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	12/05/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #1) reviewed for transfers with assistive devices. The facility failed to ensure staff followed Resident #1's care plan and safe transfer procedures. The facility failed to ensure CNA B used a mechanical lift with assistance from another staff person to transfer Resident #1 on 10/24/25. This failure placed residents at risk of falling, injuries and a decline in health. Findings included:Record review of Resident #1's admission record, dated 10/24/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses that included Weakness, Muscle Weakness, Difficulty in Walking, and Lack of Coordination. Record review of Resident #1's MDS assessment, dated 9/11/25, reflected the resident had a BIMS scored of 15 out of 15, which indicated cognition was intact. The MDS assessment under Section GG-Functional Abilities, revealed the resident needed assistance with ADLs. The MDS assessment also revealed Resident #1 required substantial assistance with sitting to stand, chair/bed-to-chair transfer and toilet transfer. Record review of Resident #1's care plan, dated initiated 7/25/24, reflected Focus: ADL Self Care Performance Deficit r/t general weakness, limited mobility, Morbid Obesity, Rhabdomyolysis (destruction of striated (long, thin parallel streaks) muscle cells). Goal: Will safely perform bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene with modified independence through review date. Interventions: Converse with resident while providing care. Explain all procedures/tasks before starting. Praise all efforts at self-care. Promote dignity by ensuring privacy. Staff will provide the level of physical assistance as needed with ADLs due to self-ability may fluctuate. TRANSFER: Requires extensive assist with 2 staff participation with transfers via [mechanical] lift. In an observation and interview on 10/24/25 at 10:05 AM, CNA B was observed alone in Resident #1's room assisting Resident #1 with a transfer from her bed to the wheelchair. CNA B was observed standing behind Resident #1, lifting her under her armpits then sitting her in the wheelchair. CNA B positioned Resident #1 in the wheelchair then adjusted her clothing. The observation further revealed no mechanical lift was used to transfer Resident #1. Resident #1 was successfully transferred into her wheelchair without any injuries. CNA B stated he should have used the mechanical lift with assistance from one staff-person for the transfer. He stated he was in a rush to get Resident #1 to therapy and was not thinking. He also stated staff were elsewhere helping other residents. In an interview on 10/24/25 at 3:23 PM, CNA B stated he got Resident #1 out bed without the use of a mechanical lift. CNA B revealed he did not follow the facility's policy regarding transfers. He also revealed he did not follow Resident #1's care plan regarding her transfer. CNA B stated it was the first time he had transferred Resident #1 alone without a mechanical lift. CNA B stated he mistakenly did not have another staff person to assist with the transfer. CNA B stated other staff were completing duties with other residents. He stated Resident #1 had to go therapy, so he was in a rush. He stated he usually transferred Resident #1 with another staff person assisting. CNA B stated by not using a mechanical lift, he and/or resident could have been hurt or injured. CNA B stated the policy for a resident unable to bear weight was that two staff-persons transferred the resident with a mechanical lift. In an interview on 10/27/25 at 9:23 AM, Resident #1 revealed CNA B usually used a mechanical lift to transfer her. She also revealed it was two staff people that did her transfer with the mechanical lift. Resident #1 stated she was not hurt during the transfer with CNA B. She stated she had never been hurt in the process of transfer. An observation on 10/27/25 at 11:15 AM, revealed Resident #1 was properly transferred with two staff using a mechanical lift. In an interview on 10/27/25 at 1:01 PM, the DON revealed she was not aware that CNA B did not utilize the mechanical lift during transfer with Resident #1. She also revealed she did not know CNA B had transferred the resident alone. The DON stated CNA B should have had another staff person and used the mechanical lift. The DON stated CNA B risked hurting the resident and/or himself. The DON also stated policy was two people assist and a mechanical lift when a resident cannot bear weight. She stated she would complete an in-service with staff. Record review of the facility's policy, no date, titled Policy: Mechanical Lift and Slings, revealed in part the following: Nursing Policy Manual Purpose: The facility will provide for the safety needs of a resident requiring the use of a mechanical lift for transfers. Guideline: 2. Two or more assistants must be used for all mechanical lift transfers.

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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 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. Based on observation, interviews, and record review, the facility failed to ensure all drugs and biologicals were securely stored for 2 of 2 medication carts (Medication Cart A and B) reviewed for storage of drugs and biologicals. The facility failed to ensure medication carts A and B were locked and secured. On 10/24/25 MA A left medication cart A unlocked and unsecured. On 10/27/25 MA D left medication cart B unlocked and unsecured. This failure could place residents at risk of medication misuse or drug diversion. Findings included: On 10/24/25 at 10:01 AM, an observation revealed medication cart A was left unlocked by pulling the drawers. The medication cart was also unattended in the hall near the nurse's station, facing out into the main pathway where residents and staff were observed walking. Further observation revealed MA A was standing directly across the hall at the nurse's station near another medication cart. During an observation and interview on 10/24/25 at 10:02 AM, MA A revealed medication cart A belonged to her, and it was locked. MA A walked to the cart and pulled the drawer which revealed the medication cart was unlocked. MA A then locked the drawer on the medication cart and said, I thought I locked it. In a follow-up interview on 10/24/25 at 3:03 PM, MA A stated her medication cart was unlocked because she was distracted. She stated she thought she locked her medication cart before she walked off to retrieve something from another cart. MA A stated the risk of an unlocked and unattended medication cart was residents having access to the medications. She also stated another risk was a resident stealing the medication. She stated the top lock on the medication cart was unlocked which held over-the-counter medications. During an interview on 10/27/25 at 1:01 PM, the DON stated medication carts were supposed to be locked anytime left unattended. She stated the expectation was that staff double checked to ensure medication carts were locked. The DON stated the risk of an unattended and unlocked medication cart was a resident taking medications. On 10/27/25 at 7:30 AM, surveyor observed medication cart B near the nurse's station unlocked by pulling the opened drawer. There was also no nursing staff in attendance of the opened cart. MA D approached the surveyor. The surveyor addressed the medication cart B not being locked. MA D confirmed it was her cart and replied, I know it wasn't locked, and I know it should be locked. I was just getting my stuff; you can't hold that against me. Record review of the facility's policy, revised 07/2024, titled Policy/Procedure-Nursing Clinical with subject Medication Access and Storage/Drug Destruction, revealed in part the following: Policy: It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed to access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep and store confidential information as required, except when requested by an approved place or person for 1 of 1 resident (Resident #2) reviewed for unsecured confidential information on top of medication cart. The facility failed to ensure resident specific medication materials were secured for Resident #2 on 10/24/25. This failure had the potential to expose sensitive information to unauthorized individuals. Findings included:Record review of Resident #2's admission record, dated 10/7/2025, reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Resident #2 had diagnoses which included: Acute (sudden) respiratory failure with hypoxia (inadequate supply of oxygen to body tissues), heart attack, pneumonia, candidiasis (yeast infection) of skin and nail, anoxic (complete or near absence of oxygen) brain damage, cognitive (mental process) communication deficit, tracheostomy (surgical procedure that creates a direct opening of the windpipe) status and gastrostomy (surgical procedure that creates a direct opening of the stomach) status and an indwelling (remains inside the body) urethral catheter for draining urine from the bladder. Record review of Resident #2's admission MDS assessment, dated 10/7/25, reflected no BIMS score. On 10/24/25 at 10:01 AM, surveyor observed an empty medication packet containing identifiable resident information left unattended on top of a medication cart on the long-term hallway. The medication cart was in the hallway outside resident rooms across from the nurse's station. Further observation revealed two empty medication packets on top of the medication cart which displayed, Resident #2's name, Baclofen 10mg, [Resident #2], delivery and pharmacy address. The medication cart was observed unattended for approximately 2 minutes, during the time other residents and staff had access to the hallway. During the observation, Investigator inquired which staff the cart belonged to. Medication Aide A stated it belonged to LVN C. Medication Aide A also stated she did not know where LVN C went. Medication Aide A removed Resident #2's empty medication packets and securely stored them in the medication cart. In an interview on 10/24/25 at 3:47 PM, LVN C stated she was a floor nurse. LVN C stated she administered Resident #2's medication for the G-tube and his breathing treatment. LVN C revealed she was aware she should not leave any resident's empty medication packets unattended. LVN C also revealed she had left Resident #2's empty medication packet unattended. She revealed she had pulled Resident #2's medication packets from the nurse's cart and sat them on top of the cart as a reminder to order more. She also revealed she had stepped away to place an order. LVN C revealed she had been gone for 5 minutes. LVN C stated it was the first time she had left a resident's medication packet unattended. LVN C stated her leaving any resident identifiable information unattended was a HIPAA violation. She stated someone could have walked past and seen the resident's information. In an interview on 10/27/25 at 1:01 PM, the DON revealed she was not aware that LVN C left Resident #2's empty medication packets unattended. She stated staff knew that was a violation. She stated the expectation was that staff ensured all resident information was secure. She stated someone could have walked past and looked at Resident #2's information. She stated she would complete an in-service with LVN C. Record review of the facility's notice of private practices policy, original effective date on 4/13/03 and revised date 3/1/16, revealed in part the following: Our Responsibilities: We are required to maintain the privacy and security of your protected health information

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections, for two residents (Resident #2 and Resident #3) of three residents reviewed for infection control. The facility failed to ensure Resident #2, who was on enhanced barrier precautions for Candidiasis (yeast infection), unspecified, received Tracheostomy care via sterile technique. The facility failed to ensure Resident #3, who was on enhanced barrier precautions for osteomyelitis (infection of bone caused by bacteria) and sacral (base of the spine) pressure ulcer received wound care using aseptic (free from microorganisms) technique. This failure placed all residents at risk for the spread of infections and decreased quality of life. Findings included:Record review of Resident #2's admission MDS assessment, dated 10/7/25, reflected he was readmitted from an acute care hospital. Record review of Resident #2's face sheet, dated 10/7/25, reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE]. Resident #2 had diagnoses which included: Acute (sudden) respiratory failure with hypoxia (inadequate supply of oxygen to body tissues), heart attack, pneumonia, candidiasis (yeast infection) of skin and nail, anoxic (complete or near absence of oxygen) brain damage, cognitive (mental process) communication deficit, tracheostomy (surgical procedure that creates a direct opening of the windpipe) status and gastrostomy (surgical procedure that creates a direct opening of the stomach) status and an indwelling (remains inside the body) urethral catheter for draining urine from the bladder. Record review of Resident #2's physician orders, dated 10/07/25, reflected need for change in all respiratory connecting tubes, humidifying water bottle, oxygen tubing, suction catheters, suction canisters, and masks weekly on Wednesday nights. Resident #2 was to receive tracheostomy care daily using sterile techniques and change inner trach cannula (a curved hollow tube inserted into the neck to maintain an open airway) daily with tracheostomy care. Record review of Resident #2's care plan, dated 10/7/25, reflected the resident had a deficit with activities of daily living related to limited mobility and contractures (permanent shortening of muscle, tendon, leading to fixed loss of joint motion) to upper arms and lower legs requiring assistance for turning and repositioning. Resident #2 had a risk of bleeding due to blood thinning medication administration, at risk for falls due to disease processes, potential for nutritional problems due to disease process and gastronomy (resident receives nourishment via feeding tube) status and had a potential for pressure ulcers development due to limited mobility. Record review of Resident #2's physician history and physical progress note, dated 10/14/25 at 2:30 PM, reflected the following:[Resident #2] is a poor historian due to cognitive/psychiatric impairment. Chief complaint/reason for this visit is to follow up on anoxic brain injury. [Resident #2] is in vegetative status (awake but not aware) and is tracheostomy dependent and continues with peg tube feeding. [Resident #2] had suspected tracheostomy site infection and was treated initially with intravenous (into the vein directly into the bloodstream via line) then oral (by mouth) antibiotics. [Resident #2] requires medications by mouth to be crushed and mixed with liquid to be administered via gastronomy tube directly into the stomach. Interview with the ADON on 10/27/2025 at 9:30 AM, revealed there were sufficient sterile supplies to provide care daily for one resident requiring tracheostomy care. The ADON stated she was the wound care nurse and the Infection Preventionist for the Infection Control and Prevention program for this nursing facility. LVN stated she provides all infection control in-services for all facility staff. The ADON stated she provided daily tracheostomy care on her work rotation for Resident #2. Observation of tracheostomy care on 10/27/2025 at 9:40 AM for Resident #2 revealed resident lying on his back with the head of the bed slightly elevated. Resident #2's oxygen was administered via tracheostomy tube. Resident #2 was unable to speak or make eye contact. A sign was on Resident #2's door indicating Enhanced Barrier Precautions were required for infection control. The ADON put on a personal protective gown and washed her hands. The ADON did not speak to Resident #2 to explain the procedure. The ADON gathered supplies and placed them on a clean bed over the table. The ADON put on clean gloves and proceeded to set up a sterile field (contamination free zone). The ADON opened the box of sterile contents with clean gloves and immediately contaminated the materials inside with her gloved hands. The ADON then took off the clean gloves and attempted to put on both sterile gloves. Both sterile gloves developed a tear and the ADON contaminated the sterile gloves by adding a clean glove over the sterile glove. Sterile field (contamination free zone) was not maintained during