

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455576	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Richland Hills Rehabilitation and Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791</p> <p>Based on interviews and record reviews, the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation, which includes but not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms for 1 (Resident #1) of 3 residents reviewed for involuntary seclusion.</p> <p>The facility failed to ensure the ADON did not tip Resident #1's wheelchair forward, dump him onto his bed, remove his wheelchair from the room, and close the resident's door.</p> <p>This failure could place residents at risk of injury, falls from bed, and decreased sense of self worth.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which including stroke, history of falls, and depression.</p> <p>Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 2, which indicated he had severe cognitive impairments. His Functional Status reflected he required complete assistance with his ADLs except eating. Resident #1's Mobility Assessment reflected he required partial assistance with transfers.</p> <p>Record review of Resident #1's care plan, dated 05/28/24, reflected he had impaired cognitive processes, and impaired communication related to his stroke.</p> <p>Record review of Resident #2's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included paralysis below the waist, and depression.</p> <p>Record review of Resident #2's admission MDS, dated [DATE], reflected a BIMS score of 15 which indicated he was cognitively intact.</p> <p>(continued on next page)</p>

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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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's investigation report reflected the ADON was witnessed to have taken Resident #1 into his room, via his wheelchair, and tilting the wheelchair forward so that Resident #1 fell on to his bed. The ADON then left the room with Resident#1's wheelchair and closed the door. The incident was witnessed by another resident sitting in the hall with Resident #1.</p> <p>Record review of witness statement written by CNA A reflected she saw the ADON exiting Resident #1's room with his wheelchair and closing the door. She stated the ADON said, I'm not dealing with him tonight.</p> <p>Interview on 07/10/24 at 11:00 AM with Resident #1 revealed he was in the hall outside his room asking about his shower when the ADON came up to him, mad about something, and stated she was not going to deal with this tonight. The ADON pushed him into his room and dumped him onto his bed, used a racial slur, and left the room with his wheelchair, closing the door behind her. Resident #1 stated he had to position himself in bed. He needed a blanket but could not find his call light button, and no one responded to him yelling. Resident #1 stated he was able to transfer himself to his wheelchair as long as it was positioned by his bed. He stated his wheelchair was not brought back to him until the morning. Resident #1 stated he never had any problems with the ADON before, and he thought she was just having a bad day. The resident stated he did not like being treated like that, and he did not have any injuries from the encounter.</p> <p>Interview on 07/10/24 at 11:05 AM with Resident #2 revealed he was sitting in the hall with Resident #1. Resident #1 was yelling at the staff about a snack, his shower, and just causing chaos with his yelling. He stated the ADON came over and pushed Resident #1 in his wheelchair into his room and tilted the wheelchair forward. He stated he saw Resident #1 fall onto his bed. The ADON then brought Resident #1's wheelchair back to the hallway and closed the door. The ADON then said something to the effect of not dealing with him tonight.</p> <p>Interview on 07/10/24 at 1:45 PM with the DON revealed she was not involved in the investigation other than gathering staff statements. The DON stated when she spoke with the ADON she denied the events occurred as described. Other staff stated Resident #1 was very disruptive and was cursing at the staff. The DON initially stated she had written statements from the staff, and she only submitted a phone interview from CNA A.</p> <p>Interview attempts with the Administrator (on vacation), the ADON (terminated and calls not returned), and CNA A (calls not returned) were unsuccessful.</p> <p>Record review of the facility's policy Abuse: Prevention of and Prohibition Against, dated December 2023, reflected:</p> <p>It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of property, exploitation, and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any kind of physical or chemical restraint .</p>		