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	05/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two of eight residents (Residents #3 and #4) reviewed for dignity. 1. The facility failed to ensure the urinary collection bag for Resident #3's catheter was covered with a privacy bag. 2. The facility failed to ensure the urinary collection bag for Resident #4's catheter was covered with a privacy bag. These failures could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem. Findings include: Record review of Resident #3's face sheet, dated 05/17/2024, indicated an [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included, unspecified dementia with agitation (mild cognitive impairment easily agitated), cerebral ischemia (acute brain injury), encephalopathy (a disease of the brain, especially one involving alterations of brain structure), depressive disorder (mood disorder that causes persistent loss of interest), and anxiety disorder (persistent and excessive feelings of worry, fear, or dread that interfere with daily life). Record review of Resident #3's quarterly MDS Assessment, dated 04/26/2024, reflected a BIMS score of 4, which indicated a severe cognitive impairment. Resident #3 used a wheelchair to ambulate, was totally dependent for toileting, showers, dressing and hygiene. He required partial assistance for transfers. He had an indwelling catheter and was always incontinent of bowel. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's Comprehensive Care Plan dated 04/01/2023 reflected, Focus: [Resident #3] has alteration on cognition resulting from CVA that resulted in cognitive impairment and communication deficit. Intervention: Cueing, reorientation as needed. Focus: [Resident #3] is receiving PASRR services for PASRR positive diagnosis of schizoaffective disorder/MI with major depression. Interventions: outline case management Coordinate and group skills training and development services with a representative from the LMHA. Focus: [Resident #3] has a suprapubic Foley Catheter-Urethral stricture. Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door (resident refuses at time). Secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental. Discussed with resident/representative the risks and benefits of the use of a catheter, removal of the catheter when criteria for use is no longer present and the right to decline the use of the catheter. Resident refuses to keep catheter bag inside the privacy bag and attached to the side of the bed or to his wheelchair. He states that, He was to see that he is peeing. He carries the catheter bag in his lap above his bladder. Focus: [Resident #3] is at risk for injury/infection related to placement of foley catheter removal. Focus: [Resident #3] is resistive to care at times r/t Anxiety AEB noncompliance with care, striking out at others. Interventions: if resident resists with ADLs, reassure resident, leave, and return 5-10 minutes later. Praise when behavior is appropriate. Record review of Resident #4's face sheet, dated 05/17/2024, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included, unspecified paraplegia (a type of paralysis the prevents you from moving the lower half of the body), hypo-osmolality and hyponatremia (levels of electrolyte, proteins, and nutrients are lower than normal) and major depressive disorder (mood disorder that cause persistent sadness). Record review of Resident #4's admission MDS Assessment, dated 04/03/2024, reflected a BIMS score of 15, which indicated cognitively intact cognition. Resident #4 used a wheelchair to ambulate, required substantial/maximal assistance for showers, hygiene. He had an indwelling catheter and was always incontinent of bowel. Record review of Resident #4's Comprehensive Care Plan, dated 04/02/2024, reflected, Focus: [Resident #4] has ADL Self Care Performance Deficit r/t Paraplegia, weakness, Limited mobility. Interventions: Staff will Physically assist with ADLs as needed. Focus: [Resident #4] has an indwelling catheter r/t neurogenic bladder. Interventions: Position catheter bag and tubing below the level of the bladder and away from entrance room door. Secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. An observation and interview on 05/17/2024 at 9:20 AM revealed, Resident #3 was outside on the facility patio. Resident #3's catheter bag was hanging on the side of his wheelchair, uncovered and exposed the urine inside the bag. Resident #3 answered in mumbles when asked about his catheter bag. Another resident and two family members were observed on the patio across from Resident #3. An observation and interview on 05/17/2024 at 9:30 AM revealed, Resident #4 was inside the facility, at the door leading to the patio. Resident #4's catheter bag was hanging under his wheelchair and was uncovered exposing the urine inside the bag. Resident #4 said staff usually covered the bag and did not know when it was not covered today. He said he did prefer to have it covered so the could not be seen. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/17/2024 at 10:05 AM, the ADON stated all catheter bags should be covered to ensure residents' privacy and dignity. She said Resident #3 often took the privacy bag off his catheter bag. She said staff needed to constantly remind him to leave the bag on. She said Resident #4's catheter bag should be on and did not know why it was not. In an interview on 05/17/2024 at 10:15 AM, the Clinical Resources Coordinator said she was aware Resident #3 often removed the privacy bag from his catheter bag. She said this issue was documented in Resident #3's care plan and staff were expected to do their best to ensure the bag was covered at all times. She said she was looking into getting catheter bags that had the cover built-in. She said Resident #4's catheter bag should be covered as well. She stated this was to ensure the resident's dignity and privacy. In an interview on 05/17/2024 at 11:00 AM, the Marketer stated she saw Resident #3 on the patio and his catheter bag was not covered. She said she knew he often took it off, but the bag should always be covered to ensure his dignity and the dignity of other residents in the facility. She said no one wanted to look at a bag full of urine. She stated she did place a cover on the bag when she saw it but Residnet #3 was resistant. In an interview on 05/17/2024 at 11:08 AM, the Administrator said he expected the catheter bags to be covered to ensure all residents dignity. He said the covers also assisted in limiting the possibility of the bag being torn or leaking. In an interview on 05/17/2024 at 12:40 PM, CNA A stated Resident #3 often would remove the catheter bag cover. She said she typically would distract him with conversation while another CNA would cover the bag and place it under his wheelchair. She said this worked most times, but she had to constantly check that the bag was on. She said Resident #4 should also have a cover on his catheter bag to ensure dignity. She said she did not recall putting a cover on Resident #3 or resident #4's catheter bags this morning. In an interview on 05/17/2024 at 12:48 PM, CNA B stated Residents #3 and #4's catheter bags should be covered to ensure their dignity. She said she knew Resident #3 needed to be watched as he often took his cover off the catheter bag. In an interview on 05/17/2024 at 1:18 PM, LVN C stated all catheter bags should be covered to ensure resident's dignity. She said it was all staff's responsibility to watch for this. She said although Resident #3 often would remove his catheter bag cover, staff should continue to try to cover it as outlined in his care plan. Record review of the facility's policy titled, Resident Rights, dated 10/04/2016, reflected As a resident of this nursing facility, you have the right to a dignified existence, self-determination . You have the right to be treated with respect and dignity, including the right to: reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger your or other residents' health or safety . You have the right to self-determination through support of your choice . You have the right to personal privacy .you have a right to personal privacy, including accommodations .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review the facility failed to ensure the residents had the right to personal privacy and confidentiality of his or her personal space for two of eight residents (Residents #1 and #2) reviewed for privacy. The facility failed to ensure there was a privacy curtain in Resident's #1 and #2's room since Resident #2's admission to the facility on [DATE]. This failure could place residents at risk for a loss of privacy, dignity, and decreased self-worth and self-esteem. Findings include: Record review of Resident #1's face sheet dated 05/17/2024 indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included, unspecified dementia (mild cognitive impairment), cognitive communication deficit (trouble understanding or responding to communication), depression (serious mood disorder), and chronic kidney disease (a gradual loss of kidney function over time). Record review of Resident #1's quarterly MDS Assessment, dated 04/16/2024, reflected a blank BIMS score. Resident #1 required partial/moderate assistance for toileting and transfers. She was always continent of bowel and bladder. Resident #1 was on hospice care. Record review of Resident #1's Comprehensive Care Plan, dated 05/05/2024, reflected, Focus: [Resident #1] has a terminal prognosis r/t: senile degeneration of the brain, admit under the care of hospice. Interventions: Work with nursing staff to provide maximum comfort for the resident. Focus: ADL Self Care Performance Deficit. Interventions: Toilet use, transfer, and hygiene requires assistance. Record review of Resident #2's face sheet, dated 05/17/2024, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included, unspecified fracture of upper end of left humerus, dementia without behavioral disturbance (mild cognitive impairment), hypothyroidism (thyroid gland does not release enough thyroid hormone into the bloodstream), and chronic obstructive pulmonary disease (inflammatory lung disease that causes obstructed air flow). Record review of Resident #2's admission MDS Assessment, dated 05/06/2024, reflected a BIMS score of 7, which indicated mild cognitive impairment. Resident #2 used a wheelchair to ambulate, she was totally dependent for toileting and showers. She required substantial/maximal assistance for transfers and was always incontinent of bowel and bladder. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Comprehensive Care Plan, dated 05/01/2024, reflected Focus: [Resident #2] is risk for impaired cognitive function/dementia or impaired thought processes. Interventions: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Focus: ADL self-care performance deficit. Intervention: staff will physically assist with ADLs as needed. Focus: [Resident #2] has bowel/bladder incontinence. Intervention: uses disposable briefs, change and prn. An observation on 05/17/2024 at 9:40 AM of Resident # 1's room revealed the privacy curtain between A and B beds was missing. There was a curtain at the end of B bed in the room but only covered the end of the bed and not the area between the residents in the room. In an interview on 05/17/2024 at 9:45 AM, Resident #1 stated she was aware the privacy curtain that separated her and Resident #2 was missing. She said she did not know how long it was missing but prefered it be closed when staff provided her care. In an interview on 05/17/2024 at 9:55 AM, Resident #2 said the privacy curtain that separated her and Resident #1 was missing. She said the curtain was not there when she moved into the room on 04/229/2024. Resident #2 stated she wished it were there because she would like it to be closed when Resident #1 was in the room because Resident #1 often yelled out. She said she only wanted to have her own private space. In an interview on 05/17/2024 at 10:05 AM, the ADON stated the room where Residents #1 and #2 stayed used to be a private room and the privacy curtain was removed at that time. She said they must have forgotten to replace the curtain when Resident #2 was moved into the room with Resident #1. She said it should be there to ensure each resident had privacy during personal care. In an interview on 05/17/2024 at 10:15 AM, the Clinical Resources Coordinator said she was not aware there was no privacy curtain in Residents #1 and #2's room. She said each resident had a right to privacy when they choose and the curtain between all resident beds needed to be in place to ensure that privacy. In an interview on 05/17/2024 at 11:08 AM, the Administrator said he expected the nursing staff to ensure privacy curtains were in place and available in all rooms to ensure all resident's right to a private space when they wanted it. In an interview on 05/17/2024 at 12:18 PM, the Maintenance Director stated he did recall someone telling him about the missing privacy curtain but did not remember when. He said all maintenance of room issues needed to be recorded in the maintenance log and he followed up with them daily. He said the missing privacy curtain in Residents #1 and #2's room was not recorded in the maintenance log. He said staff knew to use the maintenance log but often did not. In an interview on 05/17/2024 at 12:40 PM, CNA A stated she did not notice the privacy curtain in Residents #1 and #2's room was missing. She said it should be in place to ensure residents had privacy when they required personal care. She said she always closed the door when providing personal care to residents but with no curtain between resident beds, residents still would not have the privacy they deserved. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/17/2024 at 12:48 PM, CNA B stated Resident #1 used the bathroom but Resident #2 needed incontinence care. She stated the curtain should be in place to ensure each resident had privacy as needed. She said she had not noticed the curtain was missing in the room until today. She stated she had only ensured privacy Residents #1 and #2 from the hall but not from each other. In an interview on 05/17/2024 at 1:18 PM, LVN C stated the CNAs had not told her the privacy curtain was missing in Residents #1 and #2's room. She said the curtain was meant to provide privacy to residents. She said she was not sure how long the curtain was not in the room, but maintenance should have replaced it if they were aware. Record review of the facility's policy titled, Resident Rights, dated 10/04/2016, reflected, As a resident of this nursing facility, you have the right to a dignified existence, self-determination .You have the right to be treated with respect and dignity, including the right to: reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger your or other residents' health or safety .You have the right to self-determination through support of your choice .You have the right to personal privacy .you have a right to personal privacy, including accommodations