

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 02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236</p> <p>Based on observation, interview, and record review, the facility failed to provide an ongoing program of in-room activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being of 1 of 18 (Resident #46) residents reviewed for activities.</p> <p>The facility did not provide Resident #46 ongoing individualized in-room activities for a minimum of fifteen minutes three times per week for the period between 02/25/25 to 02/27/25.</p> <p>This failure could place residents who required in room activities at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Record review of Resident #46's quarterly MDS, dated [DATE], reflected Resident #46 was a [AGE] year-old male with an initial admitted [DATE]. Resident #46's MDS reflected active diagnoses of anxiety disorder, depression, schizophrenia, profound intellectual disabilities, cognitive communication deficit, other disorders of psychological development, and morbid obesity. Resident #46's MDS also reflected that the resident is rarely/never understood. Therefore, no BIMS score could be recorded. The MDS quarterly assessment did not reflect activities for Resident #46. Resident #46's MDS reflected that he was substantial/maximal assistance for ADL's.</p> <p>Record review of Resident #46's undated care plan indicated Resident #46 was dependent on staff for activities, cognitive stimulation, and social interaction relating to cognitive deficits. The care plan reflected two goals: Will attend/participate in activities of choice by next review dated and will maintain involvement in cognitive stimulation, social activities as desire through review date. The care plan reflected the following interventions: Engage resident in simple, structured activities such as (Specify), all staff to converse with resident while providing care, assistance with ADLs as required during the activity, invite to scheduled activities, needs 1 to 1 bedside/in-room visits and activities if unable to attend out of room events.</p> <p>Observation on 02/24/25 at 7:47 PM revealed Resident #46 was sitting in his bed yelling out loudly. Staff attempted to calm resident but was unsuccessful. Surveyor attempted interview but was unable due to resident's cognitive deficit. There was no evidence of activity sheets or any other type of activity in the resident's room.</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
---	-------	-----------

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 02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/25/25 at 10:37 AM revealed Resident #46 appeared to be sleeping in his bed. Resident's television was turned on. There was no evidence of activity sheets or any other type of activity in the resident's room besides the television for Resident #46. His breakfast tray was bedside and appeared to be partially eaten.</p> <p>Observation on 02/25/25 at 4:08 PM revealed Resident #46 appeared to be sleeping in his bed. Resident's television was turned on. There was no evidence of activity sheets or any other type of activity in the resident's room besides the television for Resident #46. His lunch tray was bedside but was not eaten.</p> <p>Observation on 02/26/25 at 9:47 AM revealed Resident #46 appeared to be sleeping in his bed. Resident's television was turned on. There was no evidence of activity sheets or any other type of activity in the resident's room besides the television for Resident #46. Resident's breakfast tray was bedside and appeared to activity have been eaten by the resident.</p> <p>Observation on 02/26/25 at 2:00 PM revealed Resident #46 appeared to be sleeping in his bed. Resident's television was turned on. There was no evidence of activity sheets or any other type of activity in the resident's room besides the television for Resident #46.</p> <p>Interview on 02/25/25 at 4:22 PM with Resident #46's RP revealed the resident was non-verbal. The RP stated the resident liked to watch cartoons and musicals. She stated Resident #46's mother had passed away, and she knew more about the resident because she had been his primary care giver his whole life. She confirmed the resident did not have a consistent sleep pattern and had not had a consistent sleep pattern when living at home.</p> <p>Interview on 02/27/25 at 12:56 PM with the Activities Director revealed she had been employed with the facility for about a month. The Activities Director stated PASRR services visited Resident #46 monthly. The Activities Director said she attempted a 1:1 activity with Resident #46 approximately twice per week for about 15 minutes. The Activities Director stated she attempted to play with a ball with the resident as well as puzzles. She said she ordered a fidget [NAME] type accessory for the resident. She stated Resident #46 did not respond to her attempts at activities with him. The Activities Director revealed the resident did not respond to her attempts with him at activities in his room. She stated she had not attempted to take Resident #46 outside or help him into a wheelchair. She stated he could walk when he chose to walk. The Activities Director said activities was important for the resident, so he could socialize with others and not isolate in his room. The Activities Director revealed she was not trained on how to manage residents who were IDD. The Activities Director stated she would report to the charge nurse, DON, and Administrator if the resident was refusing activities, so that she could get assistance. The Activities Director also stated she should be attempting activities three times per week with Resident #46 for 15 minutes each time as well as reach out to other sources for different activity ideas for PASRR positive residents. The Activity Director also revealed that she did not document on paper or in the EHR activity minutes or activity attempts with Resident #46. The Activity Director was unable to locate documentation for Resident #46's activities or time spent with the resident.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/27/25 at 2:30 PM with Social Services Staff revealed Resident #46 was receiving PASRR services. She stated she was working with Texas Department of State Health Services, a parent organization of MHMR for Resident #46 and his placement. She stated MHMR felt that another facility may be a better fit. The Social Services Staff also said Resident #46 was recently approved for speech services, so he would be receiving services soon in hopes to decrease his yelling out. The Social Services Staff revealed she felt the resident was withdrawn and isolated because the facility was not meeting his needs. She stated she reported this to the Administrator in morning meetings as well as in Resident #46's care plan meetings.</p> <p>Interview on 02/27/25 at 2:13 PM with the DON revealed the Activities Director attempted to have a 1:1 activity with Resident #46, but it was difficult because the resident yelled out if he was awake. The DON stated the resident should interact with someone daily. The DON said the PASRR Coordinator came out regularly to visit Resident #46. The DON stated the resident was not getting his needs met which was why he continually yelled out when he was awake. She stated she would speak with the Social Services Staff and PASRR individual to discuss assisting the resident get to a place that could better meet his physical and social needs met.</p> <p>Interview on 02/27/25 at 2:45 PM with the Administrator revealed she was unaware how often Resident #46 received 1:1 activity with the Activities Director. The Administrator stated she would refer to the facility policy on activities and get back with me about how often residents should receive activities. The Administrator said Resident #46 liked cartoons, so staff kept his television on cartoons for him in his room. The Administrator also revealed the resident was non-verbal and did not follow instructions. The Administrator stated the resident slept often in the daytime. The Administrator stated was unaware of how missing socialization with activities would affect Resident #46.</p> <p>Record review of the facility's Activities Program policy, dated July 2017, reflected:</p> <p>Policy: Is the policy of the facility to ensure each resident has daily social, recreational, or rehabilitative activities provided and available to them.</p> <p>Procedures:</p> <ol style="list-style-type: none"> 1. Activities are planned according to the residents' preferences, needs, and abilities. Every resident will be interviewed for preferences. 2. A calendar of activities is: <ol style="list-style-type: none"> a. Prepared at least one week in advance from the date the activity will be provided b. Conspicuously posted c. Reflects all substitutions in the activities provided d. Maintained on the premises for 12 months after the last scheduled activity 3. Equipment and supplies are available and accessible to accommodate each resident who chooses to participate in an activity. <p>(continued on next page)</p>

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 02/27/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Daily newspapers, current magazines, and a variety of reading materials are available and accessible to all residents in assisted living.</p>		

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 02/27/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859</p> <p>Based on observation, interview, and record review the facility failed to ensure residents with wounds receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 3 of 3 residents (Residents #25, #30 and #107) reviewed for wound care.</p> <p>1. The facility failed to ensure Resident #25 and Resident #107 received wound care everyday as per physician orders on 02/25/25.</p> <p>2. LVN A failed to update physician wound care orders in the MAR when Resident #30 was seen by the Wound Care Physician on 02/17/25.</p> <p>These failures placed residents at risk for infection and delay in healing of existing wounds.</p> <p>Findings included:</p> <p>1. Record review of Resident #25's Admission MDS dated [DATE] reflected the resident was a [AGE] year-old female. Resident admitted to the facility on [DATE]. Her diagnoses included Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain). Resident #25 had a BIMS of 4 indicating her cognition was severely impaired.</p> <p>Record review of physician's orders dated 02/24/25 revealed Resident #25's had a skin tear to right lateral ankle. The order reflected: Cleanse right lateral ankle skin tear with NS or WC, pat dry, apply xeroform; cover with dry dressing daily and as needed for soilage or dislodgement.</p> <p>Observation on 02/26/25 at 4:20 PM with LVN A who was the wound care nurse, providing Resident #25 with wound care revealed she disinfected the table and left it to dry. She removed her gloves, washed her hands, and put the supplies together. She wheeled the table to Resident #25's bedside. She then washed her hands, put on gloves, and removed the old dressing on Resident #25's right ankle. The old dressing was observed to be dated 02/24/25 meaning she had missed her wound care on 02/25/25. LVN D removed her gloves, washed her hands, and put on new gloves. She cleansed the wound with normal saline, removed her gloves, washed hands, and put on new gloves and then applied xeroform and covered with a dry dressing dated 02/26/25.</p> <p>2. Record review of Resident #30's Quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male. Resident admitted to the facility on [DATE]. His diagnoses included cellulitis (common bacterial infection of the skin and underlying tissues). Resident #30 had a BIMS of 15 indicating his cognition was intact.</p> <p>Record review of physician's orders dated 02/17/25 revealed Resident #30's had a wound on the left foot 4th digit. The order reflected: Left Fourth toe trauma 1.5 x 1.5 x undetermined 40% slough,20% granulation and 30% eschar and 10% epithelial. Cleanse left foot 4th digit with normal saline or wound cleanser, pat, apply xeroform and cover with dry dressing 3x/week (M/W/F) and as needed for soilage or dislodgement every day shift every Mon, Wed, Fri for trauma.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident 30's February 2025 MAR and TAR revealed there were no new wound care orders for 02/17/2025. The old orders were to apply betadine solutions dated 02/10/25.</p> <p>Record review of Resident #30's Wound Care Physician's notes/assessment, dated 02/17/25, revealed the resident was assessed to have a 1.5 centimeters x 1.5 centimeters x undetermined (depth) wound on left fourth toe. The orders were to cleanse with normal saline, apply Xeroform on Mondays, Wednesdays, and Fridays and as needed and cover with dry dressing.</p> <p>Observation and interview on 02/24/25 at 8:05 PM revealed Resident #30 was in his room lying on his bed. He was observed to have open wounds on the medial foot and the left fourth toe and cellulitis on bilateral legs. No draining was observed. He stated staff in facility apply dressing when the wounds were weeping and when not they left them open. He stated he did not recall the last time the dressing was applied. He stated they applied betadine, but he did not mention how often.</p> <p>Observation and interview on 02/25/25 at 12:24 PM with LVN A, who was the facility's Wound Care Nurse, revealed there were no dressings on Resident #30's open wounds. LVN A stated Resident #30 was seen by the Wound Care Doctor on 02/17/24. She stated the doctor gave orders to cover Resident #30's wounds, but she got busy working on the floor, and she did not update the orders on the Treatment Administration record. She stated Resident #30 had not received the new wound care to date. She stated they had not been applying dressing since she forgot to update the orders. She stated she was aware he was supposed to be getting his wound care three times a week. She stated the doctors also saw the resident on 02/24/25 and some wounds were healed, but they were supposed to continue with the same orders for the left fourth toe, but she still had not updated the orders. She stated failure to update the orders made the resident miss treatments. She stated the risk for Resident #30 was that his wounds could get infected and there could be a delay in healing. She stated she was aware wound care needed to be updated once the doctor gave the orders. She denied notifying management of not having updated the orders.</p> <p>3. Record review of Resident #107's Entry MDS dated [DATE] reflected the resident was a [AGE] year-old male. Resident admitted to the facility on [DATE]. His diagnoses included acute hematogenous osteomyelitis, left ankle and foot (an acute infection of the bone or bone marrow diagnosed within 2 weeks from the onset of signs and symptoms). Resident #107 had a BIMS of 14 indicating his cognition was intact.</p> <p>Record review of Resident #107's February 2025 MAR and TAR revealed there were wound care orders. The orders were to cleanse left medial foot surgical incision with normal saline and wound cleanser, pat dry, pack distal part of incision with iodoform ribbon, cover with Xeroform and 4x4 gauze, wrap with Kerlix and then with ACE wrap daily every day shift for surgical wound.</p> <p>Record review of physician's orders dated 02/15/25 revealed Resident #107's had a surgical wound on left ankle and foot. The order reflected: Cleanse left medial foot surgical incision with NS or WC, pat dry, pack distal part of incision with iodoform ribbon, cover with xeroform and 4x4 gauze, wrap with kerlix and then with ace wrap daily every day shift for surgical wound.</p> <p>Interview with Resident #107 on 02/26/25 at 10:36 AM revealed he was supposed to get wound care every day, but the last time he got his wound care was 02/24/25. He stated he feared his wound would get infected.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with LVN A on 02/26/25 at 2:37 PM revealed she washed her hands and put on gloves. She opened the ACE wrap and the kerlix covering the Resident #107's wound, and it was revealed the wound dressing was dated 02/24/25. LVN A stated she last did the wound care on 02/24/25 after the Wound Care Doctor saw Resident #107. She stated she did not change the dressing on 02/25/25 for Resident #25 and Resident #107 because she was not able to finish rounding all the wounds. She stated she knew the wound care was supposed to be provided every day. She stated she did not notify management or the on-coming nurse of the wounds she had not completed changing the dressing. LVN A stated failure to perform wound care as per the physician orders could lead to infection.</p> <p>Interview on 02/26/25 at 3:26 PM with the DON revealed her expectation was physician orders were supposed to be updated the same day they were received. The DON stated she and ADON were supposed to follow-up and ensure the new orders were updated in the treatment administration record weekly. The DON stated it was all nurses' responsibility to ensure wound care was being provided to residents. She stated she was not aware the residents were not getting wound dressing changes because the ADON was responsible of following with nurses to ensure the wound care was being provided. She stated the ADON updated her weekly. The DON stated failure of the nurses to act upon physician orders could create a problem because every change made by the doctor was necessary for the resident's treatment. She stated failure to offer wound care to residents might cause the wounds not to heal properly and infection.</p> <p>Record review of the facility's Wound Care and Treatment Guidelines policy, revised May 2007, reflected:</p> <p>.It is the policy of this facility to provide excellent wound care to promote healing.</p> <p>.11.There must be a specific order for the treatment</p>		

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 02/27/2025
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 5 residents (Resident #9) reviewed for restorative care.</p> <p>The facility failed to apply splint to Resident #9's left hand to reduce the risk of further loss of range of motion on 02/25/25 and 02/26/25.</p> <p>This failure placed ten residents on with devices for contractures at risk for decline in range of motion, decreased mobility, and worsening of contractures.</p> <p>Findings included:</p> <p>Record review of Resident #9's Admission Record dated 02/27/25 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE].</p> <p>Record review of Resident #9's quarterly MDS assessment dated [DATE] reflected his diagnoses included unspecified dementia, stiffness of left shoulder, stiffness to left elbow, stiffness to left hand, muscle weakness, cognitive communication deficit, anxiety disorder. Resident #9's BIMS score was not complete. The MDS further revealed Section GG - Functional Abilities indicated the resident had upper and lower extremity impairment on both sides.</p> <p>Record review of Resident #9's Care Plan dated 12/03/25 reflected: Focus; Has limited physical mobility r/t Contractures. Goal: Will demonstrate the appropriate use of adaptive device(s) to increase mobility through the review date. Interventions: Hand splint to left hand for contracture management. Applied by therapy.</p> <p>Record review of Resident #9's physician order dated 11/01/24 revealed the following:</p> <p>Pt to wear L hand splint, applied by therapy, 5x/wk for up to 8 hours a day, for contracture management.</p> <p>Observation on 02/24/25 at 8:02 PM of Resident #9 lying in bed, resident was a Spanish speaker and would respond with to yes or no questions. Observed residents' both hands to be contracted. Resident denied any pain. The resident was not able to open his hand on command, and there was not a contracture management device in place.</p> <p>Observation on 02/25/25 at 12:34 PM revealed Resident #9 in bed watching television. There was not a contracture management device in place at the time of the observation. Resident #9 hand splint was observed to be on the floor. Resident unable to state when was the last time he had it on.</p> <p>(continued on next page)</p>

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 02/27/2025
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/25/25 at 3:25 PM revealed Resident #9 was in bed watching television. There was not a contracture management device in place at the time of the observation. Resident #9 hand splint was observed to be on the floor.</p> <p>Observation on 02/26/25 at 10:26 AM revealed Resident #9 was in bed sleeping. There was not a contracture management device in place at the time of the observation. Resident #9 hand splint was observed to be on a chair next to resident's bed.</p> <p>Observation on 02/26/25 at 12:09 PM revealed Resident #9 was in watching television. There was not a contracture management device in place at the time of the observation. Resident #9 hand splint was observed to be on a chair next to resident's bed.</p> <p>Interview on 02/26/25 at 1:31 PM with CNA E revealed Resident #9 both hands were contracted. She stated she was unaware of any splint. She stated she has never put any splint device on his hands. She stated either the charge nurse or therapy put on a splint. CNA E observed Resident #9's splint and stated she had never put one on the resident.</p> <p>Interview on 02/26/25 at 1:45 PM with LVN B revealed she was the nurse assigned to Resident #9. LVN B stated Resident #9 hands were contracted and was receiving therapy services. She stated she was not aware Resident #9 required a splint. LVN B reviewed Resident #9's physician orders and stated resident had an order for a splint; however, the order states splint should be applied by therapy. LVN B stated therapy had not mentioned anything to them about applying a splint.</p> <p>Interview on 02/26/25 at 1:51 PM with the Dir . of Rehabilitation revealed Resident #9 was receiving OT and was discharged on [DATE]. She stated therapy was putting on Resident #9 left hand splint and was once he discharged the nurses were responsible to put the splint on. Dir. of Rehabilitation reviewed Resident #9's physician order and stated therapy forgot to discontinue the order. She stated Resident #9 order should had been updated with a new order. She stated it was the responsibility of the therapist and herself to review resident's orders when discharged from therapy. She stated Resident #9's order was missed. She stated the potential risk of not applying the splint could cause contracture to tighten.</p> <p>Interview on 02/27/25 at 2:00 PM with the DON revealed when a resident discharges from therapy, therapy staff will notify the nursing staff regarding any restorative care. The DON stated therapy would provide an order and, on the order, it would state who would be responsible for putting on a splint or any other devices. The DON stated she was not aware Resident #9 had an order for a splint. She stated during morning meeting she goes over any new physician orders. She stated the Director of Rehabilitation and herself were responsible for any new orders. She stated the risk of not putting on a splint could lead residents to be more contracted.</p> <p>On 02/27/25 at 3:00 PM, the Administrator was asked to provide the facility's policy regarding range of motion/contracture management devices or restorative care. At 4:20 PM, the Administrator stated they could not locate a policy regarding range of motion/contracture management devices or restorative care.</p>		

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 02/27/2025
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859</p> <p>Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 2 of 2 residents (Residents #56 and #107) reviewed for intravenous fluids.</p> <p>The facility failed to ensure Resident #56 and Resident #107 Midline/PICC line (used to deliver medications and other treatments directly to the large central veins near heart) dressing change was completed and the change date was documented on the dressing. Resident #56 and Resident #107 were observed without change dates and initials on 02/24/25.</p> <p>The failures could affect residents by placing them at risk for infections and cross-contamination due to not knowing when the dressing was last changed.</p> <p>Findings included:</p> <p>Record review of Resident #56's entry MDS assessment, dated 02/12/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses which included: Pneumonia, (lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe) and acute and subacute infective endocarditis (fatal inflammation of your heart valves' lining and sometimes heart chambers' lining). Resident #56 had had intravenous access. BIMS score not completed she was newly admitted .</p> <p>Record review of Resident #56's physician's orders dated 02/12/25 reflected: right upper arm midline care: change central line/midline dressing every 7 days if visible for assessment. Change dressing as needed if wet, soiled, saturated or loose.</p> <p>Record review of Resident #56's February 2025 TAR reflected there was documentation of midline/PICC line dressing changes dated 02/17/25 and 2/24/25.</p> <p>Record review of Resident #56's current care plan initiated 02/12/25 revealed IV medication was addressed with a goal of not having any complications. Interventions included monitoring for signs and symptoms of infection at the insertion site and Checking dressing at site daily.</p> <p>Observation and interview on 02/24/25 at 7:22 PM revealed Resident #56 was in her room, sitting on her bed. She was observed to have a midline line on her left arm, dressing, intact but looked dirty on the surface. Resident #56 stated the peripherally inserted central catheter dressing was put after the midline fell of and another midline was inserted, but she could not tell which day.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 02/24/25 at 8:41 PM with LVN G revealed Resident #56 had a mid-line on her left upper arm covered with a transparent dressing with no date. LVN G stated she worked with Resident #56 on 02/20/25 and themidline came out and was reinserted by the midline company. LVN G stated she was aware the dressing was supposed to be changed every 7 days. She stated she was aware she was supposed to check the dates on the dressing, but it was not the major thing to look for while administering medications she looked for infiltration and redness. She stated the risk of not having the dressing dated would be infection since the nurse will not know when to change the dressing. She could not recall having done in-service on PICC /midline dressing.</p> <p>Interview with LVN A on 02/25/25 at 3:18 PM revealed she was the nurse for Resident #56, when the midline was reinserted on 02/21/25. She stated she administered the 2:00 PM dose, and she did not notice the technician did not put the date on the dressing. She stated she was aware when they administered IV medication, they should check the date on the dressing and the site for infection, but she had not checked. She stated failure to check the date could lead to a resident missing the dressing change and causing infection to the site.</p> <p>2. Record review of Resident #107's Entry MDS dated [DATE] reflected the resident was a [AGE] year-old male. Resident admitted to the facility on [DATE]. His diagnoses included acute hematogenous osteomyelitis, left ankle and foot (an acute infection of the bone or bone marrow diagnosed within 2 weeks from the onset of signs and symptoms). Resident #107 had a BIMS of 14 indicating his cognition was intact. He was on intravenous medication.</p> <p>Record review of Resident #107's physician's orders dated 02/17/25 reflected: right upper arm midline care: change central line/midline dressing every 7 days if visible for assessment. Change dressing as needed if wet, soiled, saturated or loose, one time a day every Sunday.</p> <p>Record review of Resident #107's February 2025 TARs revealed there was documentation of PICC line dressing changes dated 02/23/25.</p> <p>Record review of Resident #107's current care plan initiated 02/17/25 reflected the following focus area: On intravenous antibiotics medications rule out osteomyelitis (infection of the bone that causes inflammation and destruction of bone tissue). Goal: -Check dressing at site daily.</p> <p>Observation and interview on 02/24/25 at 8:03 PM revealed Resident #107 were in his room, lying on his bed. He was observed to have a midline line on his left arm, dressing, was peeling off and was not dated. Resident#107 stated that was the dressing that he left the hospital with more than a week and half ago.</p> <p>Observation and interview on 02/24/25 at 8:28 PM with LVN G revealed Resident #107 had a mid-line on his left upper arm covered with a transparent dressing with no date and she had not noticed. LVN G the dressing was peeling off. She stated the dressing was supposed to have date and initials of the person that changed it. LVN G stated she was aware the dressing was supposed to be changed every 7 days. She stated she was aware she was supposed to check the dates on the dressing. She stated the risk of not having the dressing dated would be infection since the nurse will not know when to change the dressing. She could not recall having done in-service on PICC /midline dressing.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LVN A on 02/26/25 2:13 PM revealed she was the nurse that had changed the dressing on 02/23/25 for Resident #107, and she forgot to put the date and initials. She stated she was aware she was supposed date the dressing so that other staff would know when dressing change was done. She stated she had done training on dressing change.</p> <p>Interview on 02/26/25 at 3:37 PM with the DON revealed she expected staff to change the dressing every seven days to prevent infection. She stated nurse are supposed to follow the doctors order and they should also change the dressing if the midline is infiltrated and if dressing peeling off. She stated she was aware Resident #56 midline was reinserted, but she was not aware there was no date on the dressing. She stated she expected the nurses to be checking for dates when administering medications. She stated it was the responsibility of the DON and the ADON to check after the nurses and ensure all orders were being followed and dressing were being changed and dated weekly. She stated she remember it was reported to her Resident #56 and Resident #107 dressing change was done and it was looked at by the ADON and everything was okay. She stated the risk of not putting the date other staff will not be able to tell when dressing was changed and resident risk being infected. She stated she had done training with staff on labeling and putting initials on bags and tubing and on dressings.</p> <p>Interview with the ADON by phone was unsuccessful on 02/26/25. She did not respond, and there was no space for voicemail.</p> <p>Interview with the Wound Care Doctor was attempted on 02/27/25 via phone with no response prior to exit.</p> <p>Record review of the facility's training record reflected an in-service on PICC line dressings dated 01/22/25. The training reflected: all PICC line dressing should be changed on admission and every 7 days from last dressing change and LVN A and LVN G were not in attendance.</p> <p>Record review of the facility's current Midline/Picc line dressing change dated July 2013, reflected the following:</p> <p>The transparent dressing are changed every 7 days and sooner when it becomes loosened to the point of compromising sterility or presents a risk of accidental dislodgment of the catheter. An accumulation of moisture, fluid, blood, or exudate could also be criteria for a dressing change.</p>		

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 02/27/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored securely for 2 of 2 residents (Resident #15 and Resident #40) reviewed for medication storage.</p> <p>1. The facility failed to ensure Resident #40's 1 bottle of nitroglycerin 0.4 mg was stored in a secured place when they were stored in her room on her bed side table on 02/24/25.</p> <p>2. The facility failed to ensure Resident #15's 1 bottle of 100 mg/Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, 1 bottle of Linzess prescription with the label peeled for whom it was prescribed to, and 1 bottle of acetaminophen 325 mg was not stored at the resident's bedside table.</p> <p>These failures placed residents at risk of receiving medications that were not prescribed by the doctor, overdose and reactions with other medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #40's quarterly MDS assessment, dated 01/18/25, revealed Resident #40 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. She had a diagnosis that included Atherosclerosis (the build-up of fats, cholesterol, and other substances in and on the artery walls). Her cognition was intact with a BIMS score of 15.</p> <p>Record review of Resident #40's February 2025 physician's order revealed Resident #40 did not have an order for nitroglycerin 0.4 mg tablets.</p> <p>Observation and interview on 02/24/2025 at 7:40 PM revealed Resident #40 was in her room. Observation revealed a bottle of nitroglycerin 0.4 mg tablets sitting on her bedside table beside the resident's bed. Resident #40 stated she used the nitroglycerin tablets herself when she had chest pains. She stated she used each after 5 minutes x 3 times. She stated she took one tablet last in January. She denied saying how she got the tablet.</p> <p>Observation and interview on 02/26/25 at 2:51 PM with LVN A revealed she was not aware the resident had nitroglycerin tablets in her room. LVN A stated she was not supposed to have medication in the room because she did not self-administer medication to self. LVN A stated all medications are supposed to be locked up. She stated she could not understand how she got the medications, and she does not have orders. LVN A said the risk of Resident #40 having medications in her room was she can overdose, and other resident could get hold of them.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 02/26/25 at 3:19 PM with the DON revealed Resident #40 was not supposed to have nitroglycerin tablets on her bedside. The DON stated all medications were supposed to be locked up. She stated there was a time the resident had transferred to an assisted living, and she thought that was when she brought the medication. She stated she expected staff to be looking and if they see medication in resident rooms to collect and report to her. She stated the risk of having medication in the room is overdose.</p> <p>2. Record review of Resident #15's Quarterly MDS, dated [DATE], reflected a [AGE] year-old male with an admitted [DATE] and a diagnosis of heart failure and malignant neoplasm of the lungs (tumors in the lungs that may spread to other parts of the body). Resident #15 had a BIMS score of 14, meaning the resident was cognitively intact.</p> <p>Record review of Resident #15's undated Care Plan reflected no Focus, Goal, or Intervention relating to Self-Administration of Medications.</p> <p>Record review of Resident #15's undated orders reflected no orders for Stool Softener with stimulant, Clear Eyes, heartburn relief tablets, allergy relief 25 mg, Linzess prescription, and acetaminophen 325mg.</p> <p>Observation on 02/24/25 at 7:41 PM in Resident #15's room revealed 1 bottle of 100 mg/ Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, and 1 bottle of Linzess prescription with the label peeled off whom it was prescribed to were bedside. Resident #15 was resting peacefully.</p> <p>Observation on 02/25/25 at 10:20 AM in Resident #15's room revealed 1 bottle 100 mg/Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, and 1 bottle of Linzess prescription with the label peeled off whom it was prescribed to were bedside. Resident #15 was speaking with a visitor.</p> <p>Observation on 02/26/25 at 3:41 PM in Resident #15's room revealed 1 bottle 100 mg/Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, and 1 bottle of Linzess prescription with the label peeled off whom it was prescribed to were bedside. Resident #15 was resting peacefully most of the time due to his diagnoses.</p> <p>Observation and interview on 02/26/25 at 4:00 PM with CNA D revealed 1 bottle 100 mg/Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, and 1 bottle of Linzess prescription with the label peeled off whom it was prescribed to were bedside. CNA D revealed that he worked 6:00 AM to 6:00 PM four days per week. CNA D stated that any medication not prescribed by a resident's primary care physician should be given directly to the resident's charge nurse. CNA D revealed that any resident in the facility was at risk for an overdose because residents would not know the proper dosage of each medication. CNA D said that the responsibility of continued observation of residents' rooms for medications was the nurse and CNA on duty of each shift. CNA D did not recall the last time in-service was completed on the topic of bedside medications.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 02/26/25 at 4:17 PM with LVN B revealed 100 mg/Stool Softener with stimulant, 2 bottles of Clear Eyes .5 ounces each, 1 bottle of 190 heartburn relief tablets, 100 capsules allergy relief 25 mg, 1 bottle of Linzess prescription with the label peeled off whom it was prescribed to were bedside. One additional bottle of acetaminophen 325 mg was in the resident's dresser drawer which was found by LVN B. LVN B revealed that she worked 6:00 AM to 6:00 PM four days per week. LVN B stated residents were not supposed to have OTC and prescription meds in their rooms. LVN B said Resident #15 was not supposed to self-administer medications. LVN B also said Resident #15 was at risk for overdose and allergies to the medications as well as other residents that took the medications without orders from their primary care physician. LVN B stated when medications were found bedside, the charge nurse was supposed to report it to the DON. LVN B also said the responsibility for checking residents' rooms for medications was all staff. LVN B did not recall the last in-service on medications at bedside.</p> <p>Interview on 02/26/25 at 4:40 PM at with the DON revealed residents were not supposed to keep OTC and prescriptions in their rooms or bedside if they had not been assessed and cleared for self-administration. The DON stated she expected her staff to observe for medications when they made rounds and when providing care. The DON said the primary risk for patients was overdose for all residents with access to OTC medications and prescription medications. The DON stated it was everyone's responsibility to look for medication in residents' rooms including management who conducted angel rounds. The DON also said she last in-serviced in December 2024 in the all-staff meeting on observation in resident rooms for medication. The DON concluded by stating she would report medication at bedside to the Administrator.</p> <p>Record review of the facility's Medication Access and Storage, dated May 2007, reflected:</p> <p>Policy: The policy of this facility to store all drugs and biological in locked compartments at proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications:</p> <p>Procedures:</p> <p>.2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access .</p> <p>48236</p>		

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 02/27/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236</p> <p>Based on observation, interview and record review the facility failed to ensure the menu was followed for one of one meal (lunch on 02/26/2025) reviewed for food and nutrition services.</p> <p>The facility failed to ensure the menu was followed for the lunch meal by leaving out the dinner roll with margarine for all diet types on 02/26/2025.</p> <p>This deficient practice could place residents at risk of dissatisfaction, poor intake, and/or weight loss.</p> <p>Findings included:</p> <p>Observation on 02/26/25 at 11:30 AM of the kitchen's steamtable (foods are kept at a warm temperature) revealed the following items: chicken fried steak, peas with onions, mashed potatoes, and gravy. No dinner rolls were observed, and none were placed on the residents' trays to serve to the residents.</p> <p>Interview on 02/26/25 at 3:50 PM with the Dietary Supervisor revealed that the dinner rolls were not served because the Dietary Supervisor could not locate them. The Dietary Supervisor said she was not aware that the delivery truck did not deliver the rolls the previous day. The Dietary Supervisor stated that she forgot to do a substitution for the dinner rolls. The Dietary Supervisor also stated that she should have logged a substitution like a slice of bread onto the substitution log and serve it to the residents along with the margarine. The Dietary Supervisor stated the dinner roll, or a substitution was important because the residents needed their starches to prevent weight loss due to loss of nutrients that they required. The Dietary Supervisor revealed that she did not tell the residents about the change and did not post the information anywhere in the facility for residents to see. The Dietary Supervisor stated that she in-serviced on following menus on 12/05/24.</p> <p>Interview on 02/26/25 at 3:42 PM with the [NAME] revealed she forgot to serve the substitution for the dinner rolls. The [NAME] said that she knew they had not received the dinner rolls from the delivery truck the previous day. The [NAME] stated that if residents did not receive the dinner rolls on the menu, they could be affected by possible weight loss because they would not receive all the necessary starch and nutrition that was required by the dietician. The [NAME] also revealed that she should report the menu substitution to the Dietary Supervisor and record a substitution in the substitution logbook. The [NAME] stated that if the Dietary Supervisor was not available and a dietary item was needed, the Administrator would provide the funds, and the [NAME] would purchase the necessary items from a local grocery store. The [NAME] stated she was last in-serviced on following menus on 12/05/24.</p> <p>Record review of the facility's menu, dated 02/26/25, reflected for Wednesday (02/26/25) the following: Lunch-Country Fried Steak, Mashed Potatoes/Gravy, Peas with Onions, Roll/[NAME], Boston Cream Pie, Beverage.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the facility's Food and Nutrition Service Menus policy, revised January 2022, reflected:</p> <p>Policy: It is the policy of this facility to assure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.</p> <p>.4. If any meal served varies from the planned menu, the change and the reason for the change are noted on the posted menu in the kitchen and/or in the record book used solely for recording such changes.</p>

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 02/27/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48236</p> <p>Based on observation, interview, and record review, the facility failed to prepare foods according to the established food preparation practices and safety techniques in 1 of 1 kitchen reviewed for appropriate sanitation, as evidenced by:</p> <p>The warewasher (dish machine) sanitizer was not dispensing sanitizer, leaving the dishes used for the afternoon meal, of 02/24/25 through afternoon meal of 02/26/25, unsanitized.</p> <p>This failure could place residents at risk of infection.</p> <p>Findings included:</p> <p>Observation on 02/24/25 at 6:14 PM revealed the Dishwasher ran the warewasher and then used a test strip to test the sanitizer strength. The test strip showed no sanitizer at all in the warewasher. The Dishwasher repeated the test three times. Each time the test strip showed no sanitizer. Further observation revealed the sanitizer did not appear to be coming through the tubing from the bucket of solution to the warewasher.</p> <p>Observation and interview on 02/25/25 at 9:30 AM revealed the warewasher was not repaired and the facility was waiting on the repairman. The Dietary Supervisor revealed that she had contacted the repairman, and that it usually took about 24 hours for the repairman to arrive to the facility. The Dietary Supervisor stated that she would be serving all meals on paper and/or plastic and utilizing the three compartment sink with the sanitizing solution until the repairman came and fixed the warewasher.</p> <p>Observation and interview on 02/26/25 at 10:09 AM revealed the Dietary Aide ran the warewasher, and then used a test strip to test the sanitizer strength. The test strip showed no sanitizer at all in the warewasher. The Dietary Aide stated the repairman had just left the facility within an hour previously, and the warewasher was functioning properly at that time. The Dietary Aide said it was producing 50 ppm of chlorine at that time. The Dietary Aide then said the policy for washing the dishes was that she should test the chlorine level before starting the warewasher before each meal's dishes and record the results in the log book. The Dietary Aide stated if the warewasher was not functioning at the correct temperature of chlorine level, she would report it to the Dietary Supervisor. The Dietary Aide revealed chlorine was used to sanitize the dishes to kill bacteria and other germs. The Dietary Aide said germs could make residents sick. The Dietary Aide stated she was last in-serviced on the warewasher about 90 days ago.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation and interview on 02/26/25 at 10:55 AM with the Dietary Supervisor revealed the warewasher was not functioning properly. The Dietary Supervisor stated she had notified the repairman on 02/24/25. The Dietary Supervisor said the repairman arrived the morning of 02/25/25 and repaired the machine. She stated it was working when the repairman left, and it was now not working again. The Dietary Supervisor said she had just put in another call for him to come back to the facility. She stated when dietary equipment was not functioning properly, she reported it to the Administrator and Maintenance. The Dietary Supervisor also revealed the importance of chlorine was to kill bacteria because it prevented residents from getting illnesses. She stated that the dietary policy stated dishes were to be sanitized in the three compartment sink as well as serve the residents on disposables when the warewasher was not functioning properly. She revealed staff were in-serviced on 01/31/25 about kitchen equipment.</p> <p>Interview with Dishwasher X on 02/26/25 at 3:52 PM revealed he would call the Dietary Supervisor and Maintenance if the warewasher was not working properly. He stated the Dishwasher was to run a test of the machine and log the temperature and chlorine into the logbook kept near the warewasher before each meal's dishes were washed. Dishwasher X revealed the minimum chlorine ppm that the warewasher should utilize was 50 ppm. The Dishwasher stated the importance of chlorine was to kill germs, which would prevent residents from getting sick. The dishwasher said he was last in-serviced about a month ago on kitchen equipment.</p> <p>Observation on 02/27/25 at 12:01 PM revealed the warewasher was working properly. The Dietary Supervisor tested the warewasher using the test strips. The test strips revealed the warewasher was sanitizing at 50 ppm of chlorine.</p> <p>Record review of the water temperatures recorded for the dishwasher revealed a consistent water temperature of 120 degrees and chlorine of 50 ppm until 02/21/25. The entire days' logs for 02/22/25 and 02/23/25 were completed with out of order. All spaces on the form were completed on 02/24/25. All spaces on the form for 02/25/25 reflected out of order. The 02/26/25 breakfast dishes were recorded at 120 degrees and 50 ppm for chlorine, and the rest of the day had recorded on it out of order.</p> <p>Record review of the facility's Sanitation in Dietary policy, dated October 2007, reflected:</p> <p>Policy: It is the policy of this facility that the food service area shall be maintained in a clean and sanitary manner.</p> <p>Procedures:</p> <p>.2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrossions, open seams, cracks, and chipped areas</p>		

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 02/27/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859</p> <p>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 2 residents (Residents #25 and #107) reviewed for wound care administration.</p> <p>1. The facility failed to ensure staff accurately documented on Resident #25 and #107's MAR/TAR after performing wound care on 02/26/25.</p> <p>This failure could put residents at risk for treatment errors and errors in care.</p> <p>Findings included:</p> <p>1. Record review of Resident #25's Admission MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female. Resident admitted to the facility on [DATE]. Her diagnoses included Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain). Resident #25 had a BIMS score of 4, indicating her cognition was severely impaired.</p> <p>Record review of physician's orders dated 02/24/25 revealed Resident #25 had a skin tear to right lateral ankle. The order reflected: Cleanse right lateral ankle skin tear with NS or WC, pat dry, apply xeroform; cover with dry dressing daily and as needed for soilage or dislodgement.</p> <p>Record review of Resident #25's Treatment administration record for February 2025 on 02/26/25 revealed wound care marked as provided on 02/25/25.</p> <p>2. Record review of Resident #107's Entry MDS dated [DATE] reflected the resident was a [AGE] year-old male. Resident admitted to the facility on [DATE]. His diagnoses included acute hematogenous osteomyelitis, left ankle and foot (an acute infection of the bone or bone marrow diagnosed within 2 weeks from the onset of signs and symptoms). Resident #107 had a BIMS score of 14 indicating his cognition was intact.</p> <p>Record review of physician's orders dated 02/15/25 revealed Resident #107's had a surgical wound on left ankle and foot. The order reflected: Cleanse left medial foot surgical incision with NS or WC, pat dry, pack distal part of incision with iodoform ribbon, cover with xeroform and 4x4 gauze, wrap with kerlix and then with ace wrap daily every day shift for surgical wound.</p> <p>Record review of Resident #107's February 2025 TAR on 02/26/25 revealed wound care marked as provided on 02/25/25.</p> <p>Interview with Resident #107 on 02/26/25 at 10:36 AM revealed he was supposed to get wound care every day, but the last time he got his wound care was 02/24/25. He stated he was fearing the wound to get infected.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LVN A on 02/26/25 at 2:37 PM revealed she was the wound care nurse. She stated she was aware she was supposed to document on the treatment administration record every time she performed wound care, but she had documented before providing care and did not provide care due to having a lot of work to do. LVN A stated both Residents #25 and #107 were supposed to get wound care every day. She stated she did not notify the oncoming nurse that she had not provided wound care. LVN A stated the failure to perform wound care per doctors' orders would lead to infections, and documenting care before providing could lead to the resident missing care. She stated she had done in-services on documenting treatment after administration.</p> <p>Interview on 02/27/25 at 2:28 PM with the DON revealed her expectations were for staff to document accurately on the resident's TAR after providing care, but not charting before they provide care. The DON stated she was responsible of auditing the MAR with her ADON weekly. The DON said the risk of staffs not documenting care accurately could lead to care not being provided and the wounds would deteriorate. The DON stated she had done in-services on documentation.</p> <p>Record review of the in-services on 02/27/25 revealed the facility offered in-service on 01/22/25 on MAR /TAR and orders and LVN A was in attendance.</p> <p>Record review of the facility's Physician Orders policy, revised July 2022, reflected: charting and documentation was not addressed.</p>		

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 02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42859</p> <p>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 1 of 1 resident (Resident #31) reviewed for infection control.</p> <p>The facility failed to ensure LVN B put on a gown before providing g-tube medication to Resident #31, who was on Enhanced Barrier Precautions.</p> <p>This failure could place residents at risk of contracting an infection from residents on Enhanced Barrier Precautions and cross contamination, which could result in infections or illness.</p> <p>Findings included:</p> <p>Record review of Resident #31's quarterly MDS assessment, dated 12/22/25, reflected his diagnoses included cerebral palsy (a group of non-progressive neurological disorders that affect movement, posture, and balance) and dysphagia following cerebral infarction (difficulty swallowing that occurs after a stroke). Resident #31's BIMS score was not completed due to the resident being rarely/never understood. The MDS reflected the resident had a feeding tube.</p> <p>Record review of Resident #31's care plan, revised on 05/12/24, reflected: Focus: The resident requires tube feeding rule out Cerebral Palsy/Dysphagia. Goal: Will be free of aspiration through the review date. Interventions: Use Enhanced Barrier Precautions.</p> <p>Record review of Resident #31's physician order, dated 10/01/24, reflected enhanced barrier precautions: ppe required for high resident contact care activities. Indication: indwelling medical device gastronomy tube.</p> <p>Observation on 02/26/25 at 7:28 AM revealed LVN B preparing to provide Resident #31's medication. Resident #31 had a sign on the door which stated EBP and had a bin of PPE hanging on the door. LVN B conducted appropriate hand hygiene and then proceeded to don gloves. LVN B failed to don a gown. LVN B checked for residual and placement. She administered all the medications via gastronomy tube.</p> <p>Interview on 02/26/25 at 9:48 AM with LVN B revealed she was the nurse assigned to Resident #31. LVN B stated any resident who had a catheter, or wound were on Enhanced Barrier Precautions, and staff were required to put on PPE when providing care. She stated the reason why Resident #31 was on EBP was due to resident's g-tube. She stated the potential risk of not donning PPE would be contamination . She stated she had done training on enhanced barrier precautions.</p> <p>Interview on 02/26/25 at 3:15 PM with the DON revealed EBP applied to residents with wounds, catheter, and g-tubes. The DON stated her expectations were for staff to use PPE on resident on enhanced barrier. She stated the potential risk would be infection control. She stated she had done in-services on staffs on enhanced barrier.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility in-services revealed the facility did training on 01/22/25 on enhanced barrier precautions and LVN B was in attendance.</p> <p>Record review of the facility's Infection Prevention and Control Program policy, revised on March 2024, reflected:</p> <p>.3. Enhanced Barrier Precaution</p> <p>EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provided opportunities for transfer of MDRO's to staff hands and clothing then indirectly transferred to residents or from resident to resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs).</p> <p>a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with:</p> <ul style="list-style-type: none"> o Indwelling medical devices include, but are not limited to central lines, <p>peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes, and tracheostomies .</p>

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 02/27/2025
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140</p> <p>Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area, for 1 of 54 residents (Resident #29) reviewed for call lights.</p> <p>The facility did not adequately equip Resident #29 with a call light to allow the resident to call for assistance.</p> <p>This failure could place residents who rely on the call light system to have a delayed response or no way to contact staff to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #29's Admission Record dated 02/27/25 reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #29's significant change in status MDS assessment dated [DATE] reflected her diagnoses included malignant neoplasm (cancer) of liver, dysphagia (difficulty swallowing), anxiety disorder, repeated falls. Chronic obstructive pulmonary disease. Resident #29's had a BIMS score of 15 indicating she was cognitively intact.</p> <p>Record review of Resident #29's Care Plan revised date 11/24/24 reflected: Focus: [Resident #29] [is] at risk for falls r/t weakness. [Resident #29] [is] at risk for falls r/t Vertigo. Goal: Will not sustain serious injury through the review date. Interventions: Be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>Observation and interview on 02/24/25 at 7:18 PM revealed Resident #29 sitting at the edge of the bed. Observation of Resident #29's room revealed there was only one call light that belonged to Resident #29's roommate. Resident #29 stated she had not had a call light in months. She stated she did not know what happened to her call light. She stated she had not requested a call light due to not having the need to use the call light. She stated when she needed something she walked to the nurse's station or would use her roommates call light.</p> <p>Interview on 02/27/25 at 9:02 AM with CNA F revealed she was the CNA assigned to Resident #29. She stated each resident should have a call light and within reach. She stated Resident #29 had a call light in her room. During an observation of Resident #29's room, CNA F stated Resident #29 did not have a call light but could assure she had one. She stated on Thursday (02/20/25) Resident #29's bed was changed, and the call light might have been removed. CNA F stated the risk of not having a call light could lead to resident needing help and not having a way to call for help.</p> <p>(continued on next page)</p>		

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 02/27/2025
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/27/25 at 10:48 AM with LVN A revealed she was the nurse assigned to Resident #29. She stated all residents should have a call light. She stated she was not aware Resident #29 did not have a call light. She stated all staff were responsible to ensure residents had a call light and within reach. She stated during rounds, call lights should be observed. LVN A stated no one noticed Resident #29 did not have a call light. She stated the potential risk would be the resident having a fall, and she would not be able to call for help.</p> <p>Interview on 02/27/25 at 1:16 PM with the Maintenance Supervisor revealed each resident should have a call light. He stated he was made aware today (02/27/25) Resident #29 did not have a call light. He stated his expectation are for staff to notify him of when a call light was missing. The Maintenance Supervisor stated he kept a logbook outside his office for work orders. He stated he checked the logbook every day. He stated the potential risk of not having a call light could lead to a resident needing help and not being able to get a hold of someone.</p> <p>Interview on 02/27/25 at 2:04 PM with the DON revealed all resident should have a call light. She stated she was not aware Resident #29 did not have a call light. She stated she expected all residents to have a call light and if they do not have one, staff should report to the maintenance staff. She stated the potential risk of not having a call light could lead to delay of care.</p> <p>Interview on 02/27/25 at 2:53 PM with the Administrator revealed her expectations were for call lights to be answered in a timely manner and for all residents to have a call light. She stated if a resident was missing a call light staff should notify maintenance staff or anyone in management. The Administrator stated the risk of not having a call light would be residents unable to call for assistance.</p> <p>Record review of facility Maintenance Request Log start date 12/31/24 through 02/25/25 revealed no request for Resident #29 call light to be replaced.</p> <p>Record review of facility current, undated Call Light/Bell policy reflected the following:</p> <p>.It is the policy of this facility to provide the resident a means of communication with nursing staff.</p> <p>.5 .Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor</p>		