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	12/02/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and practices and were complete and accurately documented for 2 of 6 residents records (Resident #1 and Resident #2) reviewed for treatment documentation. 1. The facility failed to document on Resident #1's and Resident #2's Treatment Administration Record, when their catheter bags were emptied and the amount emptied on the night of 10/03/25 and the night of 10/11/25. This failure could affect the residents' medical record not being an accurate representation of the resident's medical condition or medical needs. Findings include: Record review of Resident #1's face sheet, dated 10/16/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had diagnoses which included, Parkinson's Disease (progressive neurological disorder that affects movement), Dementia (group of conditions that cause a decline in cognitive abilities like memory, thinking, and reasoning), and Parastomal Hernia (bulge that occurs in the abdominal wall). Record review of Resident #1's Treatment Administration Record, dated 10/16/25, reflected no documentation on her catheter bag being emptied or the amount drained from the bag, during the night shift on 10/03/25 and 10/11/25. The Treatment Administration Record reflected LVN A was the nurse responsible for documentation on the night of 10/03/25 and 10/11/25. Record review of Resident #2's face sheet, dated 10/16/25, reflected a [AGE] year-old male, with an initial admission date of 06/12/24, and a readmission date of 11/29/24. Resident #2 had diagnoses which included, Dementia (group of conditions that cause a decline in cognitive abilities like memory, thinking, and reasoning), Benign Prostatic Hyperplasia (enlarged prostate glands), and Major Depressive Disorder (mental health condition with persistent feeling of sadness, hopelessness, and loss of interest in activities). Record review of Resident #2's Treatment Administration Record, dated 10/16/25, reflected no documentation on his catheter bag being emptied or the amount drained from the bag, during the night shift on 10/03/25 and 10/11/25. The Treatment Administration Record reflected LVN A was the nurse responsible for documentation on the night of 10/03/25 and 10/11/25. In a telephone interview on 10/16/25 at 11:44 AM, LVN A stated she did work at night on 10/03/25 and 10/11/25. She stated she remembered an aide emptying the catheter bags on those nights but stated she could not remember who the aides were who emptied the bags. LVN A stated she was responsible for documenting the emptying and how much was drained. LVN A stated she failed to document the drainage of the catheter bags on the Treatment Administration Records. LVN A stated the risk of not documenting the drainage of the catheter bags was it would appear to others that it was not completed. In an interview on 10/20/25 at 12:17 PM, the Administrator stated all staff knew the importance of documentation. The Administrator stated the risk of missed documentation on the Treatment Administration Record was staff did not have enough information to properly care for the residents. In an interview on 10/20/25 at 12:23 PM, the DON stated all staff were trained on documentation and the importance of documentation. The DON stated the risk of no documentation was inaccurate information. The DON stated failed documentation would not provide a true picture of what actually took place. Record review of the facility's policy titled, Perineal Care, dated 05/11/22, reflected the following: An incontinent resident of urine and/or bowl should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible.It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations. Conclude. 33. Document