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	04/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of abuse were reported to the State Survey agency and the administrator of the facility, immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse for 1 of 1 resident reviewed for abuse and neglect for one (Resident #1) of 1 resident reviewed for abuse. The facility did not report immediately to the State Survey agency when Resident #1 accused LVN A touched him inappropriately on 03/08/25 and LVN A did not report the allegation immediately to the Administrator. These failures could place residents at risk for abuse, neglect, and exploitation. Findings included: Review of Resident #1's Face Sheet dated 04/24/2025 indicated a [AGE] year-old male readmitted on [DATE], with initial admission on [DATE]. Admitting diagnoses included Cerebral Infarction Unspecified (a blood vessel supplying blood to the brain has been blocked, leading to brain tissue damage. the cause and location unknown); Heart Failure, Unspecified (a condition where the heart cannot pump enough blood to meet the body's needs, and the specific type or cause is not clearly documented); Bipolar Disorder, Current Episode, Depressed Moderate (periods of intense mood swings, including both manic/hypomanic episodes and depressive episodes). Record review of Resident #1's Change of Condition MDS dated [DATE] noted BIMS Score to be 14/15 with memory intact. Functional ability r/t catheter care is Resident #1 has an indwelling catheter which is managed by the nursing staff in relation to changing the catheter, tubing, and bag as needed. Resident #1 is always incontinent of bowel movements and requires incontinent care by the CNAs. Review of the facility's Provider Investigation Report, dated 03/21/25, revealed the incident occurred on 03/08/25 where Resident #1 alleged LVN A touched him inappropriately. Report indicated resident had a history of making false accusations and calling 911. Findings were unfounded. In an interview on 04/24/2025 at 12:50 pm, Resident #1 revealed that LVN A needed to change his catheter bag and the tubing due to leaking. Resident #1 could not remember what day the incident of abuse occurred. Resident #1 denied ever saying that LVN A touched him inappropriately. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/24/2025 at 4:40 pm the ADM revealed an incident occurred between Resident #1 and LVN A on 03/08/2025 at 12:00 pm where Resident #1 alleged LVN A inappropriately touched Resident #1. ADM first learned of the alleged incident on 03/10/2025 from a note that had been placed on her office door by LVN A. An assessment was completed on Resident #1 on 03/10/2025 and an investigation was started. Reported to HHSC on 03/10/25. The ADM admitted that the incident was not reported on 03/08/2025, but the staff have been in-serviced to contact administration immediately with all accidents and incidents to that she can determine the need to report. Internet search of [state database] revealed discrepancies in reporting timeline. Incident was reported on 03/10/25, which was two days after the incident first occurred. Review of facility's In-service, dated 03/11/25, relating to Abuse/Neglect, types of abuse, and timely abuse of any alleged abuse reviewed LVN A was in-serviced. Review of LVN A's written statement, dated 03/10/25, revealed the allegation Resident #1 had against her occurred on 03/08/25. Record review of the facility's Abuse/Neglect policy revised 03/29/2018 revealed in part: F. Investigation - Comprehensive investigations will be the responsibility on the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. The Administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' medical, nursing, mental and psychosocial needs, for 1 Resident (Resident #2) of 1 resident reviewed for care plans. The facility did not provide interventions as outlined in Resident #2's comprehensive person-centered care plan to address Resident #2's weight loss issues with not interventions including nutritional supplements to improve weight. These failures could place residents identified at risk for weight loss at risk for their medical, physical, and psychosocial needs not being met. The findings were: Record review of Resident #2 Face Sheet, dated 04/24/2025, revealed a [AGE] year-old admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #2's diagnoses included Other Sequelae Following Cerebrovascular Disease (long -term consequences and complications that can result from a stroke or other cerebrovascular issues, including impaired movement, speech difficulties, memory loss, and other neurological deficits); Essential (Primary) Hypertension (high blood pressure where no specific underlying cause can be identified); Type 2 Diabetes Mellitus Without Complications (an individual who has been diagnosed with type 2 diabetes, but has not developed any long-term health problems (complications) that can arise from high blood sugar levels). Record review of the facility's Physician's Order List, dated 04/24/2025, listed Resident #2's diet as, regular texture, regular consistency. Record review of Resident #2's Assessment, by the facility's Dietitian, dated 09/11/2024, revealed Resident #2 had an admission weight of 184.2 pounds, with weight history stable. Nutritional Goal: Gradual weight loss 5% current body weight over the next 60 days 2. No s/s dehydration 3. Maintain adequate nutrition. Record review of Resident #2's Quarterly MDS assessment, dated 01/29/2025, revealed Resident #2's BIMS (cognitive assessment) score of 15 indicated intact cognition. Eyesight was severely impaired and assistance was needed from staff for set up and clean up for eating. Resident #2 had the ability to feed herself. No swallowing disorder and no significant weight loss/gain were noted. Record review of Resident #2's comprehensive care plan, dated 03/26/2025 and revised 04/10/2025, revealed: Resident has potential for weight loss due to refusal of most meals and prefers to eat a sandwich (grilled cheese). Goal: Resident will maintain ideal weight and receive proper nutrition daily x 90 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions include: Determine food preferences and provide within dietary limitations. Encourage meal completion and document amount consumed. Monitor weight per facility protocol. RD assess per facility protocol. Serve diet and snacks as ordered. The facility failed to implement interventions as outlined in the care plan. Record review of Resident #2's electronic chart listed the following weights recorded on the following dates: -04/09/2025: 166.4 lbs. (pounds) -03/10/2025: 171.1 lbs. -03/06/2025: 170.1 lbs. -01/08/2025: 175.1 lbs. -12/09/2024: 179.4 lbs. -11/08/2024: 175.2 lbs. -10/07/2024: 178.1 lbs. -09/06/2024: 184.2 lbs. -08/08/2024: 183.6 lbs. The percentage of Resident #2's weight loss is calculated as: 1 month - 03/10/25 - 04/09/25 2.75% weight loss 3 month - 01/08/25 - 04/09/25 4.95% weight loss 8 month - 08/06/24 - 04/09/25 9.37% weight loss (10% in 6 months is considered significant weight loss) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of nursing progress note dated 04/23/2025 at 11:28 am revealed that Resident #2, Resident has a trend of eating <51%. Res reports she is eating her own food in addition to [facility] meals. She denies nausea, vomiting, or difficulty swallowing. Appetite is good. In an interview on 04/24/2025 at 12:20 pm Resident #2 said she did not like the food because the food does not taste good. Resident #2 stated that she likes to eat snacks her family member brings and go out to eat with her family. In an interview on 04/24/2025 at 2:30 pm the ADM said that their company's policy is to address residents who have a 10% or greater weight loss in six months. Resident #2 has not had that much of a weight loss according to their company policy, which the facility would be prompted to provide interventions if a resident experienced significant weight loss. ADM revealed that the facility provides Resident #2 a grilled cheese sandwich. In an interview on 04/24/2025 at 2:40 PM the Dietitian said that she visits the facility once a month. She stated she only sees the residents who had a significant weight loss to provide recommendations for them. The Dietitian stated that she did make a recommendation to the Speech Therapist to evaluate Resident #2 for swallowing issues for a possible reason resident was not eating, but she did not document the conversation. The Dietitian said the nursing staff could make the decision for supplements. The Dietitian stated she will investigate this issue with the resident. In an interview on 04/24/2025 at 3:00 PM Resident #2's family member said that she has had concerns with resident not wanting to eat. Family member was aware of Resident #2's weight loss and knows that she does not care for the food. Family member brings her snacks to eat. Family member stated resident was much larger when she moved into the facility and has gradually lost weight. She stated that Resident #2 could lose some weight but has lost so much weight. Family member will speak to Resident #2 about eating her meals better. Record Review of facility's Resident Weight policy revised 02/13/2007 revealed in part, An acute care plan for weight loss will be initiated and the clinical record reviewed for possible need of significant change of condition MDS assessment. Assess the resident for possible reason for weight loss .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident's clinical condition demonstrated that this was not possible for 1 (Resident #2) of 1 resident reviewed for weight loss. Resident #2 had a 9.37% weight loss in 8 months between 8/6/24 and 4/9/25 with no documentation from the Dietitian on nutritional concerns or recommended interventions to address Resident #2's weight loss. This failure could place residents at risk of not having needs addressed and/or met r/t weight loss. The findings were: Record review of Resident #2 Face Sheet, dated 04/24/2025, revealed a [AGE] year-old admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #2's diagnoses included Other Sequelae Following Cerebrovascular Disease (long -term consequences and complications that can result from a stroke or other cerebrovascular issues, including impaired movement, speech difficulties, memory loss, and other neurological deficits); Essential (Primary) Hypertension (high blood pressure where no specific underlying cause can be identified); Type 2 Diabetes Mellitus Without Complications (an individual who has been diagnosed with type 2 diabetes, but has not developed any long-term health problems (complications) that can arise from high blood sugar levels. Record review of the facility's Physician's Order List, dated 04/24/2025, listed Resident #2's diet as, regular texture, regular consistency. Record review of Resident #2's Assessment, by the facility's Dietitian, dated 09/11/2024, revealed Resident #2 had an admission weight of 184.2 pounds, with weight history stable. Nutritional Goal: Gradual weight loss 5% current body weight over the next 60 days 2. No s/s dehydration 3. Maintain adequate nutrition. Review of Resident #2's electronic medical record revealed no Dietitian notes from 09/11/24 to 04/24/25. Record review of Dietary Profile dated 04/16/2025 completed by the Director of Food and Nutrition revealed Resident #2's appetite is poor, favorite meal is lunch, and no chewing or swallowing issues. Resident's current weight to be 166.4 taken on 04/09/2025. Noted resident has had a weight loss of 8 lbs. in the last 6 month. Resident #2 on a regular diet with no supplements noted. Record review of Resident #2's Quarterly MDS assessment, dated 01/29/2025, revealed Resident #2's BIMS (cognitive assessment) score of 15 indicated intact cognition. Eyesight was severely impaired and assistance was needed from staff for set up and clean up for eating. Resident #2 had the ability to feed herself. No swallowing disorder and no significant weight loss/gain were noted. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's comprehensive care plan, dated 03/26/2025 and revised 04/10/2025, revealed: Resident has potential for weight loss due to refusal of most meals and prefers to eat a sandwich (grilled cheese). Goal: Resident will maintain ideal weight and receive proper nutrition daily x 90 days. Interventions include: Determine food preferences and provide within dietary limitations. Encourage meal completion and document amount consumed. Monitor weight per facility protocol. RD assess per facility protocol. Serve diet and snacks as ordered. The facility failed to implement interventions as outlined in the care plan. Record review of Resident #2's electronic chart listed the following weights recorded on the following dates: -04/09/2025: 166.4 lbs. (pounds) -03/10/2025: 171.1 lbs. -03/06/2025: 170.1 lbs. -01/08/2025: 175.1 lbs. -12/09/2024: 179.4 lbs. -11/08/2024: 175.2 lbs. -10/07/2024: 178.1 lbs. -09/06/2024: 184.2 lbs. -08/08/2024: 183.6 lbs. The percentage of Resident #2's weight loss is calculated as: 1 month - 03/10/25 - 04/09/25 2.75% weight loss (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 month - 01/08/25 - 04/09/25 4.95% weight loss 8 month - 08/06/24 - 04/09/25 9.37% weight loss (10% in 6 months is considered significant weight loss) Record review of nursing progress note dated 04/23/2025 at 11:28 am revealed that Resident #2, Resident has a trend of eating <51%. Res reports she is eating her own food in addition to hospital meals. She denies nausea, vomiting, or difficulty swallowing. Appetite is good. In an interview on 04/24/2025 at 12:20 pm Resident #2 said she did not like the food because the food does not taste good. Resident #2 stated that she likes to eat snacks her family member brings and go out to eat with her family. In an interview on 04/24/2025 at 2:30 pm the ADM said that their company's policy is to address residents who have a 10% or greater weight loss in six months. Resident #2 has not had that much of a weight loss according to their company policy. ADM revealed that the facility provides Resident #2 a grilled cheese sandwich. In an interview on 04/24/2025 at 2:40 PM the Dietitian said that she visits the facility once a month. She only sees the residents who are having a significant weight loss to provide recommendations for them. The Dietitian said that she did make a recommendation to the Speech Therapist to evaluate Resident #2 for swallowing issues for a possible reason resident is not eating, but she did not document the conversation. The Dietitian said the nursing staff could make the decision for supplements. The Dietitian stated she will investigate this issue with the resident. In an interview on 04/24/2025 at 3:00 PM Resident #2's family member said that she has had concerns with resident not wanting to eat. Family member is aware of Resident #2's weight loss and knows that she does not care for the food. Family member brings her snacks to eat. Family member stated resident was much larger when she moved into the facility and has gradually lost weight. She agrees that Resident #2 could lose some weight but has lost so much weight. Family member will speak to Resident #2 about eating her meals better. Record Review of facility's Resident Weight policy revised 02/13/2007 revealed in part, Significant Weight Loss, The facility review resident weights after monthly weights are obtained, to determine residents with significant weight changes. A significant weight change will be defined as 5% or greater in one month, 7.5% or greater in three months, or 10% or greater in six months. The Weight change will be recorded on the appropriate weight watcher's form along with interventions, and follow-up will also be recorded in the designated location. The physician and family will be notified.