STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675018	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Health and Rehabilitation Center	2416 NW 18th St Fort Worth, TX 76106

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51826 Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 4 residents (Resident #1) reviewed for abuse . The facility failed to protect Resident #1 from physical abuse by Resident #2. This failure could place residents at risk of abuse, injury, and emotional distress. The noncompliance was identified at PNC. The noncompliance began on 11/25/2024 and ended on 11/25/2024. The facility had corrected the non-compliance by monitoring Resident #1 and Resident #2 every 15 minutes and issuing a discharge notice to Resident #2. Findings include: 1. Record review of Resident #1's admission record, dated 12/11/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included severe dementia with behavioral disturbance, anxiety disorder, and mixed obsessional thoughts and acts. Record review of Resident #1's quarterly MDS assessment, dated 11/25/2024, reflected a BIMS score of 0, which indicated severe cognitive impairment. Record review of Resident #1's care plan, dated 11/12/2024 , reflected Resident #1 had impaired cognitive function (i.e. impaired judgement related to dementia), has a behavioral problem (i.e. urinating on floors, throwing food on walls, pull call light out of wall), has a mood problem, has potential to demonstrate physical and verbal behaviors (i.e. hitting staff, pushing cleaning cart into people, yelling, throwing items related to anger secondary to dementia), is an elopement risk/wanderer and is at risk for injury due to wandering aimlessly. Record review of Resident #1's skin assessment, dated 11/25/2024, reflected scattered dark colored bruising on the right forearm from the elbow to the wrist, right hand 2nd finger, and left eye extended to below the eye socket. (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 0600 Level of Harm - Actual harm Residents Affected - Few	2. Record review of Resident #2's admission record, dated 12/11/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2 had diagnoses which included depression, anxiety disorder, bipolar disorder and intermittent explosive disorder. Record review of Resident #2's most recent optional state assessment MDS, dated [DATE], reflected a BIMS score of 15, which indicated intact cognition. Record review of Resident #2's care plan, dated 10/18/2024, (with 12/10/2024 revisions) reflected behavioral problem evident by verbally abusive behaviors, and is/has potential to be physically aggressive and verbally aggressive related to impulse. Record review of Resident #2's Notice of Immediate Discharge, dated 12/03/2024, reflected Resident #2 would be discharged on [DATE] due to recent and ongoing behaviors which included verbal and physical aggression towards other residents and staff. Record review of provider investigation report, dated 11/25/2024, reflected in part, Dietary Manager reported to the ADM that she was sitting in her office when she heard someone hollering, she stepped out to see what was going on. When she got to the dining room area, she witnessed [Resident #2] holding onto [Resident #1's] hand. The Dietary Manager separated the two residents, made sure that [Resident #1] was safe, then reported the incident to the ADM. When questioned, [Resident #2] denied the allegation. When questioned, [Resident #1] was able to identify [Resident #2] as his aggressor. [Resident #1] stated that a white man with long hair, mean, was here in hallway and in a wheelchair, twisted his arm and punched him in the eye. [Resident #1] looked over his shoulder and pointed at [Resident #2]. Further investigation, documentation, and evidence indicate/confirm the allegation happened . Observation and interview on 12/10/2024 at 11:21 AM, revealed Resident #2 was in the dining room . Resident #2 stated he and Resident #1 were in the dining room area, next to the beverage dispensers where residents could get beverages themselves. Resident #2 stated, Apparently, I grabbed his (Resident #1) hand . that is what the kitchen lady (dietary manager) told me; but did not recall the action. Resident #2 took a cup out of Resident #1's hand and Resident #1 was nasty and had behavioral actions in the dining room area where he had urinated on the floor and stuck his fingers into the beverage dispensers. When asked about if staff members were present for the incident, Resident #2 stated there were never staff members in the dining room area , but he informed staff members of Resident #1's actions prior to the alleged incident. Resident #2 was aware of the 30-day discharge notice and further stated they (the facility) want me out and he did not appeal the discharge. He stated he would understand why he would get kicked out if the incident had happened. Resident #2 continued to deny the incident and did not think there was an incident. Observation and interview on 12/10/2024 at 12:47 PM, Resident #1 was in the dining room, drinking coffee. Resident #1 indicated he only spoke Spanish. The State Surveyor attempted to use the language line with an interpreter and google translate, but Resident #1 stated he was deaf. At 12:54 PM, the Laundry Aide entered the dining room and told the State Surveyor she spoke to Resident #1. She translated Resident #1 said he was good, but hungry and that he fell , but nobody hurt him. The State Surveyor asked when he fell , Resident #1 stated he did not know when and it had been days and to forgive him because he could not communicate. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/10/2024 at 1:14 PM, the Dietary Manager stated she had been in her office at the time of the altercation between Resident #1 and Resident #2. She stated she heard a different distress like scream. She opened her door and went to the dining room and saw Resident #2 holding onto Resident #1's wrist, identifying the scream was from Resident #1. The Dietary Manager told Resident #2 to back away from Resident #1, Resident #2 responded by saying He (Resident #1) touches all the things we fucking use and fucking eat. The Dietary Manager took Resident #1 to his room to get him into a safe area and had Resident #2 go to the tv area. She then reported the incident to the ADM. Interview on 12/10/2024 at 1:36 PM, LVN A stated he did the assessments on the residents following the incident. LVN A stated Resident #1 had bruises on his right forearm and bruises to the left eye that looked new based on its coloring . He did not recall Resident #1 having bruises that significant prior to the incident. LVN A stated Resident #2 did not have bruises or scratches. LVN A stated he saw the video of the incident and stated Resident #2 did hit Resident #1. Observation and interview on 12/10/2024 at 2:58 PM, with the Administrator, revealed she was able to receive a video of the incident on 11/26/2024. Surveyors viewed the video with the Administrator. The video revealed Resident #1 and Resident #2 were in the dining room on 11/25/2024. Resident #1 was seen in his wheelchair and rolled to the beverage dispensers. Resident #2 was seen in his wheelchair, and he watched Resident #1 go to the beverage dispensers. Resident #2 then rolled to the beverage dispensers where Resident #1 was. Resident #1 and Resident #2 had initially interacted without physical altercation, and then Resident #2 punched Resident #1 in the face. Resident #1 rolled backwards in his wheelchair and tried to get away from Resident #2, but Resident #2 held onto Resident #1. The ADM stated after she watched the video and confirmed the allegation was true, she questioned Resident #2 about the incident again. He denied it. She then showed Resident #2 the video, and he then stated, I guess you got me. He was then notified with a 30-day discharge. Interview on 12/10/2024 at 4:05 PM, RN C stated he was in-serviced on resident to resident altercations. He stated he was not there for the incident with Resident #1 and Resident #2 and was still monitoring both residents every 15 minutes. RN C stated they were still monitoring to ensure no other incidents would happen, not only with Resident #1 and Resident #2, but with other residents. Interview on 12/11/2024 at 10:27 AM, RN B stated she was not there when the incident with Resident #1 and Resident #2 happened. She stated she had been in-serviced on resident to resident altercations and they were doing 15 minute interval checks for both residents. She said they documented where each resident was, and if needed they could preemptively redirect. Interview on 12/11/2024 at 2:39 PM, the ADM stated to prevent resident to resident altercations, they in-serviced staff on de-escalation, customer service and redirection. She stated some residents got to the point where their medications needed to be reviewed. She said some residents needed a dementia unit and Resident #2 did not understand dementia. Record review of resident to resident monitoring dated 11/25/24 and 11/26/24 reflected no staff had seen an altercation between Resident #1 and Resident #2. Record review of inservices dated 11/25/2024 reflected staff were inserviced on the topics of De-escalation training and Abuse and Neglect (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy titled, Abuse/Neglect revised 3/29/18, reflected in part; The resident has the right to be free from abuse, neglect, misappropriation of resident property as defined in this subpart . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals . Resident to Resident The above policy will apply to potential resident-to-resident abuse. Provider letter 19-17 will be reviewed to determine if resident-to-resident abuse occurred

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 4 Residents (Resident #3 and Resident #4) reviewed for pharmacy services. The facility failed to administer Resident #3's PRN pain medication and Resident #4's routine pain medication due to not ordering medications timely. These failures could place residents at risk of not receiving the therapeutic benefit of the prescribed medication. Findings include: 1. Record review of Resident #3's Admission Record, dated 12/11/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #3 had primary diagnosis which included Alcoholic Cirrhosis of liver with ascites, other diagnoses included major depressive disorder, post-traumatic stress disorder, and type 2 diabetes mellitus . Record review of Resident #3's Quarterly MDS assessment, dated 11/10/2024, reflected a BIMS score of 14, which indicated intact cognition. Record review of Resident #3's order summary report, dated 12/11/2024, reflected Tramadol oral tablet 50mg Give 50 mg by mouth every 8 hours as needed for pain order date 11/11/2024. Record review of Resident #3's nursing note, dated 11/11/2024 at 1:02 PM, reflected N.O of Tramadol 50mg po q 8 hrs . r/t pain. Record review of Resident #3's MARs, dated November 2024 and December 2024, reflected no Tramadol was administered. Observation and interview on 12/10/2024 at 3:43 PM, Resident #3 had his call light on. He stated he was waiting for his pain medicine. He stated he asked about a half hour ago when the CNA came in to change him, and the last time he had pain medicine was last night. RN C entered Resident #3's room, Resident #3 stated his pain was 5-6 and was in his scrotum. RN C stated he would get Tylenol . Interview on 12/10/2024 at 4:05 PM, RN C stated Resident #3 actually had tramadol for pain but was out . RN C stated he just filled the triplicate for his meds . He said yesterday (12/09/2024) was the first time Resident #3 asked for pain medicine and when he looked on the cart there was nothing. RN C stated medication was supposed to be reordered when there was a week left, less than 10. He said the risk to the resident was they could go without medicine or be in pain. RN C stated he checked the e-kit yesterday and there was no medication for Resident #3 . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/11/2024 at 10:27 AM, RN B stated Resident #3 did not complain of pain normally and had Tramadol for pain. She stated staff were supposed to reorder medications when there was less than a week left. She stated the Tramadol was a new order and she had been off work between October and November when it was first ordered. RN B stated if staff did not reorder medications residents could run out of medicine, suffer side effects of not having timely medication and specifically for pain , they could have increased pain and have a little bit of psychological distress. RN B stated if she reordered something and it had not come in that next day, she would reach out to the pharmacy. She said if it was a schedule II, she would reach out to the physician to see if the triplicate was signed. She said their e-kit did not have schedule II's, but did have Tylenol with Codeine and Ultram . Interview on 12/11/2024 at 12:13 pm, the ADON stated medications, including tramadol, were supposed to be reordered when they got to the blue line [on the medication blister card] so the resident would not run out. She said the blue line was about 10 pills remaining. She stated she was made aware of Resident #3's tramadol last night by the DON. She stated she spoke with RN C, and explained he could go to her with medications because she was an agent for the doctor. She stated nurses were responsible for reordering medicine and if not ordered timely resident could have no have their pain controlled. 2. Record review of Resident #4's Admission Record, dated 12/11/2024, reflected a [AGE] year-old male who admitted to the facility on [DATE] with type 2 diabetes mellitus, morbid obesity, other chronic pain, and dorsalgia . Record review of Resident #4's Quarterly MDS, dated [DATE], reflected a BIMS of 15, which indicated intact cognition. Record review of Resident #4's Care plan, dated 04/24/2024, reflected Resident #4 required pain management (chronic pain) r/t nerve pain and muscle spasms. Record review of Resident #4's order summary report, dated 12/11/2024, reflected the following physician orders: - Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for mild pain or fever greater than 100.1 F . Order date 04/23/2024. - HYDROcodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours for For pain Do not administer if Bp =<90/50 or RR =<12 Hold sedation every eight hours. Order date 06/10/2024. - Pregabalin Oral Capsule 225 MG (Pregabalin) Give 1 capsule by mouth two times a day for neuropathic pain. Order date 06/06/2024. - Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain/ headache. Order date 04/23/2024 - Tylenol with Codeine #3 Tablet 300-30 MG (Acetaminophen-Codeine) Give 2 tablet by mouth every 4 hours as needed for pain. Order date 09/22/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's MAR reflected 10 of 16 doses of hydrocodone were missed in September 2024. Further review reflected 9 out of 16 doses of hydrocodone from 09/23/2024 through 09/27/2024 had either 5 or 9 coded to see nurse notes. Pain levels from 09/24/2024 through 09/27/2024 were marked 0. The midnight dose for 09/25/2024 was blank with no entry. Record review of Resident #4's nursing notes from 09/23/2024 through 09/27/2024 reflected 9 entries that hydrocodone was not given due to awaiting pharmacy or pending delivery. Nurse note, dated 09/24/2024, reflected Tylenol with Codeine #3 2 tablets were given by mouth and were effective with follow-up pain scale 0. There was no nurse note indicating why hydrocodone was not given on 09/25/2024 . Interview on 12/11/2024 at 1:15 PM, Resident #4 stated he took Lyrica for neuropathy, and muscle relaxers and hydrocodone for his back. He stated he got hydrocodone 4 times a day, every 6 hours and had no issues with getting his medication except when he ran out . He stated about 3-4 months ago he went 8 days without hydrocodone, he said the facility said it was because the pharmacy and the pharmacy said it was because of insurance. He stated he had not missed any other doses, and his pain was being managed . Interview on 12/11/2024 at 1:34 PM, the DON stated her expectation for reordering medications from the pharmacy was when a resident got down to 7, the nurse would send the refill order. She stated tramadol did not require a triplicate. The DON stated if medications were not ordered timely the resident could go without medicine and could be a medication error. The DON stated she did not know anything about Resident #4's missed hydrocodone . Interview on 12/11/2024 at 2:39 PM, the Administrator stated her expectation was for staff to reorder medications timely and not wait until the last dose. She stated they had meds in the e-kit and tramadol was in the e-kit . She said the risk to the resident was not managing their pain . Record review of the facility's policy titled, Ordering Medications dated 2003, reflected in part: Medications and related products are received from the pharmacy supplier on a timely basis . 2. Repeat medications (refills) are written on a medication order form for that purpose and ordered as follows: Reorder medication three to four days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (e.g., Schedule II controlled substances, VA prescriptions), order at least seven days in advance of need. The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. The refill order is called in, faxed, or otherwise transmitted to the pharmacy. 3. New medications,: If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery. Use the emergency kit when the resident needs a medication prior to pharmacy delivery. If not in the emergency kit, contact the pharmacy for possible local pharmacy to fill enough of the medication until the next scheduled delivery .