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	05/28/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 of 5 residents (Resident #22) reviewed for accidents.The facility failed to ensure Resident #22's non-slip mat was placed in his wheelchair for fall prevention. This failure could place residents at risk of falls and injury. Findings included:Record review of Resident #22's Quarterly MDS assessment, dated 04/24/26, reflected the resident was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. This MDS reflected the resident had severe cognitive impairment with a BIMS score of 0, and he was dependent upon staff for assistance with all care. The MDs reflected Resident #22 had an active diagnosis of paraplegia (inability to voluntarily move or control the lower parts of the body), and he used a wheelchair.Record review of Resident #22's Comprehensive Care Plan, dated 03/30/26, reflected the resident was a fall risk related to Paraplegia, Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), Right and Left-hand contracture (shortening and stiffening of soft tissues, such as muscles, tendons, and ligaments). Goal: Will not sustain serious injury. Interventions included needed a safe environment: floors were free from spills and or clutter, adequate, glare free light; a working reachable call light, bed in lowest position. and two of the interventions were to ensure a fall mat was placed alongside the resident's bed. Resident #22 had an actual fall 05/13/26, unwitnessed, non-injury fall with the goal will not sustain serious injury. Interventions included the use of a non-slip mat which was added to the resident's wheelchair. Resident #22's last fall was 04/30/25.During an observation and interview on 05/28/26 at 9:45 AM, Resident #22 was sitting in his wheelchair heading to smoke break. Resident #22 stated he recalled the fall incident on 05/13/26. He stated he did not get hurt and had no injuries. Resident #22 stated the reason he fell was due to him sliding off his wheelchair due to the mechanical lift sling. Resident #22 stated the facility had not added anything to his wheelchair to prevent him from falling. Resident #22 stated instead of trying to readjust himself he would notify staff and they would assist with repositioning. Observation revealed Resident #22 with his sling underneath him without the use of a non-slip mat. During an interview and observation on 05/28/26 at 12:41 PM, CNA A stated she worked closely with Resident #22 but was not present during the fall. CNA A said she was notified of the fall during her next shift the day after. CNA A stated Resident #22 had the tendency to slide down while sitting in a wheelchair and staff were responsible for monitoring him for repositioning. CNA A stated there was not a non-slip mat added to his wheelchair to prevent him from sliding out of the wheelchair. Resident #22 did not have a non-slip mat on his wheelchair seat. During an interview on 05/28/26 at 1:08 PM, LVN B stated she heard about Resident #22's fall the next day at the start of her shift. LVN B stated during her assessment Resident #22 had no delayed injuries. LVN B stated she had not added any interventions to his wheelchair to keep him from sliding out the wheelchair. LVN B stated all staff were responsible for monitoring Resident #22 while he was seated in the wheelchair for repositioning. LVN B stated the monitoring was necessary to prevent him from sliding out the wheelchair and to prevent injuries. During an interview on 05/28/26 at 1:41 PM, the ADON stated Resident #22 fell while in the hallway (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	waiting to go outside for a smoke break. The ADON stated Resident #22 utilized a mechanical lift for transfers and staff left the sling underneath him. The ADON stated Resident #22 often would try to reposition himself which created a risk for him to slide out of the wheelchair. The ADON stated it was decided to add a non-slip mat to his wheelchair to prevent him from sliding out of the wheelchair. The ADON stated she was responsible for adding the non-slip mat which she did after his fall on 05/13/26. During an observation on 05/28/26 at 2:00 PM, Resident #22 was taken to his room for incontinent care and transferred with a mechanical lift to bed. Observation of Resident #22's wheelchair did not reveal a non-slip mat. During an interview on 05/28/26 at 3:04 PM, the DON stated she had spoken with the ADON about Resident #22 having a non-slip mat added to his wheelchair. The DON stated the use of the non-slip mat was needed to prevent him from sliding out the wheelchair. The DON stated the ADON was responsible for providing the non-slip mat and responsible for educating staff to ensure it remained in his wheelchair. The DON stated the ADON would initially provide and place the non-slip mat on the wheelchair, aides were responsible to ensure the non-slip mat was in place on the wheelchair prior to transferring Resident #22 to his wheelchair daily and as needed. The DON stated when the ADON failed to place the non-slip mat on Resident #22's wheelchair placed him at risk of sliding out of his wheelchair causing potential injuries. Record review of the facility's policy titled, Fall Prevention, revised 02/2026 reflected, It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize potential for injury.