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	02/27/2025

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to permit the resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility for 1 of 2 residents (Resident #199) reviewed for facility-initiated discharges. The facility failed to permit Resident #199 to remain in the facility and discharged the resident from the facility. Resident #199 was not allowed to return to the facility following a neurologist's appointment on 12/18/24 due to the facility having the resident sign an AMA form before she left for the appointment. After refusing Resident #199 to enter back into the facility, the facility called EMS who took her to a hospital for an evaluation. The failure could affect residents by placing them at risk of not having access to adequate care in a nursing home facility. Findings included: Record review of Resident #199's MDS Nursing assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #199's diagnoses included diabetes mellitus (disease that results in too much sugar in the blood), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breath), and cognitive communication deficit (communication difficulty caused by a cognitive impairment). Resident #199's MDS did not reflect a BIMS score, which meant that she did not complete the interview. MDS also reflected that Resident #199 did not have impairment in her upper or lower extremities. Record review of Resident #199's undated care plan reflected Focus: Potential for a behavior problem. Resident signed AMA on 12/18/24. This was created by the DON. There were no care plan goals or interventions documented. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #199's Progress Notes, dated 02/27/25 at 1:06 PM by the ADON, reflected: RP called facility to update staff about her mother//Residents whereabouts, Resident was still at the Doctor's appointment status. RP states, I'm going to try and look for a homeless shelter for my mom, because she is not allowed to come back to my house due to a former APS case and False accusations of family members . AMA was signed and RP is aware, advice was given to RP that Resident could go to hospital for further evaluation and placement . Record review of Resident #199's Progress Notes, dated 02/27/25 at 12:19 PM by LVN C, reflected: Resident informed writer that she has a doctor's appt and needed to be there by 1300 [1:00 PM]. Writer contacted social services to inquire if there's any appt set and the social worker confirmed that there was no appt set for the resident. Resident was notified about the social services' lack of knowledge of the appt and was asked if she can reschedule the appt, so that proper transportation arrangements can be made. Resident refused stating, 'No one tells me what to do. If it's transportation, I can get my own ride so don't worry about that.' Resident was further educated about her safety and the need for her to have a facility recognized personnel to take her to the appt but insisted that she must go. At around 11 am, resident came to the station ready to leave, AMA form was presented and explained to her what it means by the ADON witnessed by writer. Resident signed the form and was picked up by her ride outside the facility. Record review of Resident #199's Progress notes, dated 02/27/25 at 12:17 PM by the ADON, reflected: Resident agitated about Dr appointment not being accommodated. Resident schedules her own appointment to Neurologist. Resident scheduled her own transportation and told staff that she will not be coming back and was yelling. Once asked where Resident was going to go Resident stated, 'I will find a hotel.' This Nurse explained to Resident that it is cold and not safe for her to be outside without assistance. This Nurse offered to re-schedule her appointment to have transportation, and a staff member accompany. Resident stated, 'I'm sick of being here,' This Nurse explained that AMA will have to be filled out if she has no plan on returning to the facility. Resident signed paper. This Nurse explained that AMA is leaving again Medical Advice if there's no plans on returning to the facility. Resident's daughter was called and told about Resident leaving facility with own transportation and signing AMA form. Daughter notified of Resident leaving and was asked to talk to her mom about the situation or if she can accompany her. Resident's RP stated, 'My mom doesn't listen to me, it's ok if she wants to leave.' Ombudsman was called. PCP was notified. Record review of Leaving Facility Against Medical Advice form, dated 12/18/24, reflected signatures from LVN C, the ADON, and Resident #199. The form reflected, I am leaving the facility against the advice of Dr. [ ] and a representative of the facility administration. The form was blank with the physician's name. The physician's signature was also missing from the form. Record review on 02/27/25 of Resident #199's Electronic Health Record reflected no 30-day discharge letter issued for Resident #199 since her admitted on 10/31/24 by staff member from the facility. Interview on 02/25/25 at 2:20 PM with the Ombudsman was attempted but was not successful. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/26/25 at 11:48 AM with Resident's RP revealed Resident #199 had an appointment with the neurologist. The RP stated the facility told her they could not take her to the appointment that day and would have to reschedule it. The RP said Resident #199 had called a car service to pick her up and take her to the appointment. The RP stated the ADON shoved a piece of paper in front of her, and she did not know what she was signing. The RP called the facility to tell them Resident #199 was on her way back to the facility, and the results of the appointment. At that time, the RP said the facility told them they would have a police officer at the building waiting because she was not allowed back in the building. The RP stated they would be sending her out via EMS. The facility also did not release Resident #199's medications to the RP when she went to get the resident's belongings after she was discharged . Interview on 02/26/25 at 12:04 PM with Resident #199 revealed she had scheduled an appointment herself with a neurologist. Whe she returned to the facility from the appointment that same day, the resident stated she was met by the police. She stated she wanted to live at the facility. She also said she did not understand why she could not set up her own transportation to and from an appointment without being discharged from the place she chose to live. Resident #199 stated she did not receive her medications back from the facility after she was discharged . Interview on 02/26/25 at 12:05 PM with the ADON revealed she was speaking with Resident #199 when Resident #199 told her she had an appointment with a neurologist over two hours away. The ADON stated the facility could not accommodate the resident and would have to reschedule the appointment. She stated Resident #199 explained to her that she had arranged her own transportation and would stay at a hotel if she could not find a way home. The ADON then explained that going to the appointment by herself and getting her own hotel was considered leaving AMA. The ADON also stated the Resident's RP was notified. The ADON revealed Resident #199 was angry because she was already discharged from the computer system. The ADON also said she notified the police because the Resident #199 was angry and became physical with the staff. The ADON felt it was unsafe for the resident to be out alone in the winter with her diagnoses. The ADON also stated the DON was there and communicated with her during this event. Interview on 02/26/25 at 2:05 PM with the Social Services Staff revealed she was contacted the day before by Resident #199's RP. The Social Services Staff stated Resident #199's appointment was over two hours away, and she did not feel it was safe for the resident to go alone because the resident did not have a good memory. She stated the resident stated she would get a car service to take her there. The Social Services Staff said the resident said she would get a hotel if she could not find transportation back that night. She revealed the facility produced an AMA form and asked the resident to sign it before she left. The Social Services Staff stated Resident #199 came back to the facility after her appointment. She stated Resident #199 became angry when the staff told her she could not go to her room and was no longer a resident. The Social Services Staff stated the police were called, and Resident #199 was sent out by EMS to a hospital. Interview on 02/27/25 at 12:43 PM with the Administrator revealed she was not in the building the day of the incident. The Administrator stated the DON was the designee of the building on 12/18/24. The Administrator said she did not know the facility policy on residents scheduling their own doctor appointments. The Administrator also revealed she was not aware of the facility's policy on residents scheduling their own transportation to their doctor appointments. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 1:39 PM with the DON revealed when she was called up to the front desk on 12/18/24, Resident #199 had already been asked to sign an AMA form. The DON stated the facility policy stated that residents must let the facility know ahead of time about appointments, so they could get a family member, or a staff member, to assist the resident with the appointment by going with them. The DON stated she overheard Resident #199 say she was not coming back. The DON revealed when Resident #199 returned from the appointment, the resident was very angry and aggressive when the ADON told her that she could not stay at the facility and must leave. The police and EMS were called, and the resident was transported to the hospital. Record review of the facility's Discharge or Transfer policy, dated July 2015, reflected: Policy: It is the policy of this facility to provide the Resident with a safe organized structured transfer and or discharge from the Facility to include but not limited to hospital, another healthcare facility or home that will meet their highest practical level of medical, physical and psychosocial well-being. Expiration of Resident within facility is known as a Discharge. A transfer and or discharge shall be considered for the following reasons as regulated by Federal, State and other Regulatory Agencies. 1. Transfer/Discharge: Emergency 2. Transfer/Discharge: Other Healthcare Facility (Planned) 3. Transfer/Discharge: Home/Community (Planned) 4. Transfer/Discharge: Leaving Against Medical Advice .