STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675018	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843 Based on observation, interview and record review, the facility failed to prepare food by methods that conserve nutritive value, flavor, texture and appearance for 3 or of 5 (Residents #4,# 12 and #18) residents reviewed for regular diets. The facility failed to ensure that regular diets served were prepared by methods that conserve nutritive value, flavor, texture, and appearance. This failure could place residents on regular diets at risk for a decrease in quality of life and possible weight loss. Findings included: Review of Resident #4's Admission Record reflected she was a [AGE] year-old woman, admitted on [DATE], with a primary diagnosis of Atrial Fibrillation (irregular heart rhythm). Review of Resident #4's Care Plan dated 11/25/2024 reflected Intervention provide diet as ordered. Review of Resident #4's MDS dated [DATE] reflected Resident #4's BIMS score was 15 (cognitively intact). Review of Resident #4's Order Summary Report reflected Resident #4 is on a regular diet, regular texture, regular consistency. Review of Resident #12's Admission Record reflected an [AGE] year-old woman admitted to the facility on [DATE] with a primary diagnosis of Type 2 diabetes mellitus without complications. Review of Residents #12's Care Plan dated 11/15/2024 reflected focus; Resident #12 has Diabetes Mellitus. Intervention; Educate regarding medications and importance of compliance. Review of the MDS dated [DATE] reflected Resident #12 had a BIMS score of 14(cognitively intact). Review of the Order Summary Report reflected Resident #12 was ordered Regular Diet, Regular texture, Regular consistency. (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 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of Resident #18's Admission Record reflected a [AGE] year-old male admitted on [DATE] with a primary diagnosis paraplegia.

Review of Resident #18's Care Plan dated 01/06/2025 reflected focus; Resident #18 has Diabetes Mellitus. Interventions; Dietary consult for nutritional regimen and ongoing monitoring.

Review of Resident #18's MDS dated [DATE] reflected Resident #18 had a BIMS score of 15(cognitively intact).

Review of Resident #18's Order Summary Report reflected regular diet, regular texture, Regular consistency, Large portion.

Observation on 01/28/2025 at 12:12 PM sample tray revealed bar-b-que chicken, potato casserole, coleslaw, biscuit, and desert. Potato dish revealed potatoes were crunchy in texture and the coleslaw was not set in form and unpalatable.

Observation and interview on 01/28/2025 at 12:16 with Resident #4 revealed she had eaten 50% of her meal. She stated the potatoes were not cooked and crunchy. She consumed less than 50% of the coleslaw.

Observation and interview on 01/28/2025 at 12:18 PM with Resident #12 revealed she had eaten less than 50% of the coleslaw and did not eat any of the potatoes. She stated when they serve her food like this it makes her want to slap them. She stated that she has voiced her concerns regarding the food, but it doesn't do any good.

Observation and interview on 01/28/2025 at 12:20 PM with Resident # 18 revealed he only ate the chicken. When asked how his lunch was, he responded you try it when told that a simple tray was consumed by the surveyor he responded, then you know this is bullshit.

Interview on 01/28/2025 at 12:22 PM with the dietary manager revealed after tasting the potato casserole, she stated not all of them were the same exact texture. Potatoes were supposed to be soft. She stated that she does not like coleslaw, but it tastes like coleslaw. She stated that the coleslaw has a mix used to prepare it. The potato comes in a box, and you cook it in the oven. She stated that she does not taste the food before it is served but she will eat it after residents were served.

Interview on 01/28/2025 at 12:34 PM with the cook revealed potato dish was mixed in bowl then layered in casserole dish. She stated that she should have layered the mixed potatoes in two shallower dishes instead she combined she combined the potato mix into one deep pan. She stated she used the deeper dish instead of two shallow pans to conserve space on the steamtable. She stated the potatoes were done (cooked to time and temperature) the potatoes on top were soft, however, as she started to serve the potato casserole I noticed they [potatoes] got a little harder . She stated the coleslaw normally had a coleslaw dressing, but they were out so she made her own dressing for the coleslaw. The dressing contained 1 cup of mayo, tablespoon of lemon juice and sprinkle of salt and pepper. She stated that she did not taste coleslaw because she does not eat coleslaw.

Interview on 01/30/2025 at 3:10 PM with the DON revealed she stated that she has not tasted the food. They do provide supplements and fortified meals for residents at risk of weight loss. The risk of not serving meals that residents enjoy eating was weight loss, skin issues and a decline in ADL's.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/30/2025 at 4:10 PM with the Administrator revealed her expectation was that the dietary staff follow the recipes for preparing food and taste the food before serving it to the residents. The risk to the residents was weight loss. Record review of Weekly menu dated week 1 revealed Tuesday lunch; BBQ Chicken Quarter, Party Potato Casserole, creamy diced coleslaw, garlic cheese biscuit, margarine, banana pudding w/wafers and iced tea. Record review of the facility policy titled; Test tray evaluation form dated 2012 revealed; 3. Once the food temps have been taken and recorded, the overall appearance of the tray should be assessed. Then all foods should be tasted. Once all scores have been completed, the form should be returned to the dietary service manager or administrator. 4. Results of the test trays will be used to determine where improvements to the tray line or food production process need to be made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 51047 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control measure designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #21) during medication administration, and 3 of 16 residents (Residents #27, #32, #40) reviewed for infection control in that: 1.MA A attempted to perform hand hygiene in another resident's room after measuring blood pressure on Resident #21 who was on Enhanced Barrier Precaution (EBP). 2.MA A did not sanitize blood pressure machine after it was used to measure blood pressure for Resident #21. 3. LVN D failed to ensure EBP procedure was followed throughout the wound care treatment and dressing change for Resident #27. LVN D did not put on his gown for PPE when he returned to complete wound care on Enhanced Barrier Precautions. LVN D failed to ensure two used towels with blood on them were handled with care and in a bag and not rolled in a ball and placed in his left arm pit after completion of wound care for Resident #27 4. RN E failed to sanitize her hands after touching Resident #32's radio that was inside his pants before getting and covering Resident #40 in a blanket and moving his bedside table. These failures could place residents and nursing staff at risk of transmission of communicable diseases and infections. Findings include: Record review of Resident #21's face sheet, dated 1/30/2025 revealed, resident was a [AGE] year-old male admitted on [DATE] with type 2 diabetes, obstructive uropathy (a condition in which the flow of urine is blocked), and leukemia (cancer of blood cells). Record review of Resident #21's care plan, dated 12/30/2024, revealed that Resident #21 was on enhanced barrier precautions, with the goal of no transmission of infection from or to the resident. One of the interventions included performing hand hygiene before entering the room and prior to leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/29/2025 at 07:30 AM, before medication pass, MA A entered Resident #21's room to measure blood pressure. Resident #21 was on EBP as marked by the posting at the door. MA performed hand hygiene and proceeded to don gown, mask & glove respectively and entered Resident #21's room with the blood pressure measuring machine. Upon completion, MA A did not perform hand hygiene when exiting the room but instead MA A attempted to enter a different resident's room to wash his hands. The surveyor then stopped him from entering another resident's room. MA A stated that he will go wash his hands at the nurse's station. Observation on 1/29/2025 at 07:40 AM, MA A put the blood pressure cuff used to measure blood pressure on Resident #21 on top of 3 other blood pressure cuffs in the basket included in the blood pressure machine. MA A only wiped down the cuff used to measure Resident #21 blood pressure. CMA A did not wipe down the remaining cuffs and the machine. Interview with MA A on 1/29/2025 at 8:00 AM, MA A stated that he has been in-serviced about providing care for resident on EBP multiple times. MA A also stated that he did not want to use hand sanitizer after measuring Resident #21's blood pressure and wanted to wash his hands. MA stated he should have sanitized all the remaining blood pressure cuffs, but he did not. MA A stated he understood the surveyor stopped him from washing hands in another resident room to prevent the spread of infection after providing care to Resident #21. Record review of Resident #27's face sheet dated 01/29/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included peripheral vascular disease (this is a circulation condition that causes vessels to reduce blood flow to the limbs), chronic venous hypertension idiopathic (this is a brain condition that is caused by a buildup of spinal fluid around the brain), ulcer of left lower extremity, and diabetes mellitus (uncontrolled blood sugars) due to underlying condition with diabetic polyneuropathy (a complication of diabetes that affects multiple nerves in the body). Record review of Resident #27's quarterly MDS dated [DATE] revealed a BIMS score of 14, which indicated cognitive status was intact. MDS also revealed Resident #27 was a 2 person plus extensive assist for bed mobility, transfers, toileting. Resident #27 was coded as having venous and arterial ulcers present. Record review of Resident #27's January 2025 physician orders reflected dressing change 3 times a week and as needed for right lower leg and left lower leg. Cleanse with hibiclens, rinse and pat dry. Apply Betadine to scabbed over areas. Collagen to open areas. Roll with gauze. Record review of Resident #27's care plan, dated 11/26/24, revealed, the resident was on enhanced barrier precautions for wounds. The goal would be no transmission of infection from one or another resident. Interventions included: Gloves and gowns should be donned if any of the following activities were to occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Perform hand sanitation before entering the room and prior to leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/29/25 at 11:10 AM, LVN D and wound NP were at the bedside, both wearing PPE. LVN D placed a bath towel on each leg of Resident #27. LVN D was wearing PPE for EBP. He removed the old dressings and cleaned Resident #27's leg wounds and pat dried the wounds with the bath towel. Blood was seen oozing from some areas of Resident #27's wounds. LVN D then left Resident #27's bedside and went outside the room to the treatment cart. LVN D took his PPE off before he left the room. When he returned, he put on his gloves and continued wound care. LVN D did not wear a gown when he returned to continue wound care. After LVN D was finished with Resident #27's dressings, he took the bath towels from underneath Resident #27's legs with some blood on them and rolled them and tucked them under his left arm pit. In an interview with the wound NP on 01/29/25 at 11:30 AM, she stated having some bleeding on some for Resident #27's wounds were a good sign because it showed that he was getting blood flow to the extremities (legs). She stated that CDC a couple of years ago or last year started to do Enhanced barrier precautions, gowns, gloves and even mask, as layer of protection against those with chronic should wounds and indwelling lines to prevent in to prevent infection of MDROS to residents with chronic issues including wounds. She stated a gown, and gloves should be worn for EBP infection control. In an interview with LVN D on 01/29/25 at 01:04 PM, he stated he was one of the infection control preventionist, and he was aware of what Enhanced barrier precautions and just forgot to wear his gown when he returned to finish Resident #27's wound care. He stated he did not mean to put the soiled towels in his arm pit, he was actually looking for a bag to put them into. He stated EBP was followed to prevent transfer of infections from clothing to dressing. He stated the gown was used as a barrier to prevent MDRO's infections., He stated the towels were contaminated after use and the risk for not following EBP was Infection. Resident #32 Record review of Resident #32's face sheet dated 01/30/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were cerebral palsy (a congenital disorder of movement, muscle tone, or posture), abnormal posture, lack of coordination, difficulty speaking, and [NAME]-[NAME] syndrome (this is a genetic disorder that causes intellectual disability, and shortness in height), and attention deficit hyperactivity disorder. Record review of Resident #32's quarterly MDS dated [DATE] revealed a BIMS score could not be complete due to cognitive impairment. She had no indicators of delirium, depression, or behaviors. Resident #32 had impaired range of motion, both upper and lower body, on both sides of his body, and was completely dependent on staff for all his ADLs and movement in bed. Resident #32 was always incontinent of bowel and bladder. Record review of Resident #32's care plan initiated 07/07/22 with a revision date of 12/26/24 revealed Resident #32 had a communication problem (non-verbal. The goal was to be able to make basic needs known by gestures on a daily basis. The interventions were to anticipate and meet his needs, residents required hands to communicate; staff would ensure availability and functioning of adaptive communication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's face sheet dated 01/30/25 revealed a [AGE] year-old male with an initial admitted [DATE] and readmitted [DATE]. His diagnoses included epilepsy (seizure disorder), paraplegia (paralysis), enlarged prostatic with lower urinary infection, metabolic encephalopathy (this is a brain disorder caused by a chemical imbalance in the blood that affects brain function, anemia and hematemesis (low blood count and vomiting of stomach content mixed with blood). Record review of Resident #40's quarterly MDS dated [DATE], revealed cognitive skills for daily decision making was a 0 which indicated he was severely impaired. It was further revealed he was extensively dependent on two staff for bed mobility and was totally dependent on one staff for eating. Record review of Resident #40's care plan initiated 01/28/25 revealed Resident #40 was on Enhanced Barrier Precautions for wounds. The goal for Resident #40 was there would not be any transmission of infection from or to the resident. The interventions were; Gloves and gown should be worn if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity, perform hand sanitation before entering the room and prior to leaving the room, Posting at the residents room entrance indicating the resident is on enhanced barrier precautions, and therapy should use gown and gloves, when transfer training, mobility training, or other high-contact activity. Observation on 01/28/25 at 09:32 AM to 10:24 AM, revealed Resident #32 at the nurse station in his wheelchair. He was listening to the radio that was placed inside his sweatpants at the nurse station. Resident #32 took the radio out of his pants and handed it to RN E. RN E stated Resident #32 had lost his radio channel. She took the radio and went to the medication cart and opened her computer. Resident #40 started to complain that he was cold, and he needed extra blankets. RN E set Resident #32's radio on top of the medication cart and went to the cart in the hallway with linen and took a blanket off the cart. RN E did not perform hand hygiene after touching the radio that was inside Resident #32's pants. RN E took the blanket to Resident #40's room and covered him. RN E pushed Resident #40's bedside and placed the call light within reach. RN E then left Resident #40's room. RN E did not sanitize her hands. She returned to the medication cart and picked up Resident #32's radio and resumed programing the radio. Interview with RN E on 1/30/2025 at 10:06 AM she said she had been at the facility for 2.5 years. She stated she did not perform hand hygiene after she touched Resident #32's radio because she forgot. She stated she then proceeded to enter Resident #40's room to assist him with his blanket without performing hand hygiene. She stated she always does hand hygiene, but she got distracted. She also said the radio was not inside Resident #32's brief, it was in his pants . She stated the purpose of hand hygiene was to promote cleanliness, prevent cross contamination, and infection control for residents and staff. She has had in-service on hand hygiene before. She stated hand hygiene must be done between each resident's care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/29/25 at 09:30 AM the regional compliance nurse wanted to clarify the confusion between isolation & enhanced barrier precaution. She stated that MA A did not have to wear gown and mask when measuring blood pressure on Resident #21. She also agreed that he should perform hand hygiene right after he left Resident #21 room and not enter another resident's room to wash hands to prevent the spread of infection. She stated she provided one-on-one in-service training on hand hygiene with MA A. Interview with the DON on 01/30/25 at 3:34 PM, she stated all staff had all been trained and in- serviced on infection control, hand hygiene, and EBP. She stated the expectation was that they do what they are supposed to do following the infection control policy. She stated infection control monitoring was done by the nursing administration which included the ADON, wound nurse and herself. She stated the purpose for EBP, sanitization of equipment, and hand hygiene was to prevent infection control. Interview on 01/30/2025 at 4:14 PM with the Administrator, she stated her staff has had hand hygiene training. The facility has hallway hand sanitizer, staff were to wash hands when hands were visibly soiled, perform hand hygiene between resident care, medication pass and tray pass during mealtimes. The purpose was to stop the spread of infection. She said the facility provides in-service training on infection control anytime facility identifies an infection control issue; DON also provides in-service training on infection control randomly. Record review of facility's Infection Control Policy & Procedure, Hand Hygiene section, dated 03/2024, some situations that require hand hygiene includes before and after direct resident contact, upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse of blood pressure . Record review of facility's Infection Control Policy & Procedure, Resident care equipment and articles section, dated 3/2024, Non-invasive resident care equipment is cleaned daily or as needed between use. Record review of facility's Enhanced Barrier Precautions, dated 4/1/2024, Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities.