident #1's Care Plan, dated 09/05/24, reflected:Resident #1 had a PASARR positive status (indicating that Resident #1 had been screened and found to have a serious mental illness or intellectual/developmental disability) related to intellectual disability. Review of the Facility Provider Investigation Report for Resident #1 dated 12/09/25 reflected the resident reported an allegation of verbal abuse on 12/02/25 that occurred on 10/15/25. Resident #1 said that he asked to attend the Fall Festival and was told, shut up, mind your business, and don't say anything by the Administrator and Activity Director. The findings of the investigation by the DON revealed the allegation was unfounded.Witness Statement from Activity Director:Activity Director did not speak to Resident #1 on the day of the Fall Festival.Witness Statement from the Administrator:Resident #1 voiced at the end of the PASSAR meeting on 12/02/25 that he complained about not being able to participate at the Fall Festival and was told by the Administrator and Activity Director to shut-up, be quiet and mind his business. The MDS Nurse got the Administrator to attend the meeting. Resident #1 had not reported the allegation prior to 12/02/25. Resident #1 said he was holding a grudge because he was told he could not sell items out of his room.Witness Statement from the MDS Nurse:During his (Resident #1's) PASSAR meeting he complained about the Fall Festival and said when he complained he was told to shut up and mind his business by the Administrator and Activity Director. The MDS Nurse said she excused herself from the meeting to get the Administrator because, I am a firm believer that all accused have the right to face their accuser and this is a strong allegation. The Administrator and MDS Nurse returned to the meeting and the Administrator told the resident that she never said that to him. The meeting came to an end and it was suggested that the Administrator and Resident #1 have a meeting to hash out their differences.The Provider Investigation report did not reflect that Resident #1 was interviewed or given a safe survey. An interview on 01/06/26 at 11:30 AM with Resident #1 revealed in October 2025 (10/15/25) during a fall festival, the Administrator and Activity Director told him to shut up, mind your business and don't say anything. Resident #1 said he was told this because he said it was not fair that the festival was not just for the residents. Other people came to the facility for the festival. He said the Activity Director was just joking with him when she said it, but the Administrator meant it. He said the Administrator took it to a whole new level. Resident #1 said he had a PASSAR meeting in December 2025 (12/02/25) and he told the staff present that the Administrator told him to shut up, mind your business and don't say anything during a festival in October 2025. He said he did not report the allegation before the meeting in December but did not say why. Resident #1 said the MDS Nurse went to get the Administrator. The resident said he was upset but was not afraid to face her. The Administrator came to the meeting. Resident #1 said he told the Administrator that she told him to shut up, and she told the resident, No I did not. The resident said he tried to argue with her, but every time he tried to say something, the Administrator would put her hand up to make him stop talking. Resident #1 said if the Administrator said something to him, then he had the right to speak up. Resident #1 said (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator was trying to talk to the people in the room and clear it up and he let her speak. He said he felt upset at the time of the meeting but did not hold any grudges and did not feel bad anymore. Resident #1 said the Administrator stayed in the room and argued with him about what she said to him, then left the room right before the other staff did. Resident #1 said he did not know if the Administrator left for the day but did tell him that she would not speak to him without a witness. The resident said he did not speak to the Activity Director about the statement, because she was just joking. An interview on 01/06/26 at 10:55 AM with the Administrator revealed she entered the conference room and reported she wanted to give information about the self-reports the facility made. The Administrator said the facility had a fall festival on 10/15/25 and vendors came to the facility. She said there was a cake walk and a grilling station. The Administrator said she was working at the grill station. The Administrator said there was a self-report regarding Resident #1. She said Resident #1 accused her and the Activity Director of verbally abusing him during his PASSAR meeting in December 2025 (12/02/25). She said she was not in the meeting. She said the MDS Nurse came and got her because Resident #1 reported concerns during the meeting. The Administrator said she went to the meeting and the resident said he was told residents could not go to the festival and that she said to shut up, mind your business. The resident was never at my grill station. She stated she told him that she did not interact with him at that time of the party and that she doesn't use the word shut up. The Administrator said the Activity Director was not at the meeting. The Administrator said it was not facility policy to allow the alleged perpetrator to question the resident, but at the time it was just a conversation between the resident and her. She said in hindsight she should not have talked to the resident if he made a verbal allegation of abuse against her, but she thought Resident #1 wanted to [NAME] the [NAME]. The Administrator said the resident made the allegation of verbal abuse before the MDS Nurse went to get her to go to the meeting. The Administrator said she did not know who else was in the meeting other than the MDS nurse. The Administrator said after she spoke to Resident #1 in the meeting she suspended herself for one day and notified the Owner of the facility. The Administrator said the DON completed the self-report investigation. An interview on 01/06/26 at 12:00 PM with the MDS Nurse revealed she was at the PASSAR meeting for Resident #1 on 12/02/25. She said the meeting was held in her office and the Therapy Director and PASSAR staff were there. The MDS Nurse said Resident #1 made an allegation of verbal abuse against the Administrator and Activity Director that occurred during the Fall Festival. The MDS Nurse said she felt the accused had the right to face their accuser. She said she left the meeting to get the Administrator because she was the Abuse Coordinator. The MDS Nurse said the Administrator asked Resident #1 what his concerns were. Resident #1 told the Administrator that she told him to shut up and mind his own business. The Administrator said she explained to everyone in the room how the set-up was for the Fall Festival and then she left the room. The MDS Nurse said if a resident had to face their alleged perpetrator they could have a fear of retaliation and feel it was not a safe place to report their concerns. An interview on 01/06/26 at 1:00 PM with the ECC Service Coordinator revealed she was at the PASSAR meeting for Resident #1 on 12/02/25. She said Resident #1 made an allegation of verbal abuse against the Administrator. Resident #1 said the Administrator told him to shut-up. Resident #1 said he had not reported the allegation prior to the meeting. She said the MDS Nurse left the room to get the Administrator and address the allegation. The ECC Service Coordinator said the Administrator came to the meeting and negated Resident #1's claim of verbal abuse. She said the Administrator said he was fabricating the allegation due to retaliation. She said the Administrator argued back and forth with the resident about the allegation and she denied the allegation. She said the Administrator did not immediately (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leave the room after the resident made the allegation. An interview on 01/07/26 at 11:40 AM with the Activity Director revealed she said she did not verbally abuse Resident #1. An interview on 01/06/26 at 2:45 PM with the Administrator revealed she said facility staff were supposed to contact the DON or Corporate Staff if she was named as the alleged perpetrator. She said since the summer of 2025, Resident #1 had made 4-5 calls to the state and that he would say his rights were affected. She said Resident #1 was upset because he could not sell stuff out of his room. The Administrator said after he made the verbal allegation against her she told him that she would make the appropriate phone calls. She said later that night she was suspended pending the investigation. An interview on 01/06/26 at 4:30 PM with the DON revealed she completed the investigation for the self-report regarding Resident #1. She also said the Corporate Staff assisted her. The DON said she did not interview Resident #1 and just spoke to the MDS Nurse and Administrator. The DON said she did safe surveys with other residents, but not with Resident #1. She said she was probably supposed to interview the resident but did not know what the policy said without reading it. The DON said she did not identify any issues with her investigation. The DON said based on her investigation there was no abuse. The DON said Resident #1 was a fabricator of instances and stories and was care planned for it. The DON said she was told Resident #1 said the Administrator and Activity Director told him to shut up and mind his business. The DON said she spoke with both the Administrator and Activity Director, and they denied the allegation. The DON said she reviewed the witness statements of the MDS Nurse and Administrator. The DON said she did not see the MDS Nurse notified the Administrator so she could confront her accuser (the resident) regarding the allegation of verbal abuse. She also said she did not interview any other members who were present at the PASSAR meeting on 12/02/25. An interview on 01/07/26 at 9:30 AM with Corporate Staff revealed he assisted the DON with the investigation of Resident #1's allegation of verbal abuse. He said he was not aware of any issues with the investigation. He said he did not know the resident was not interviewed but should have been. He said he did speak with the Administrator but thought she removed herself from the room when the resident made the allegation of verbal abuse. He said he did not know the other members present in the meeting were not interviewed. The Corporate Staff said the MDS Nurse should not have notified the Administrator and should have notified the DON. The Corporate Staff said he thought Resident #1 wanted to speak to the Administrator. The Corporate Staff said that failure to complete a thorough investigation could result in missed information. Record review of the facility policy, Abuse/Neglect, not dated, reflected:E. InvestigationAll investigations of abuse.will be investigated.