STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455576	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Hills Rehabilitation and Healthcare Cente	3109 Kings CT Fort Worth, TX 76118

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 Based on interview and record review, the facility failed to ensure care plans were developed in consultation with the resident and the resident's representative for 3 of 13 residents (Resident #3, Resident #7, Resident #17) reviewed for Comprehensive Care Plan in that: The facility failed to ensure Resident #3, Resident #7, and Resident #17 or the resident's representatives were invited to participate in the residents' care plan meeting. This failure could place residents at risk for a loss of independence, psychosocial well-being, and the opportunity for them to participate in the planning of their cares. Findings include: Record review of Resident # 3's face-sheet dated 02/01/2024 revealed a [AGE] year-old female, readmitted to facility on 01/19/2023. Her diagnoses included: Other Symptoms and Signs involving the musculoskeletal system (aching and stiffness & muscles twitches, pain), Heart Failure, Unspecified (Heart unable to pump enough blood), Type 2 Diabetes Neuropathy, Unspecified (a chronic condition that affects the way the body processes blood sugar). Record review of Resident #3's file revealed no documentation of quarterly care plan meetings with resident representative. Interview on 01/25/2024 at 2:00 PM, Resident #3 revealed that she and her daughter have never been to a meeting concerning her care. Interview on 01/25/2024 at 2:45 PM, Resident #3's daughter revealed there has never been a formal meeting to discuss Resident #3, but the staff do call her and give her updates on Resident #3. Record review of Resident #7's face-sheet dated 01/25/2024 revealed a [AGE] year-old male readmitted to facility on 05/24/2023. His diagnoses included Parkinsonism, Unspecified (conditions with similar, movement-related effects), Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (high blood sugar that can lead to significant nerve damage), (continued on next page)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Schizoaffective Disorder Bipolar Type (risk for suicidal thoughts, social isolation, mental illness/mental health episodes) Record review of Resident #7's file revealed no consistent documentation of quarterly care plan meetings with resident or resident representation. Record review revealed Resident #7 rooms with Resident #17 and they were in a relationship. One care plan meeting was held on 08/17/2023 and Resident #17 was in attendance as a family representative. Record review of Resident #17's face sheet dated 01/25/2024 revealed a [AGE] year-old female readmitted to facility on 01/22/2024. Her diagnoses included Cerebral Infarction, Unspecified (Stroke - not enough blood getting through certain blood vessels in the brain), Hypertensive Heart Disease with Heart Failure (thickening of the heart muscle, coronary artery disease, and other diseases), Schizoaffective Disorder, Bipolar Type (feelings of euphoria, racing thoughts, increased risky behaviors and other symptoms of mania. Record review of Resident #17's file revealed documentation of quarterly care plan meeting held with resident on 08/17/2023. Care plan dated on 12/05/2023 was not completed. No other documented care plan meetings noted. On 01/25/2024 at 3:00PM, was not able to interview Resident #17 because she was not feeling well. Resident #17 was her own responsible party. Interview on 01/24/2024 at 2:00 PM with the Social Worker stated that she was new at the facility and would not know about the past care plan meetings. The Social Worker would try and locate them. The new Social Worker could not produce any further care plans that had not been uploaded in resident files. Record review of the facility's policy on Care Planning, dated July 2020. The policy states: to the extent possible, the resident, the resident's family and/or responsible party should participate in the development of the care plan; every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party; when the resident has no family or responsible party, and is unable to make his/her own health care decisions, the IDT will act as surrogate decision makers.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 48520 Based on observation, interview, and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 3 (Resident #3, Resident #7, and Resident #27) of 13 residents reviewed for call lights. Staff failed to ensure Resident #3 and Resident #7's, and Resident #27's call buttons were within reach. This failure could place residents at risk for decreased quality of life, self-worth, and dignity. Findings included: Record review of Resident # 3's face-sheet dated 02/01/2024 revealed a [AGE] year-old female, readmitted to facility on 01/19/2023. Her diagnoses included: Other Symptoms and Signs involving the musculoskeletal system (aching and stiffness & muscles twitches, pain), Heart Failure, Unspecified (Heart unable to pump enough blood), Type 2 Diabetes Neuropathy, Unspecified (a chronic condition that affects the way the body processes blood sugar). Review of Resident #3's Comprehensive Care Plan revised 01/23/2024 reflected Resident #3 was at risk for falls related to muscle weakness and generalized bowel/bladder incontinence. Intervention noted to be sure call light is within reach. Review of Resident #3's Quarterly MDS Assessment (Minimum Data Set) dated 01/13/2024 revealed Resident #3 to be cognitively intact. Resident's BIMS (Brief Interview for Mental Status) Score was: 15/15. Observation and interview on 01/23/2024 at 11:40 a.m., revealed Resident #3 was in her bed and her call light was lying on the floor under the bed. Resident #3 could not reach the call light if she needed to push the button. Resident #3 revealed that the call light was always on the floor or up above her head on the headboard. Resident #3 revealed that she can never reach her call light. Record review of Resident #7's face-sheet dated 01/25/2024 revealed a [AGE] year-old male readmitted to facility on 05/24/2023. His diagnoses included Parkinsonism, Unspecified (conditions with similar, movement-related effects), Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (high blood sugar that can lead to significant nerve damage), Schizoaffective Disorder Bipolar Type (risk for suicidal thoughts, social isolation, mental illness/mental health episodes). Review of Resident #7's Comprehensive Care Plan revised 04/20/2022 reflected Resident #7 was at risk for falls related to weakness to bilateral lower extremities, cognitive impairment, and difficulty walking. Intervention noted to be sure call light is within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Quarterly MDS (Minimum Data Set) assessment dated [DATE] reflected the resident was severely cognitively impaired. Resident #7's BIMS (Brief Interview for Mental Status) Score was: 0/0. Resident #7 could not participate in interview. Observation on 01/25/2024 at 11:30 AM revealed Resident #7 was in his wheelchair with his head on his bed and blanket over his head sleeping. The call light was hanging from the plug between the wall and bed. Call light was in the floor under the bed. Resident #7 would not be able to reach the call light. Record review of Resident #27's face sheet dated 01/25/2024 revealed a [AGE] year-old female readmitted to the facility on [DATE]. Her diagnoses included: Other Encephalopathy (brain disease that alters brain function or structure), Altered Mental Status, Unspecified (stems from certain illnesses, disorders, and injuries affecting the brain), Essential (Primary) Hypertension (occurs when there is an abnormally high blood pressure that's not the result of a medical condition). Review of Resident #27's Comprehensive Care Plan revised 01/17/2019 reflected Resident #27 was at risk for falls. Intervention noted to be sure call light is within reach. Unable to review Resident #27's Quarterly MDS (Minimum Data Set) Assessment or BIMS (Brief Interview for Mental Status). Resident #27 was cognitively aware. Observation on 01/25/2024 at 11:50 AM, Resident #27 was sitting in her wheelchair with her overbed table in front of her waiting on lunch. Observed the call light behind her laying on the bedside nightstand. Asked Resident #27 if she could reach the call light. She responded that she was not able to reach the call light. In an interview on 01/23/2024 at 12:00 PM with CNA A revealed that she did not know the call lights were not within reach for Resident #3 or Resident #27. CNA A revealed the negative outcome of residents who are unable to reach their call light were resident could try and get up and fall, may be sick and need assistance, or may just need water. CNA A revealed she would make sure all call lights were within reach. Resident #12 Review of Resident #12 's admission record, dated 01/25/2024, revealed a [AGE] year-old man admitted to facility on 05/11/2023 with diagnoses that included Epilepsy (a condition that cause a brief disturbance of normal electric function AKA Seizure disorder), Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture), mild protein calorie malnutrition, anemia, high blood pressure, fungus (candidiasis) infection of skin and nails, high cholesterol, heart burn (Gerd), and difficulty walking. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's quarterly MDS assessment, dated 11/30/23, reflected Resident #12 had a BIMS (Brief Inventory of Mental Status) of 14, indicating cognitive intact. He had no indicators of delirium, depression, or behaviors. He had a functional limitation in range of motion and used a manual wheelchair. Resident #12 was not dependent on staff for personal hygiene, he had the ability to maintain his own personal hygiene such as combing hair, brushing teeth, washing, and drying his face and hands. Review of Resident #12's care plans reflected a care plan initiated 05/07/2023, Focus: .has had an actual fall, 1/18/23-no injury, 5/07/23- fall with laceration/sutures to forehead, 6/29/23-No injury, 10/9/23-No injury, 10/18/23-No Injury; Goal: Will have any fall/injuries promptly identified, interventions initiated and risk minimized through next review; interventions: Non- skid socks, Education given to ask for assistance when items fall to the floor and need to be picked-up. Lock wheelchair if leaning over, Resident encouraged to call for assistance when going to the RR [restroom] for safety, hour safety checks, Continue with therapy services. Encourage rest after seizure activity, educated to use call light for assistance to restroom, encourage calls for assist. Record review of facility incidents, accidents and falls date range 11/24/2023 to 01/24/2024, revealed Resident #12 had falls on 01/08/24, 01/21/24. Observation and interview on 01/23/24 at 11:15 AM, revealed Resident #12 lying in bed B. Floor mat next to resident's bed. Call light was not in reach. Call light was hooked on the wall close to bed A. CNA D stated that Resident #12 did not like the call light near him. When CNA D was asked how Resident #12 might reach the call light, she said that he would not be able to reach it. She said the floor mate was being utilized as an intervention for Resident #12 in case he had a seizure and or fell . CNA D was observed unhooking call light from the wall and pined it to Resident #12's fitted sheet. Call light placed within reach. CNA D said the risk for resident not being able to reach their call light was falls. Interview with ADMN on 01/24/24 at 04:40 pm, revealed he expects all staff to answer call lights in a timely manner. He said that he expects call lights to be within reach for all residents. He said if resident could not reach call light to call for help, they are at risk of fall. Record review of facility Policy and Procedure for Call Light/Bell Policy revised 08/03/2021 indicated It is the policy of the facility to provide the resident a means of communication with nursing staff. Place call light within reach before leaving the room. If call light is defective, immediately report this information to the unit supervisor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview and record review, the facility failed to ensure clean, comfortable environment and maintenance services for one esident #30) of eight residents reviewed for clean and comfortable environment. The facility failed to maintain functional plumbing in the bathroom of Resident #30, causing her sink to not drain properly, to the extent she could not get hot water in her bathroom sink. These failures could place residents at risk for lack of hygiene, and a decreased quality of life. Findings included: Review of Resident #30's face sheet reflected she was a [AGE] year-old female, admitted [DATE], with diagnoses of unspecified dementia, severe, with behavioral disturbance, cerebral infarction (stroke), and bi-polar disorder. Resident #30 was listed as her own Responsible Party Review of Resident #30's quarterly MDS, dated [DATE], reflected she was able to understand others, and to be understood. Resident #30 had a BIMS of 11, indicating possible moderate cognitive impairment. The document reflected she had no indicators of delirium, or depression, and no behaviors. Resident #30 ambulated with a walker, and was independent, or required set-up only for her ADLs, except for bathing, when she required supervision or touching assistance. An interview on 10/24/24 at 3:46 PM with Resident #30 revealed she liked the people at the facility, and had no problems with her care, but was looking for a different facility to be transferred to, because she could not get hot water in her bathroom. She said she had complained to numerous staff, and could not name anyone, but knew she told the maintenance man repeatedly, and she was very tired of it. An observation of Resident #30's bathroom on 01/24/24 at 3:47 PM, revealed the stem for lifting the sink stopper was thoroughly rusted, and had no knob. The metal drain was also rusted, and there was no plug in or near the sink. The surveyor started running the water from the left (hot) knob and waited for three minutes (timed on watch) for hot water, but had to stop the water from running because the level reached the top of the sink and was about to run over. At the point of turning the water off, it was warm to the touch, but not hot. When the surveyor turned off the water, the sound of water falling on the floor could be heard, and the surveyor observed that water was running and dripping from the pipes beneath the sink onto the floor, and into a rectangular plastic container, which was on the floor when the surveyor entered the bathroom. During the time the water was running, the surveyor had flushed the toilet, which had feces and toilet paper in it, and it did not flush, but only swirled the contents around in the bowl. An interview and observation on 01/24/24 at 3:54 PM, revealed after being informed of the problem, the Administrator was in the resident's room, explaining what happened to the Maintenance Director and asking him to fix it, and the Maintenance Director looked at the bathroom and said he needed to get a bucket to drain the sink, and he would return right away. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/24/24 at 4:09 PM, Resident #30 revealed she had never been able to run the water long enough to see if it got hot, because the sink didn't drain, and she did not want to overflow it, so she just assumed she did not have hot water. She said the toilet sometimes had problems flushing, but not always. She said she was very glad and relieved they were fixing her water, because she hated washing her hands and face with cool water, and she had to do it every day. An interview on 04/24/24 at 4:45 PM, the Administrator revealed he had never heard anything about the plumbing problem. He said the former Maintenance Director was responsible for that, and the new Maintenance Director had only been there for about two weeks. He said he checked the water temperatures and kept a lot. The Administrator said there was no form or book the staff filled out, and they used an electronic system to manage maintenance tasks, which any staff member could use, but they usually just texted the Maintenance Director. An interview on 01/24/24 at 4:30 PM, the Maintenance Director revealed he had been working in the facility for two weeks, and Resident #30 had never complained to him about her bathroom. He said he was able to fix the problem easily, that there was a lot of hair plugging the sink. He said he did check the water temperatures a log of the rooms he checked, and there had been no issues, all rooms, even the end of the hall, were 100-108 degrees. He said the temperature in Resident #30's room was within range, but it did take a while for the hot water to reach the end of the hall, if people were not using the showers or using warm water in that hall, because of the type of pump they had. He said he used the plunger on her toilet, and it was fine, there was no blockage, it was just the hair in the sink he had to fix. An interview on 01/25/24 at 5:12 PM, the Temporary Administrator (from a sister facility, sitting in for the Administrator while he was on leave) revealed the facility did not have a policy that would specifically address the plumbing in resident rooms. Review of the policy for Safe/Comfortable/Homelike Environment, revised 01/22, reflected Policy: Residents are provided with a safe, clean, comfortable and homelike environment (.) Procedure: I. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; (.) g. Comfortable temperatures.

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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** 35489 Based on observation, interview, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services according to professional standards of maintenance for one (Resident #40) of one resident reviewed for enteral feeding. The facility failed to ensure Resident #40's g-tube water and enteral administration set (tubing attached to formula and water bottles for continuous g-tube feeding) was changed when his formula was changed, and failed to ensure the formula was dated when it was changed. This failure could place residents at risk of infection due to not following appropriate procedures. Findings included: Review of Resident #40's face sheet, dated 01/25/24 revealed he was an [AGE] year-old male, admitted on [DATE], and had diagnoses of Parkinson's (a progressive nervous system disorder, which affects the ability to move muscles), dysphasia (trouble swallowing) following a stroke, and gastronomy (g-tube or feeding tube) status, and gastronomy malfunction. Review of Resident #40's quarterly MDS assessment, dated 11/04/23, reflected Resident #40 had a BIMS (Brief Inventory of Mental Status) of zero, indicating sever cognitive impairment. He had no indicators of delirium, depression, or behaviors. Resident #40 had impaired range of motion, both upper and lower body, on both sides of his body, and was completely dependent on staff for all of his ADLs and movement in bed. Resident #40 was always incontinent of bowel and bladder. The document reflected Resident #40 had a feeding tube while a resident of the facility and received 51% or more of his nutrition through the feeding tube. Review of Resident #40's care plans reflected a care plan initiated 01/29/23, Focus: (Resident #40) has nutritional problem or potential nutritional problem r/t Parkinsons, CVA, Gtube, NPO. Goal: Will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition through review date. Interventions: PT, OT, ST Therapy evaluation and treatment per physician orders; Supplement medications as ordered Review of Resident #40's care plans reflected a care plan initiated 02/20/23, Focus: [NAME] requires tube feeding r/t Dysphagia, Swallowing problem/ NPO; Goal: (.) Will remain free of side effects or complications related to tube feeding through review date.; Interventions: (.) Change Enteral Administration Set as ordered; (.) Is dependent with tube feeding and water flushes. See MD orders for current feeding orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's order summary, dated 01/25/23, reflected NPO (Nothing by mouth) diet, Active, Start Date 02/02/2023; Enteral Feed Order every shift CHANGE ENTERAL ADMINISTRATION SET WITH EVERY FORMULA CHANGE., Active, Start Date 02/03/2023; Enteral Feed Order every shift FORMULA: OSMOLITE 1.5 AT 55 ML/HR X 22 HOURS TO PROVIDE 1815 CC/CAL./DAY WITH FREE WATER FLUSH 200 ML Q 4 HOURS FEEDING PUMP TO RUN FROM 1200 TO 1000. DOWNTIME FOR ADLs AND ACTIVITY 10AM - 12N, Active, 08/04/2023; Enteral Feed Order every shift TYPE OF FEEDING TUBE: g-tube DX: Dysphagia, Active 02/03/2023; Enteral Feed Order every night shift CHANGE SYRINGE, Active 02/02/2023 An observation on 01/23/24 at 11:47 AM, revealed Resident #40 was sleeping upon surveyors entering the room, and awoke and was incoherent but alert to the surveyors' presence, and smiling. He did not appear to be able to answer any questions. Resident #40's water bag was dated 01/21/24, 8:50 PM, and was almost empty. His 1-liter formula bottle was slightly less than half-full. Surveyors attempted to find a date on all sides of the formula bottle, but there was no date. Review of Resident #40's MAR for January 2023 reflected on 01/22/23, LVN A had signed off the day shift, and LVN B had signed on the evening shift for the order Enteral Feed Order every shift FORMULA: OSMOLITE 1.5 AT 55 L/HR X 22 HOURS TO PROVIDE 1815 CC/CAL./DAY WITH FREE WATER FLUSH 200 ML Q 4 HOURS FEEDING PUMP TO RUN FROM 1200 TO 1000. DOWNTIME FOR ADLs AND ACTIVITY 10AM - 12N and for the order Enteral Feed Order every shift CHANGE ENTERAL ADMINISTRATION SET WITH EVERY FORMULA CHANGE. Review of Resident #40s nursing progress note by LVN A, effective date 01/22/24 at 4:05 PM, reflected Alert to self, no resp distress noted at the moment, lung sounds clear and equal bilaterally, abdomen soft, non tender non distended, bowel sounds x 4 quads, g tube remain Intact and patent, osmolite 1.5 @55ml/hr continuous, tolerating feeding well. There were no other nurse's notes for the dates 01/22/24, or 01/23/24, regarding the resident's feeding tube. An interview on 01/25/24 at 2:02 PM, with LVN A revealed she remembered changing Resident #40's formula and water and she changed everything, the water, and the tubing set, when she did it, not just the formula. She said she did not work on Resident #40's hall often and was struggling a little to remember the exact day (01/22/23.) She said the bottle of formula was good for 48 hours, but his was changed daily. She said it was correct practice to change everything out when you changed the formula, because you would not want the old and new to get mixed up, and for everything to be clean, or the resident could get an upset stomach, as if they drank spoiled milk. She said she always dated it, the bottles so they could tell when they were placed. An interview on 01/25/24 at 4:35 PM, with the DON revealed on 01/23/23 she had the staff check on Resident #40's g-tube feeding, and they told her there was a date on it. She said the bottle said 48 hours on it, so they had been waiting until it was almost empty and changing it, but they were going to go back to changing it every 24 hours, and it will probably be done on the night shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Gastrostomy Tube Care and Management, dated 01/22, reflected the policy did not address replacing the tubing with new tubing, or dating the bottles, specifically. It did reflect: Policy: It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes. Procedure: (.) 11. Cleaning Tubes and Accessories: a. Wash your hands before handling gastrostomy tubes and attachments to decrease the risk of infection. b. Clean the resident side of any connections to ensure that all surfaces that contact each other are free of the slick coating caused by formula residue. c. Clean the outside of the tube, feeding adapter, and bolster daily with soap and water. d. Clean the inside of the feeding adapter periodically using water and cotton swabs. e. Clean all accessories, including syringes, after each use.

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Richland Hills Rehabilitation and Healthcare Cente	3109 Kings CT Fort Worth, TX 76118

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 48520 Based on observation, interview, and record review, facility failed to provide necessary respiratory care consistent with professional standards of practice, for 1 (Resident # 22) of 4 residents reviewed for Oxygen therapy. Facility failed to ensure Resident #22 had a portable oxygen tank that was not depleted of consistent oxygen therapy. This failure could place resident at risk for difficulty breathing, anxiety, shortness of breath. Finding included: Review of Resident #22 's admission record, dated 01/25/2024, revealed a [AGE] year-old female admitted to facility on 05/12/2022 with diagnoses that included unspecified dementia, unspecified intellectual disabilities, difficulty communicating, dysphasia (difficult swallowing), anxiety, need for assistant with personal care, protein calorie malnutrition, localized swelling disorder, lack of coordination, heart failure, and difficulty catching a breath (Dyspnea). Review of Resident #22's annual MDS, dated [DATE], reflected Resident #22 had a BIMs (Brief Inventory of Mental Status) of zero, indicating severe cognitive impairment. The document reflected no behavioral issues or indicators of psychosis. The document reflected resident required oxygen therapy. Functionally Resident #22 used a wheelchair and required extensive two-person assistance for bed mobility (moving herself around in her bed), transfer, dressing, and toilet use. She was totally dependent on staff for bathing but was able to feed herself. Review of Resident #22's order summary on 01/23/2024, reflected O2 [Oxygen] AT 3L[liter]/MIN CONTINUOUS PER every shift, active 05/13/2022. Review of Resident #22's care plan reflected care plan initiated 06/07/2022, Focus: [Resident #22] Has Oxygen Therapy r/t Ineffective gas exchange; Goal: Will have no s/sx [signs and symptoms] of poor oxygen absorption through the review date; Interventions: Change O2 tubing, and Humidifier bottle as ordered, give medications as ordered by physician. Monitor/document side effects and Effectiveness, promote lung expansion and improve air exchange by positioning with proper body. alignment (if tolerated, head of bed at 45 degrees), Provide reassurance and allay anxiety: Have an agreed-on method for the resident. to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/23/2024 at 12:28 PM, Resident #22 was sitting at table in dining room with oxygen tank on zero (0), and meter shows to be just into the red (empty) portion. Oxygen tubing was wrapped around resident wheelchair. Resident #22 was non-interview able however she removed the oxygen tubing from her nose and there was nothing coming out of the tubing. One of aides in dining was asked by Surveyor to alert a nurse that Resident #22 needed a nurse. Observation and interview with ADON E on 01/23/24 at 12:40 PM, ADON E came in dining area and stood next to Resident #22. She did not access resident. ADON E said that the red meter meant that the oxygen tank was empty and needed to be refilled. She said Oxygen tank monitoring was done by the floor nurse. She said Resident #22 was on 3 liters of oxygen. She said risk of not having oxygen was increased confusion and respiratory distress. Risk of not having clean tubing was a risk for infection control. Observation and interview on 01/23/24 12:44 PM, LVN G finally arrived at 12:44 pm with a full oxygen tank and attached Resident #22 to the new full tank. LVN G did not check pulse Oxygen. LVNG said that she had checked Resident #22's tank that morning. She said reading was full in green section. She said CAN F brought resident into the dining room. She said it was the nurse's is responsible for making sure resident has her O2, and tubing was scheduled every Sunday to be changed and Tubing was dated. Resident #22's tubing was not dated. LVN G said the risks of lack of continuous supplemental oxygen were hypoxia, sob, possible death. Risk of not having clean tubbing was a risk for infection control. Interview with DON on 01/24/34 at 01:58 PM, revealed she was shocked that ADON E was in the dining area and she did not report to her. She said that was unacceptable nursing practice and she would start to in-service. risks of lack of continuous supplemental oxygen were hypoxia, shortness of breath, possible death. Review of facility's policy titled Oxygen Administration revision date 07/2013, reflected .The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. The resident's clinical record will include: 1. That oxygen is to be administered. 2. When and how often oxygen is to be administered. 3. The type of oxygen device to use (i.e., mask, nasal) 4. Any special procedures or treatment to be administered. 5. Charting and documentation related to oxygen use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not 5 percent (5%) or greater for 3 of 25 opportunities resulting in a 8 percent medication error rate for 1 of 10 residents observed for medication pass. Facility failed to ensure Resident #6 medications were administered as physician order. Facility failed to ensure Resident #6 medication were not crushed or mixed into a cocktailed without a physician order. Facility failed to ensure Resident #6 received chewable aspirin instead of safety coated aspirin that was crushed without a physician order. These failures could place residents at risk for significant medication errors and jeopardize the resident health and safety. Finding included: Review of Resident #6 's admission record, dated 01/25/2024, revealed a [AGE] year-old female admitted to facility on 04/07/2023 with diagnoses that included stroke, unspecified intellectual disabilities, difficulty communicating, dysphasia (difficult swallowing), depression, unspecified schizoaffective disorder, anxiety, blind in right eye, lack of coordination and Parkinson's disease without involuntary muscle spasms or jerks (a progressive nervous system disorder, which affects the ability to move muscles). Review of Resident #6's physician orders dated 01/25/2024, reflected Aspirin Tablet Chewable 81 MG, Give 1 tablet by mouth one time a day for blood clot prevention active date 02/17/2022. Carbidopa-Levodopa Tablet 25-100 MG Give 2 tablet by mouth four times a day for Parkinson's active date 02/17/2022, Escitalopram Oxalate Tablet 20 MG Give 1 tablet by mouth one time a day for Depression AEB feelings of hopelessness/Socially withdrawn related to DEPRESSION, UNSPECIFIED active date 04/10/2022, Bisoprolol Fumarate 5 MG Tablet Give 2.5 mg by mouth one time a day for HTN HOLD FOR SBP LESS THAN 110 OR DBP LESS THAN 60 OR PULSE LESS THAN 60 Give 1/2 tablet (2.5mg) by mouth 1 time daily *HOLD AS DIRECTED PER MAR* active 09/10/2023. GENERIC EQUIVALENT OF MEDICATIONS MAYBE DISPENSED UNLESS OTHERWISE SPECIFIED active date 02/17/2022. Review of Resident #6's quarterly MDS assessment, dated 11/10/2023, reflected Resident #6 had no BIMS (Brief Inventory of Mental Status) score. She had no indicators of delirium, depression, or behaviors. Resident #6 had impaired range of motion, both upper and lower body, on both sides of his body, and was completely dependent on staff for all his ADLs and movement in bed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's care plans reflected a care plan initiated on 04/10/2023, Focus: [Resident #6] has a nutritional problem r/t [related to] inability to feed self, dysphagia [difficult swallowing], mech altered diet; Goal Will maintain adequate nutritional status as evidence by maintaining weight with no s/sx [signs and symptoms] of malnutrition through review date.; Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness, (.). Observation and interview during medication observation on 01/25/2024 from 09:11 am to 10:24 AM, revealed CMA C put 4 tablets belonging to Resident #6 in a medication cup, she then transferred all 4 pills to a small clear bag and crushed the medication together. One of the medications crushed was a house stock of Low dose Aspirin 81 mg safety Coated not Aspirin Tablet Chewable 81 MG as ordered. CMA C then added the crushed medications into another cup with some apple sauce. She then added the 1/2 pill of Bisoprolol Fumarate, without crushing it and administered the medications to Resident #6. CMA C said that all the nursing staff that administered Resident #6 medications crushed it. She said that when she was trained, she was told that Resident #6 had swallowing problems and needed her medications crushed. CMA C said that she cannot remember if resident had orders to crush her medication. CMA C added that she was not aware that she could not mix and cocktail all Resident #6 medications together without an order. CMA C did not state the risk. Interview with the ADMN on 01/24/2024 at 4:40 pm, revealed that he expects nursing staff to follow the facility policy. An interview on 01/25/2024 at 4:35 PM, the DON said that Resident #6 had orders to cocktail her medications at some point since her initial admission in 2022. She said that she expects all medication aides and nurses to follow physician orders. She said if there is no order do not crush and cocktail resident medication. She said the risk is medication error. Review of the facility policy Administering Medications, revised 04/19, reflected . Medications are administered in accordance with prescriber orders, including any required time frame.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for 1 (Resident #15) of 10 residents reviewed for storage of drugs and Biologicals. Facility failed to ensure insulin for Resident #15 was correctly labeled with the date it was opened. Finding included: Review of Resident #15 's admission record, dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included stroke, type 2 diabetes, high blood pressure, other viral pneumonia, muscle wasting, unsteady on her feet and lack coordination, stiffness of joints, falls, depression and insomnia. Review of Resident #15's order summary, dated [DATE], reflected NovoLIN R FlexPen Injection Solution Pen-injector 100 UNIT/ML (Insulin Regular (Human)) Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 =4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; ,d+[DATE] = 12 401 OR ABOVE=12 units; recheck in 1 hour, notify MD, subcutaneously before meals for DM II NOTIFY MD OF BS <70, active date [DATE]. Observation and interview during medication storage and labelling inspection on [DATE] at 12:47pm, reveled Resident #15 insulin pen had no open and or discard date after 30 days of use. LVN A took insulin pen from the top drawer of medication cart and set the 2 units on the insulin pen and administered the insulin in the abdomen of Resident #15. LVN A said that the opening date of the insulin pen fell off the insulin pen. She stated that she did not know when insulin pen was opened, but it was recent. LVN A said that the facility policy was to use opened insulin within 30 days of opening it. Interview with the ADMN on [DATE] at 4:40 pm, revealed that he expects nursing staff to discard expired medication per manufacturer and to follow the facility policy. An interview on [DATE] at 4:35 PM, with the DON revealed all nurses should check insulin prior to administering to resident and the open insulin should be dated and should have legible resident's name on the insulin. She said all the nurses were responsible for overseeing that insulin was checked and not expired. She said the ADON E had audited the medication carts recently. She said administering a medication that had no date was a deficit nursing practice. She said this was a med error. (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 the facility's, undated, policy, Storage of Medication, reflected that, will maintain medication storage and preparation areas in a clean, safe, and sanitary manner .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy .

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35489 48520 Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 1 of 4 quarters reviewed for Fiscal year Quarter four of 2023 (July 1- September 30). The facility failed to submit RN staff hours for 07/15/23, 08/11/23, 08/18/23, 08/19/23, 08/25/23, 08/26/23, 09/02/23, 09/09/23, 09/16/23, and 09/23/23. The facility's failures could place residents at risk for needs not being met and a decreased quality of care. Findings included: Review of the CMS PBJ report for CMS for Fiscal Year Quarter four of 2023 (July 1- September 30) reflected No RN Hours was triggered, for lack of RN coverage on for 07/15/23, 08/11/23, 08/18/23, 08/19/23, 08/25/23, 08/26/23, 09/02/23, 09/09/23, 09/16/23, and 09/23/23. Review of RN time stamp detail sheets for agency RNs and direct care schedules for 07/15/23, 08/11/23, 08/18/23, 08/19/23, 08/25/23, 08/26/23, 09/02/23, 09/09/23, 09/16/23, and 09/23/23 reflected sufficient RN coverage on those dates. An interview on 01/25/24 at 3:15 PM with the DON revealed she was new to the facility, and the ADON was responsible for scheduling the nurses. She provided time stamp details for agency RNs on for 07/15/23, 08/11/23, 08/18/23, 08/19/23, 08/25/23, 08/26/23, 09/02/23, 09/09/23, 09/16/23, and 09/23/23. An interview with the Administrator on 01/24/24 at 4:10 PM revealed the facility had agency RN staffing on the weekends, facility staff was not able to cover staffing fully, but the HR Director at that time did not know she had to code agency hours for the payroll-based staffing journal, until they had passed the deadline. He said they now knew how to do it, and the new HR director had only been there a very short time. (continued on next page)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility's undated policy PROCEDURE AND GUIDANCE S483.35(b) reflected The facility is responsible for submitting staffing data through the PBJ (Refer to F851, S483.70(q)). This data is available through PBJ reports that can be obtained through the Certification and Survey Provider Enhanced Reports (CASPER) reporting system. These reports, titled PBJ Staffing Data Report will be utilized by surveyors and contains information about overall direct care staffing levels as well as licensed nurse staffing, and if an RN was onsite for 8 hours a day, 7 days a week. If concerns were identified on this report, as well as from other sources, refer to the Critical Element pathway Sufficient and Competent Staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, 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 disease and infections for 6 (Residents #6, #39, #42, #43, #49, and #204) of 10 residents reviewed for infection control. The facility failed to implement an infection control and prevention that included wound care procedures and cross contamination for Resident #39 and #43 during wound care. The facility failed to ensure CMA C sanitized blood pressure cuff between use on Residents #6, #42, #49, and #204. The facility failed to ensure CNA F maintained a contaminate free clean linen for all residents in BACK HALL ODD and BACK HALL EVEN hallway from rooms 21 to room [ROOM NUMBER]. These failures could place residents at risk of infectious diseases, cross contamination, staph infection, and hospitalization . The finding included: Review of Resident #6 's admission record, dated 01/25/2024, revealed a [AGE] year-old female admitted to facility on 04/07/2023 with diagnoses that included stroke, unspecified intellectual disabilities, difficulty communicating, dysphasia (difficult swallowing), depression, unspecified schizoaffective disorder, anxiety, blind in right eye, lack of coordination and Parkinson's disease without involuntary muscle spasms or jerks (a progressive nervous system disorder, which affects the ability to move muscles). Record review of Resident #39's Admission Record dated 01/25/2025, reflected a [AGE] year-old female admitted to facility on 11/28/2023 with diagnoses that included shortness of breath with Oxygen dependance, type 2 diabetes Meletus, heart attack, reflex, high cholesterol, high blood pressure, and Cerebrovascular diseases (a condition that affects blood flow to your brain) Review of Resident #39's order summary report dated 01/25/2024, reflected Left Buttock Moisture Associated Skin Damage, clean with Normale Saline or Wound Cleanser, Pat Dry, Apply Calcium Alginate and cover with Dry dressing. Daily and PRN for soiled or tattered dressing. As needed. Active date 01/22/2024. Left Buttock Moisture Associated Skin Damage, clean with Normale Saline or Wound Cleanser, Pat Dry, Apply Calcium Alginate and cover with Dry dressing. Daily and PRN for soiled or tattered dressing. Every shift, active date 01/22/2024. Records review of Resident # 42's Admission Records dated 01/25/24 reflected, an [AGE] year-old female who admitted to the facility on [DATE]. Resident # 42's diagnoses included Anxiety, Stroke, high cholesterol, history of blood clots, lack of coordination, abnormal posture, and Osteoarthritis, high blood pressure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's Admission Record dated 01/25/2024, reflected a [AGE] year-old female admitted to facility on 10/11/2023 with diagnoses that included alcoholic cirrhosis with ascites (this a disease of liver dysfunction fluid collection around abdomen and chest area), cocaine dependence, both legs amputated, depression, low iron anemia, blood clots, and congestive heart failure. Review of Resident #43's order summary report dated 01/25/2024, reflected Left AKA Trauma, Apply Betadine Daily and LOTA everyday every day shift for wound healing active date 12/20/2023. Review of Resident #49's Admission Record, dated 01/25/24 revealed he was a [AGE] year-old male, admitted on [DATE], with diagnoses that included Parkinson's (a progressive nervous system disorder, which affects the ability to move muscles), Brain disease that changes brain function or structure (encephalopathy), fluid imbalance, Schizophasia, repeated falls and lack of coordination unspecified. Records review of Resident # 204's Admission Record, dated 01/25/2024, revealed a [AGE] year-old female admitted to facility on 01/13/2024 with diagnoses that included local infection of skin and fat tissue (subcutaneous), high blood sugar, acute kidney failure with tubular dying/wasting (necrosis), dependence on kidney dialysis, difficulty breathing, and severe obesity. Observation and interview on 01/23/2024 at 10:56 AM, revealed CNA F pulled linen from a dark green covered clean linen cart by BACK HALL EVEN hallway. CNA F dropped a gown on the floor as she pulled linen, she picked up the gown that fell on the floor and threw it back into the clean linen cart. She took the clean linen and entered room [ROOM NUMBER] and closed the door. CNA F said that the floor was clean. CNA F said that even though it was a high traffic hallway, the housekeeper had just cleaned the floor. She then opened the green cover of linen and got a different item. She was informed that the gown had landed on the top shelf of linen, and she grabbed it and went back into room [ROOM NUMBER]. CNA F did not see any risk. Wound care observation and interview with ADON E on 01/23/24 at 02:21 PM, revealed ADON E prepared wound care items in the hallway outside Resident #43's room. ADON E wiped bedside table, after fanning table to dry with her hand, she placed her wound care items on table. 1 piece of wax paper on the left and another wax paper on the right side on the same bedside table. Puts new gloves on, bilateral Below the Knee Amputee, wiped left knee with saline, placed soiled gauze on right side wax paper. Removed gloves and placed them on right side on wax paper, hand hygiene. New gloves on. No biohazard bag or trash bag for soiled items. No pain assessment. Picked up clean gauze with wound cleaned crossed over soiled items on right side wax paper and wiped wound again, hand hygiene, new gloves. Applied betadine to wound. Removed gloves. When done with wound care, bundled the soiled items on the wax with her gloves. Resident asks her if she would wipe the right outer side of her wound. ADON E said that area was healed. ADON E washed hands and picked up the soiled wound care items and puts them in the treatment cart in a regular clear bag. Hand hygiene after disposing the soiled items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care observation and interview with ADON E on 01/23/2024 at 02:36 PM, revealed ADON E prepared wound care items in the hallway outside Resident #39. ADON E wiped bedside table, after drying placed her wound care items on table. 1 wax paper piece on the left and another on the right side on the bedside table. ADON E wears clean gloves and removed old dressing from Resident #39 from Left Buttock dated 01/22/24 and placed soiled old dressing on the right-side wax piece of paper. Removed gloves and placed them on top of old dressing next to clean dressing items on the same table. After hand hygiene gets new gloves cleans wound 3 times puts all soiled items on the right-side wax piece of paper. After hand hygiene gets new gloves puts medication cream on gauze and puts it on wound. She finished the wound care dated and initial and Resident #39 is dressed. No biohazard bag or trash bag for soiled items. ADON E took all soiled items on right-side and wax piece of paper crumped them in a ball, carried soiled outside and placed them in treatment cart trash can outside the room. She washed her hands and cleaned off Resident #39 bedside table. Interview with ADON E on 01/24/2024 at 2:10 PM, revealed that she had been nervous and that she performed multiple hand hygiene during wound care. She that today she was prepared for Resident #203 wound care observation and remembered the biohazard bag for the soiled items. She said the risk of not having a separate area for clean and soiled wound items was contamination and risk of infection. Observations and interview during medication observation on 01/25/2024 from 09:11 am to 10:24 AM, revealed CMA C went into Resident #204's room took her BP on left wrist. She went back to medication cart placed soiled BP cuff on top of medication cart. Hand hygiene is performed. Resident #204 BP 93/56, HR 77. CMA C does not sanitize the BP cuff. CMA C administered medications to Resident # 204. CMA C then wheeled medication cart to the dining room and parked cart outside the dining area. CMA C looked up resident she was looking for on the computer and went into dining room with soiled BP cuff where residents were having an activity and placed soiled BP cuff on Resident #6 wrist. Resident# 6's BP129/81, pulse 108. She then came back to the medication cart and put the soiled BP cuff on top of medication cart. CMA C obtained Resident #6 medications. Hand hygiene is performed after medication administration to Resident #6. BP cuff was not sanitized. CMA C then looked up another resident on her computer and took the soiled BP cuff off the top of medication cart and went back into the dining room and placed soiled BP cuff on Resident #49 wrist. BP reading unknown. CMA C placed soiled BP cuff back on top of Medication cart. She gave two pills to Resident # 49. CMA C performs hand hygiene after She administered medications to Resident #49. CMA C then looked up another resident on her computer. Resident is identified as Resident #42. CMA C took same soiled BP cuff and went back into dining room and placed BP cuff on Resident # 42's wrist. Resident #42's BP 172/67, pulse 61. 7. CMA C places the unsanitized and unclean BP cuff back on the medication cart. CMA C attempted to continue with another resident, but surveyor intervened and stopped CMA C. Interview with CMA C on 01/25/24 at 10:24 AM, revealed that CMA C had forgotten to sanitize the BP cuff in between the residents. She said that she was supposed to clean the BP cuff between residents, but she had been so nervous that she forgot. She said that the risk of not sanitizing and cleaning equipment between residents was the spread of infection. Interview with DON on 01/24/34 at 01:58 PM, revealed after each resident, the BP cuff should be cleaned with the purple top San cloth sanitizer cloths. She said that she expected staff to sanitize the BP cuff, thermometer, and pulse oximeter before use, in between each resident and after use. DON said that all staff are in-serviced on infection control prevention every quarter and as needed. She said the risk of not cleaning equipment in-between residents is the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455576	A. Building B. Wing	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Hills Rehabilitation and Healthcare Cente	3109 Kings CT Fort Worth, TX 76118

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility did not have policy for wound care and/ or handling biohazard items. Review of the facility's policy dated November 9, 2022, and titled Standard Precautions revealed .Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .hand hygiene is performed with soap (anti-microbial or non-antimicrobial) or alcohol-based hand rub before and after contact with the resident .Resident-Care Equipment: reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed .