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	05/07/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable environment, including but not limited to receiving treatments and support for daily living for 6 of 11 residents (Resident #2, Resident #7, Resident #16, Resident #48, Resident #56 and Resident #60) reviewed for safe, clean and comfortable environment. 1. The facility failed to ensure Residents #16 and #7's privacy curtain was clean and free of stains on 05/05/26. 2. The facility failed to ensure Resident #48 and Resident #60 had clean, stain-free sheets and bedding on 5/6/26. 3. The facility failed to ensure Resident #56 had clean stain-free sheets on 5/5/26 and 5/6/26. 4. The facility failed to ensure Resident #48 had good draining sink in his restroom. 5. The facility failed to ensure Resident #2 had a floor base board on the wall under her bed near the window. These failures could affect the residents by a decrease in quality of life, at risk of infections, a decline in skin integrity and an increase in bugs in resident room. Findings include: 1. Record review of Resident #16's face sheet undated reflected Resident #16 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] included diagnoses of lumbar disc displacement (pathological condition of the lumbar spine in which one of the discs which forms the lumbar spine moves out of its normal alignment) and Type 2 Diabetes (metabolic disorder that occurs when the body becomes resistant to insulin or when the pancreas fails to produce enough insulin). Record Review of Resident #16's quarterly MDS assessment dated [DATE] reflected he was dependent with ADLs of toileting, dressing, personal hygiene and mobility. Resident #16 had a BIMS score of 15 indicating he was cognitively intact. Record Review of Resident #7's quarterly MDS assessment dated [DATE] reflected Resident #7 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of partial paralysis on the right side after an unspecified type of brain injury or stroke, hypertension (high blood pressure) and diabetes. The assessment reflected no BIMS was completed for Resident #7. Observation on 05/05/26 at 10:16 AM revealed Resident #7 and Resident #16's privacy curtain had multiple stains and particles covering both sides of the privacy curtain. The privacy curtain was hanging to the right of Resident #16 while he was lying in the bed and in front of Resident #16's bed. The privacy curtain was to the left of Resident #7's end of his bed. Interview with Resident #16 revealed he stayed in bed per his preference and his privacy curtain had not been changed since he was moved to this room about 3 weeks ago. He stated his roommate (Resident #7) kept his side of the room cluttered and dirty. He stated he and his roommate preferred the privacy curtain to be closed for privacy. He stated housekeeping came into his room but had not replaced the privacy curtain. Observation on 05/05/26 at 2:51 PM revealed Resident #7 and Resident #16's privacy curtain had multiple stains and particles covering both sides of the privacy curtain. The privacy curtain was hanging to the right of Resident #16 while he was lying in the bed and in front of Resident #16's bed. Interview with CNA H revealed she had not seen the privacy curtains being changed on her hall and stated housekeeping was responsible for changing them since they had access to the privacy curtains. Interview on 05/07/2026 at 10:55 AM with Housekeeper L revealed they usually change privacy curtains every week but they have been waiting for a shipment of new privacy curtains to (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replace the others. She stated the last time privacy curtains have been changed was at least 2 weeks ago. Interview on 05/07/2026 at 1:48 PM with ADON D revealed housekeeping had access to privacy curtains but she was not certain if there were other privacy curtains available for replacement. She stated she could not recall the last time housekeeping had changed the privacy curtains but they should be replaced when dirty, torn or if pulled down. Interview on 05/07/2026 at 2:32 PM with DON revealed housekeeping and maintenance were responsible to ensure privacy curtains were clean and free of stains. Interview on 05/07/26 at 3:25 PM with Housekeeping Supervisor/Maintenance Director revealed the facility had clean privacy curtains in the laundry room to replace any dirty, stained or torn privacy curtains. He stated he changed the privacy curtains in resident rooms when he was made aware they needed to be changed. 2. A record review of Resident #48's Face Sheet dated 5/6/26 reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #48 had the following pertinent diagnoses: unspecified Dementia (progressive loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), muscle weakness, and cognitive communication deficit. A record review of Resident #48's Quarterly MDS assessment dated [DATE] did not reflect his cognitive abilities with no BIMS score. Resident #48 had functional limitations to one side of upper extremities. Resident #48 required supervision for most ADLs. A record review of Resident #48's Comprehensive Care Plan revised on 2/20/26 reflected .ADL Self Care Performance Deficit related tojoint stiffness Date Initiated: 08/30/2024 Created on: 08/30/2024 Will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score through the review date. Date Initiated: 08/30/2024 Created on: 08/30/2024Revision on: 12/16/2025 Target Date: 04/23/2026 Occupational, Physical, Speech-Language Therapy evaluation and treatment to establish functional maintenance program per physician orders Date Initiated: 12/03/2024 Created on: 12/03/2024 Revision on: 12/03/2024 Explain all procedures/tasks before starting. Date Initiated: 12/03/2024 Created on: 12/03/2024 Staff will provide the appropriate level of physical assistance with ADL's as needed due to (his/her) self-ability may fluctuate throughout the day Date Initiated: 12/03/2024 Created on: 12/03/2024 TOILET USE (TOILET TRANSFER, TOILET HYGIENE): requires assistance (SPECIFY) to: wash hands, adjust clothing, clean self, transfer onto toilet, transfer off toilet, to use toilet Date Initiated: 08/30/2024 Created on: 08/30/2024 Revision on: 12/03/2024 Encourage to discuss feelings about self-care deficit. Date Initiated: 12/03/2024 Created on: 12/03/2024 Encourage to participate to the fullest extent possible with each interaction.Date Initiated: 12/03/2024 Created on: 12/03/2024. Observation and interview of Resident #48 on 05/06/2026 at 11:50 a.m. reflected resident was in the restroom shaving and showed surveyor his sink was full to the top with dirty water. Resident #48 revealed the sink water did not go down by itself most days. Observation of Resident #48's bed revealed bed sheets with a large circular yellow ring and a smaller yellow ring inside of the large ring. The sheets also had other faint brownish small circles. Resident #48 stated his sheets had not been changed for 1.5 to 2 weeks. Resident # 48 stated staff did not change his sheets regularly. Observation and interview of Resident #48 on 05/06/2026 at 12:35pm revealed the sink in his restroom was half full of dirty water. Resident #48 stated he had reported the issue with the sink since he arrived at the facility over a year ago. Resident #48 stated it was a daily struggle because the sink was always full of dirty water. Resident #48 stated he last reported the issue with the sink last week and stated the Maintenance Director had used a snake to try and unclog it, but it continued to be clogged. 3. A record review of Resident #60's Face Sheet dated 5/6/26 reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #60 had the following pertinent diagnoses: muscle weakness, cognitive communication deficit, major depressive disorder (a condition characterized by persistent sadness and loss of pleasure), irritable bowel syndrome (a disorder that causes recurrent abdominal pain, and changes in bowel habits) and anxiety disorder (a condition characterized by persistent, excessive and uncontrollable fear). A record review of Resident #60's Quarterly MDS assessment dated [DATE] reflected his cognitive abilities (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were intact with a BIMS score of 15. Resident #60 had no functional limitations to either side of his extremities. Resident #60 required supervision or set up for most ADLs. A record review of Resident #60's Comprehensive Care Plan revised on 3/5/26 reflected .At risk for impaired cognitive function/dementia or impaired thought processes related to Disease Process Date Initiated: 03/05/2026 Created on: 03/05/2026 Will remain oriented to (person,place, situation, time) through the review date. Date Initiated: 03/05/2026 Created on: 03/05/2026 Revision on: 05/05/2026 Target Date: 06/01/2026 COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Date Initiated: 03/05/2026Created on: 03/05/2026 Engage in simple, structured activities that avoid overly demanding tasks. Date Initiated: 03/05/2026 Created on: 03/05/2026. An interview and observation of Resident #60's room on 5/6/26 at 11:47am revealed Resident #60's bed sheets had 4 small brownish, yellow stains on them. Resident #60 stated his bed sheets were only changed once per month. 4. A record review of Resident #56's Face Sheet dated 5/6/26 reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #56 had the following pertinent diagnoses: unspecified Dementia (a decline in mental function), muscle weakness, cognitive communication deficit, and Chronic Kidney Disease (a condition in which the kidneys are damaged and gradually lose their ability to filter waste). A record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected his cognitive abilities were severely impaired with a BIMS score of 5. Resident #56 required partial/moderate assistance, supervision or set up for most ADLs. A record review of Resident #56's Comprehensive Care Plan revised on 11/16/26 reflected .At risk for impaired cognitive function/dementia or impaired thought processes related to disease process Date Initiated: 11/17/2025 Created on: 11/17/2025 Will maintain current level of cognitive function through the review date. Date Initiated: 11/17/2025 Created on: 11/17/2025 Revision on: 02/06/2026 Target Date: 04/11/2026 COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Date Initiated: 11/17/2025Created on: 11/17/2025 Engage in simple, structured activities that avoid overly demanding tasks. Prefers: (SPECIFY ACTIVITY) Date Initiated: 11/17/2025 Created on: 11/17/2025 Revision on: 01/28/2026 Social Services to provide psychosocial support as neededDate Initiated: 11/17/2025 Created on: 11/17/2025. Observation of Resident #56's bed sheets on 05/05/2026 at 9:49 revealed resident was not in his room, however his sheets were observed to be stained with brown spots, and his pillowcase was observed with brown and red spots. Observation and interview of Resident #56 on 05/06/2026 at 9:57 AM revealed resident was lying in bed and the parts of the sheets that were visible had several tan marks on them. Resident #56 stated he did not remember the last time they changed his sheets. Observation of Resident #56's bed on 05/06/2026 at11:48am revealed his bed sheets had multiple light brown, yellowish circular stains and red small marks. An interview and observation with CNA A on 5/6/26 at 11:51am revealed he was the CNA for Resident # 48 and Resident #56. CNA A stated he changed all residents' sheets when they were visibly dirty and on shower days. CNA A observed Resident #56's sheets and stated they were dirty and needed to be changed. CNA A stated the last time he changed Resident #56's sheets was last week when he was on rotation. CNA A stated he would change Resident #56's sheets when he had his shower that day. CNA A stated Resident #56 was supposed to have a shower yesterday but he asked to have it today instead and they just showered him and were going to change his sheets. CNA A stated he was unsure if Resident #56 had his sheets changed since he changed them last week. CNA A then observed Resident #48's sheets and he stated oh there is a urine circle, I will change them right away. CNA A stated he last changed Resident #48's sheet a week ago as well. CNA A stated Resident #48 showered himself and therefore staff only saw Resident #48's sheets when he got up. CNA A stated it was the first time today Resident #48 had gotten out of the bed and therefore had not seen his sheets. CNA A stated the risk to the residents of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not changing sheets regularly, particularly when they were dirty, was skin tears, infections and transmission of bacteria. An interview and observation with CNA B on 5/6/26 at 12:00 pm revealed she was the CNA for Resident #60. CNA B stated she changed all residents' sheets daily in the morning during her first round. CNA B stated at times she will change resident's sheets again throughout the day if they were visibly soiled. CNA B observed Resident #60's sheets and stated she changed his sheets this morning, but the new sheets were stained. CNA B stated she had put on clean sheets but a lot of the sheets at the facility were stained. CNA B stated she had told the Housekeeping Supervisor about the stained sheets and the need for new ones. CNA B stated putting stained sheets on residents' beds could have affected their dignity and could have made them sad or depressed. An interview and observation with the Laundry Staff on 5/6/26 at 12:12 p.m. revealed some bed sheets, placed in linen closets for resident use, were stained but clean. The Laundry Staff stated the facility was low on bed sheets and the directive was for them to discard bedsheets only when they were torn. The Laundry Staff stated some soiled bed sheets were washed over and over with extra bleach, but stains had not come off. She was unable to state how many sheets were ordered monthly but stated sheets were ordered once per month. An interview with the Housekeeping Supervisor/Maintenance Director on 5/6/26 at 12:35pm revealed he had tried to fix Resident #48's sink several times by plunging and snaking it but it continued to get clogged. The Housekeeping Supervisor/Maintenance Director stated he has been dealing with the sink issue for over 2 weeks. Housekeeping Supervisor/Maintenance Director stated Resident #48 would come to him almost daily about the issue with his sink. The Housekeeping Supervisor/Maintenance Director stated he believed he would just have to replace the plumbing to get the issue resolved. Housekeeping Supervisor/Maintenance Director stated he ordered sheets and bedding once per month. The Housekeeping Supervisor/Maintenance Director stated the Laundry Staff would let him know how many sheets to order based on how many sheets she discarded due to them being stained or having had holes. The Housekeeping Supervisor/Maintenance Director told the Laundry Staff he wanted to see the sheets before she discarded them to ensure they needed to be discarded because he only wanted the badly stained sheets discarded. The Housekeeping Supervisor/Maintenance Director stated residents should not have to sleep on bed sheets that were stained. The Housekeeping Supervisor/Maintenance Director stated he would get with the Laundry Staff and would remove all stained linen and order new ones. The Housekeeping Supervisor/Maintenance Director stated he would also do rounds daily to make sure staff were not putting stained sheets on beds. The Housekeeping Supervisor/Maintenance Director stated stained sheets could affect the residents by making them uncomfortable in their bed and making them frustrated about the condition of their sheets. An interview with the Administrator on 05/06/2026 at 1:50 PM revealed it was the responsibility of the Laundry Staff to determine how many linens the facility needed and report it to Housekeeping Supervisor/Maintenance Director. The Administrator stated expectation for linen changes was linens for residents should have been changed daily, with the shower schedule or as needed. The Administrator stated it would depend on the type of stain whether staff used a clean linen with a stain. The Administrator stated if the stain was really bad, she would have expected the staff to discard the linen and not use it, but if the stain was light and barely noticeable, she believed it was okay. The Administrator stated it would have been best practice for staff to ask residents if they felt their linens were okay when they put on sheets that were clean with stains. She stated the staff could ask the residents daily if they felt the linens were okay. The Administrator stated having dirty or stained linens could have affected the residents by making them feel uncomfortable. The Administrator stated the expectation for an issue with a resident's sink or toilet not being fixed despite repeated attempts would have been for the Housekeeping Supervisor/Maintenance Director to notify her to ensure she got it resolved. The Administrator stated the effect on the residents of having stained or dirty sheets would have been frustration or an unwillingness to sleep in their bed. 5. Review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[AGE] year-old female admitted to the facility on [DATE] with diagnoses of heart failure and hypertension (high blood pressure). Resident #2 had a BIMS score of 1 indicating she was severely cognitively impaired. Resident #2 was dependent with ADLs. Observation on 05/06/26 at 1:30 PM revealed there was no baseboard on the wall under Resident #2's bed which was next to the window leaving multiple cracks and white particles. Observation and interview on 05/07/26 at 3:20 PM with Housekeeping Supervisor/Maintenance Director revealed there was no base board on the wall under Resident #2's bed which was next to the window leaving multiple cracks and white particles. He stated about a month ago water had flooded from the bathroom which damaged the base board. He stated he had not gotten around to replacing the base board yet. He stated the floor base board kept the bugs from coming in from the outside. Review of facility's policy Safe/Comfortable/Homelike Environment revised 1/2022 reflected .The facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect a personalized homelike setting. These characteristics include a. Cleanliness and order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety for the facility's only kitchen. 1. The facility failed to ensure the oven and stove top were free of blackened sticky residue and stove top had working burners on 05/05/26. 2. The facility failed to ensure Dietary Manager and Dietary Aide J used proper hand hygiene during lunch meal preparation on 05/06/26. 3. The facility failed to ensure Dietary Aide J wore effective hair restraints to cover about a foot of her hair in the back during lunch meal preparation on 05/06/26. 4. The facility failed to ensure Dietary Aides K wore effective facial hair restraint to cover his mustache during lunch meal preparation on 05/06/26. 5. The facility failed to ensure Dietary Aide M wore effective facial hair restraint to cover his upper part of his beard and his mustache during lunch meal preparation on 05/06/26. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness and food contamination.Findings included: 1. Observation on 05/05/26 at 9:34 AM revealed oven stove top had about 1 to 1.5 inch sticky black substance on the right side of the stove top. Observation of inside of the first oven revealed blackened substances and food particles covering the bottom of the stove all the way lengthwise near the oven door about 5 inches wide with about an inch thickness. There was a blackened substance in the back corners of the oven with right corner about 5 inches x 5 inches along with both sides of the bottom of the oven having a blackened substance of about 2 inches. Door of the oven had brownish, blackish substance covering the bottom covering about 2 inches to 6 inches inches. Observation of 2nd oven revealed blackish substance covering the bottom of the oven covering 3 inches on right side bottom of the oven. The inside door of 2nd oven had blackish substances and particles about 1/2 wide covering the bottom of the oven door. Both ovens had brownish, blackish substance covering the sides of the inner sides of the ovens. Interview on 05/05/26 at 9:41 AM with Dietary Manager revealed the oven and stove top were cleaned weekly. She stated the corrosion on the top of the stove and in the ovens had blackened. She stated two of the six stove burners did not work on the stove. 2. Observation on 05/06/26 at 11:08 AM revealed Dietary Manger temped the stuffed bell peppers. At 11:10 AM, Dietary Manager took gloves off and put new gloves on. She did not wash hands between glove changes. Dietary Manager was putting her gloved hands around the bell pepper with spatula to put in pan and placed the pan on the steam table. Observation on 05/06/26 at 11:16 AM revealed Dietary Aide K was wearing his facial hair restraint below his mouth not covering his mustache. He was separating out packets and pouring drink into cups. Observation on 05/06/26 at 11:18 AM revealed Dietary Aide M was wearing his facial hair restraint below his mouth not covering his mustache and about 2 inch on upper part of beard on both sides of face. Dietary Aide M took gloves off, put on new gloves and did not wash his hands. Dietary Aide M was pouring iced tea into cups. Observation on 05/06/26 at 11:20 AM revealed Dietary Aide J did not have a hair restraint covering about 1 foot of her hair in the back while in the kitchen for lunch meal preparation. Observation on 05/06/26 at 11:22 AM revealed Dietary Manager took gloves off, did not wash hands, put new gloves on and then stirred marinara sauce on stove top. She then put a tortilla in pan, opened the cheese and put cheese on the tortilla with gloved hands. Observation on 05/06/26 at 11:26 AM revealed Dietary Manager took gloves off, did not wash hands and put new gloves on. She grabbed clean bowls. Observation on 05/06/26 at 11:33 AM revealed Dietary Manager took gloves off, did not wash hands and put new gloves on. Dietary Manager was pouring marinara sauce on stuffed bell peppers. Observation on 05/06/26 at 11:36 AM revealed Dietary Manager took gloves off and put new gloves on without washing hands between glove changes. She went back to plating food touching bread and stuffed bell pepper with her gloved hands. At 11:40 AM, Dietary Manager took gloves off, put new gloves on, and did not wash hands. She plated food. Observation on 05/06/26 at 11:44 AM (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and 11:54 AM revealed Dietary Aide J did not wash her hands when she re-entered the Kitchen after taking a hall meal tray cart out of the kitchen. She touched the door when she re-entered the kitchen both times. Observation on 05/06/26 at 11:55 AM revealed Dietary Aide K was pouring cranberry juice into cups with his facial hair restraint below his mouth not covering his mustache. Interview on 05/06/26 at 11:59 AM with Dietary Aide K stated his facial hair restraint had fallen down. He stated he was aware it should have been covering his mustache. Interview on 05/06/26 at 12:01 PM with Dietary Aide M stated he should have washed his hands when he changed gloves before putting on the new gloves. He stated he was aware his facial restraint was not covering the upper part of his beard. Interview on 05/06/2026 at 12:05 PM with Dietary Aide J she stated she should have washed hands when she reentered the kitchen since she touched the door. Follow-up interview at 12:18 PM revealed she was not aware the back of her hair needed to be covered and thought as long as she had the front of her hair covered. Interview on 05/06/2026 at 3:12 PM with Dietary Manager she stated if she continued with same task and changed her gloves, she did not need to wash her hands between glove changes. She stated Dietary Aide J should have washed her hands when she returned back into the kitchen. She stated the importance of hand washing was not to cross contaminate and place residents at risk of bacteria. She stated hair restraints and facial hair restraints should be worn to cover loose hair only. She stated Dietary Aide J did not need to cover her hair in the back since it was not loose. She stated the importance of hair and facial hair restraints was not to contaminate the food and get loose hair in the food. She stated the facility did not have facial hair restraints to cover Dietary Aide M's full beard. She stated Dietary Aides M and K's facial hair restraints were on their faces. She stated the facility cleaned the stove and ovens weekly. The facility did not provide a policy on oven cleaning, hair restraints and hand hygiene and provided the US Food Code as their policies on 05/07/26 at 3:25 PM. Review of the Food and Drug Administration US Food Code, dated 2022, reflected 228.113. Cleaning of Equipment and Utensils.(1)Equipment food-contact surfaces.shall be clean to sight and touch. (2) The food-contact surfaces of cooking equipment.shall be kept free of encrusted grease deposits and other soil accumulations.228.114 Frequency of Cleaning. (a) Equipment food-contact surfaces and utensils. (1) Equipment food-contact surfaces and utensils shall be cleaned. Review of the Food and Drug Administration US Food Code 2022 reflected the following:-under section 2-3 Personal Cleanliness 2-301.11 Clean Condition Food Employees shall keep their hands and exposed portions of their arms clean.-under section 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 residents (Resident #2 and Resident #28) of 5 residents reviewed for ADLs. The facility failed to ensure:Resident #2 had her fingernails trimmed and cleaned on both hands on 05/06/2026.Resident #28 had his fingernails trimmed and cleaned on both hands on 05/06/2026. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life.1-Resident #2Record Review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old female with initial admission date of 07/22/2019. Her pertinent diagnoses included: hemiplegia (paralysis that affects one side of the body, causing severe or total loss of motor function in the arm, leg, and sometimes face) affecting right dominant side, dementia (a decline in cognitive abilities, severe enough to interfere with daily life), cerebral infarction (is a condition caused by a blockage in blood vessels supplying the brain, resulting in tissue death), and cognitive communication deficit. Her BIMS score was 01, which indicated Resident #2's cognition was severely impaired. Resident #2 was dependent on staff for her personal hygiene. Review of Resident #2 's Comprehensive Care Plan, revised 12/17/2025 reflected, Focus: [Resident #2] has ADL self-care performance deficit related to hemiplegia.Interventions: . staff will provide the level of physical assistance as needed with ADLs. An observation on 05/06/2026 at 1:57 PM revealed Resident #2 was lying in her bed. The nails on both hands were approximately 0.3cm in length extending from the tip of her fingers. The nails were discolored, tan and had yellow greenish colored residue underside. Resident #2 was confused and her answers were not pertinent to the subject. In an interview on 05/06/2026 at 2:05 PM with CNA E she stated that Nurses and CNAs were responsible for cleaning and clipping residents' fingernails as needed. CNA E stated the risks of long, dirty fingernails included skin tears and increased risk of infection. 2-Resident #28 Record review of Resident #28's face sheet, dated 05/06/26, revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of Paraplegia (impairment of motor or sensory function in the lower extremities), Dysphagia (difficulty swallowing), Cognitive Communication Deficit (deficits in communication skills), Contracture Right Hand and Left Hand (hand condition causing one or more fingers to curl toward the palm), and Muscle Weakness (reduction in physical strength). Record review of Resident #28's quarterly MDS assessment, dated 03/24/2026, reflected a BIMS score of 10, which indicated moderate cognitive impairment. Section GG0103-Functional Abilities revealed Resident #28 was dependent (helper does all of the effort) for personal hygiene. Record review of Resident #28's Comprehensive Care Plan reviewed 05/06/2026 revealed an ADL Self Care Performance Deficit. Staff will provide the appropriate level of physical assistance with ADLs as needed. Record review of Resident #28's Progress Notes, from 04/06/26 to 05/06/26, reflected no notes on nail cutting/trimming. During an observation and interview on 05/06/26 at 1:45 p.m., Resident #28 was observed with long fingernails, approximately 1/8 of an inch, on his contractured left hand. Resident #28 was unable to be interviewed due to his cognitive impairment. During an interview on 05/06/26 at 1:58 p.m. the Wound Care Nurse revealed she was responsible for trimming Resident #28's nails. She stated Resident #28's nails were cut every two weeks, but he probably refused. She stated refusals were noted in the progress notes. She stated nail care was important for infection control and hygiene. In an interview on 05/07/2026 at 1:08 PM, the DON stated her expectation was that ADL care be provided as needed. She stated that CNAs were responsible for providing nail care, including trimming fingernails, unless the resident had a diagnosis of diabetes. She stated that charge nurses were responsible for monitoring this care. The DON stated that residents having long, dirty fingernails could result in skin breakdown and potential of infections. Record review of the facility policy ADL, Services to Carry Out, revised on July 2024 reflected .If a (continued on next page)

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	455576	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Hills Rehabilitation and Healthcare Cente	3109 Kings CT Fort Worth, TX 76118

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition and personal oral hygiene will be provided by qualified staff.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for 1 of 8 residents (Resident #58) reviewed for dental services. The facility failed to refer Resident #58 for dental services after he was admitted to the facility on [DATE] despite having visibly decayed and broken teeth. This failure could affect the residents' comfort, dignity and their nutritional statusA record review of Resident #58's Face Sheet dated 5/7/26 reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #58 had the following pertinent diagnoses: muscle weakness, cognitive communication deficit, Hypothyroidism (under active thyroid), Type 2 Diabetes (a condition in which the body cannot use insulin properly resulting in high blood sugar), moderate protein calorie malnutrition, Major Depressive Order (a condition characterized by persistent, intense sadness or loss of interest), and altered mental status (a sudden or gradual change in a person's baseline mental function). A record review of Resident #58's Quarterly MDS assessment dated [DATE] reflected a significant cognitive impairment with a BIMS score of 4. Resident #58's oral/dental status was Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). A record review of Resident #58's Comprehensive Care Plan revised on 2/16/26 reflected .Has oral/dental health problems Date Initiated: 02/16/2026 Created on: 02/16/2026 Revision on: 02/16/2026 Will be free of infection, pain or bleeding in the oral cavity by/through review date.Date Initiated: 02/16/2026 Created on: 02/16/2026 Target Date: 05/06/2026 Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/16/2026 Created on: 02/16/2026 Provide mouth care as per ADL personal hygiene.Date Initiated: 02/16/2026 Created on: 02/16/2026. Record review of Resident #58's active orders as of 5/6/26 reflected no order for dental services. Observation and interview with Resident #58 on 05/05/2026 at 9:53 a.m. revealed numerous decayed front teeth that appeared broken. Resident #58 stated he needed to see a dentist but did not know the facility could have sent him to a dentist. An interview with LVN C on 05/06/2026 at 3:07 p.m. revealed Resident #58 had never asked to see a dentist. LVN C stated Resident #28 had not complained about his teeth. LVN C stated had Resident #58 complained about his teeth she would have asked the social worker to refer him to a dentist. LVN C stated residents were referred to dental services when the resident expressed concern. LVN C stated Resident #58 had broken or decayed teeth An interview with the Social Worker on 05/06/2026 at 3:21 p.m. revealed Resident #58 was a private pay resident and therefore had not had a dental due to not having had a payor source. The Social Worker acknowledged Resident #58 had some broken teeth but noted he had not complained of any pain or requested to see a dentist. The Social Worker stated she had registered the resident upon admission for ancillary services that included dental, however due to him not having Medicaid he had not been seen by the dentist. The Social Worker stated all residents were referred to the dentist upon admission, however if the resident did not have Medicaid the dental provider would not see them. The Social Worker stated all residents should be seen by a dentist for routine and emergency services. The Social Worker stated she had not encountered a resident who had not cooperated with obtaining Medicaid and therefore had not taken alternative steps to get his dental covered. The Social Worker stated she had community resources that she could have reached out to in order to cover dental services for Resident #58. The Social Worker was unable to provide proof that Resident #58 had been referred initially to dental services or that he had been on the dental list for the past 2 months. The Social Worker stated she would put Resident #58 on the dental list for May and should be seen on 5/13/26. The Social Worker stated the risk to the resident of not receiving routine dental care was oral infections or could even result in the resident's death. An interview with ADON D on 05/07/2026 at 1:36 p.m. revealed all residents were referred to dental services, however the long-term care residents received dental service through ancillary services (contracted providers that come to the facility) and the short-term residents (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive dentals from outside dental providers. ADON D stated the Social Worker was responsible for referring residents to outside dental providers or ancillary services. ADON D stated when residents were admitted to the facility the Interdisciplinary team would meet and discuss the resident's vision, dental or podiatry needs and the Social Worker would complete the referral forms for the necessary services. ADON D stated if there was an emergency need related to dental, they would request a dental visit immediately. ADON D stated the dental provider would come to the facility monthly and saw residents on their referred list. ADON D stated the expectation was that all residents were seen for routine dentals whether they had dental issues or not. ADON D stated she had seen Resident #58's decayed teeth and believed he would benefit from seeing a dentist. ADON D stated Resident #58 had not complained about dental issues but stated he should have been seen by a dentist. ADON D stated Resident #58 was at risk of further tooth decay or gingivitis (swelling of the gums) because he had not seen a dentist. An interview with the DON on 05/07/2026 at 2:26 p.m. revealed residents were referred by the Social Worker to dental services based on their insurance. The DON stated it was the responsibility of the Social Worker to refer all residents for their routine dental and for residents who their provider did not accept their insurance the facility was responsible for locating a dental provider that would accept the resident's insurance. The DON stated they would work with outside agencies to ensure the residents who had no insurance had gotten the necessary dental services. The DON stated it was the responsibility of the Social Worker to locate outside resources to pay for the dental service for residents without insurance. The DON stated all residents should have had dental but was unfamiliar with the requirements for the frequency of dental services. The DON stated even residents who do not complain about their teeth should have routine dentals while at the facility. The DON stated if a resident did not have routine dentals, they were at risk of infection, poor dental hygiene and declined health. Review of the facility's policy Dental Services revised 1/2022 reflected It is the policy of this facility to ensure that its resident who require dental services on a routine or emergency basis have access to such services without barrier.for Medicare and private pay resident, the Facility will ensure that the needed dental services are available, but may bill an additional charge for the services.if a resident is unable to pay for dental services, the Facility will attempt to find alternative funding sources or delivery systems (include other providers of dental services, such as a dental school or the provision of dental hygiene service at the Facility) so that the resident may receive the services needed to meet his/her dental needs and maintain his/her highest practicable level of well-being.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 residents (Resident #68 and Resident #54) of 4 reviewed for infection control. 1. The facility failed to ensure MA G changed gloves and completed hand hygiene during incontinent care for Resident #68 on 5/5/26. 2. The facility failed to ensure Resident #54's mattress was free of brownish material and stains on 05/05/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness.1. Record review of Resident #68's Comprehensive MDS assessment dated [DATE] reflected Resident #68 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, dementia (a decline in cognitive abilities, severe enough to interfere with daily life), and muscle weakness. Resident #68's BIMS score was 15, which indicated Resident #68's cognition was intact. The MDS assessment indicated Resident #68 required maximal assistance with toileting hygiene. Observation on 05/05/26 at 1:39 PM revealed CNA F and MA G entered Resident #68's room to provide incontinence care. Both staff washed their hands and donned gloves, MA G doubled gloves. CNA F unfastened Resident #68's brief; MA G provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. Both rolled resident on her side, CNA F supported resident when she was on her side. Resident had a large bowel movement. MA G wiped the resident's buttocks area with peri-wipes, front to back, she then removed one pair of gloves and continued to clean the resident buttocks with wipes. MA G then removed and discarded the soiled brief and soiled gloves. MA G sanitized her hands and she donned clean gloves. She continued to clean the resident's buttocks. She changed gloves without any type of hand hygiene. She put a clean brief under the resident buttocks; she applied skin barrier cream to the resident peri-area. She changed gloves without any type of hand hygiene. She rolled the resident on her back onto the clean brief. Once finished, both staff fastened the resident's brief. They covered resident and they removed and discarded gloves and washed their hands. In an interview on 05/05/26 at 1:52 PM, MA G stated she should change her gloves and perform hand hygiene when she went from dirty to clean. MA G stated failing to provide proper care would expose the residents to infections. In an interview on 05/07/26 at 1:08 PM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated nursing staff were trained to perform hand hygiene between change of gloves. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated she would educate all nursing staff, and she would do random rounds for monitoring. Record review of the facility's policy, Hand Washing, revised Jully 2024, reflected, . Hand Washing/hand Hygiene is generally considered the most important single procedure for preventing nosocomial infections . 2. Observation on 05/05/2026 at 12:16 PM revealed Resident #54's mattress had multiple tears down the middle about 3 ft long and smaller tears along with brownish stains on bottom half of mattress with 4 flies on his mattress. He stated he had asked to have his mattress replaced but they did not. He stated his mattress had gotten wet on 1 side so staff flipped it to other side. He stated he was told they could not replace the mattress. 5 flies on mattress. Observation on 05/05/2026 at 2:53 PM revealed Resident #54's mattress had multiple tears down the middle about 3 ft long and smaller tears along with brownish stains on bottom half of mattress with 5 flies landing on the resident's mattress. The bottom of the mattress had brownish stains about 1.5 feet long x 5 inches wide with 1/4 inch thickness. Interview with CNA H revealed she was not aware of the mattress being torn or having a brownish stain. CNA H stated the brownish stain could be feces and it should be cleaned. She stated the mattress should be replaced but she was not sure if they had more mattresses. Observation on 05/05/2026 at 2:58 PM with LVN I revealed Resident #54's mattress had multiple tears down the middle about 3 ft long and smaller tears along with brownish stains on bottom half of mattress with 5 flies landing on resident mattress. The bottom of the mattress had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brownish stains about 1.5 feet long x 5 inches wide with 1/4 inch thickness. LVN I was not aware of mattress being flipped over and it should have been cleaned. She stated this was an infection control issue. She stated housekeeping should have cleaned the mattress and the facility would get a new mattress. Interview on 05/07/2026 at 2:32 PM with DON revealed housekeeping should have seen Resident #54's nasty, dirty and torn mattress. She stated housekeeping was responsible to clean mattresses daily. She stated the risk to the resident was infection control and a dignity issue. Review of facility's policy Infection Control Policy subject: Laundry Services reflected facility to assure a clean supply of linens. Under procedures: 1. Routine Handling of Soiled Linen.C. Soiled linen should be removed from resident-care areas at least daily and may need to be removed more frequently, depending on the amount of soiled linen that is generated.