| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675018 | A. Building<br>B. Wing | 04/17/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for one of five residents (Resident #5) reviewed for medication administration. Medication Aide administered (2) Melatonin 5 mg tablets (a supplement used to treat insomnia) to Residents #5 instead of (1) 5 mg tablet as ordered by the physician. This failure could place residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings include: Record review of Resident #5's quarterly MDS assessment, dated 03/09/26, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. The assessment reflected Resident #5 had no cognitive impairment with a BIMS score of 15. The resident had diagnoses which included Non-Alzheimer's dementia (neurogenerative condition distinct from Alzheimer's with primary symptoms in behavior, language, movement, or visual-spatial skills rather than early memory loss), depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life), bipolar disorder (mental illness that causes clear shifts in a person's mood, energy, activity levels, and concentration), schizophrenia (mental disorder characterized by disruption in thought processes and social interactions with symptoms that include hallucinations, delusions, and thought disorder), and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs which results in swelling and irritation). The MDS also reflected that Resident #5 occasionally had pain that made it hard to sleep. Record Review of Resident #5's Care Plan, dated 02/21/26, reflected:Focus: Resident #5 has Insomnia - Date initiated 05/20/24Goals: Resident #5 will have no interruption in sleep through next review - Date initiated 10/18/2024; Revision Date 02/21/26; Target Date 05/06/26Intervention:Dietary Consult as orderedMonitor/document/report to MD PRN the following s/sx: Edema; weight gain of over 2 lbs a day; neck vein distension; difficulty breathing (Dyspnea); increased heart rate (Tachycardia); elevated blood pressure (Hypertension); skin temperature; peripheral pulses; level of consciousness; Monitor breath sounds for crackles.Obtain lab as ordered; notify MD of reports. Record Review of Medication Regimen Review by the Pharmacist, dated 03/05/26, reflected reduce 5 mg po at hs. The facility Medical Director designated that she agreed with this recommendation on 04/02/26 and signed the recommendation. Record review of Resident #5's April 2026 Physician's Orders reflected Melatonin Oral Tablet 10 mg (Melatonin) Give 5 mg by mouth one time a day related to Insomnia. Record review of Resident #5's MAR reflected that the Medication Aide gave Resident #5 (2) Melatonin 5 mg tablets on 04/02/26-04/03/26, 04/06/26-04/10/26, and 04/13/26-04/14/26, instead of (1) Melatonin 5 mg tablet. Interview with the Medication Aide on 04/15/26 at 4:07 PM revealed that she was the evening Monday through Friday Medication Aide for Resident #5 and had been employed at the facility for seven months. The Medication Aide stated that she gave Resident #5 two 5 mg Melatonin tablets. She stated that the order reflected 10 mg and had always been 10 mg. However, she did not question it because it did not change though the tablet changed. The Medication Aide revealed that she was trained to follow the<br>(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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | MAR. The Medication Aide stated that she used simple math and gave Resident #5 (2) 5 mg tablets to equal the 10 mg order on the MAR. The Medication Aide stated that if she saw something that looked incorrect, she would ask her nurse, and she was unaware that a gradual dose reduction was attempted on Resident #5. The Medication Aide revealed that it was her responsibility to ensure the resident received the correct medication at the right dose at the right time. The Medication Aide stated that if the resident did not receive the correct dosage of Melatonin, the resident would not sleep and complain about not sleeping. Interview with RN B on 04/15/2026 at 4:31 PM revealed she had been employed for about one month and was not aware a new order was received for Resident #5's Melatonin because the Medical Director and pharmacist recommended a Gradual Dose Reduction for it. RN B stated that she works the 6 AM - 6 PM shift and had not reviewed the night shift medication order. RN B stated that if she saw the order, she would have called the doctor to get a clarification order. RN B stated that Resident #5 could be experiencing negative side effects of Melatonin if she was receiving too strong a dosage. RN B revealed that it was the nurse's responsibility to input the correct order from the physician. RN B stated that Melatonin is a natural sleep medication with signs/symptoms of too high a dosage being fatigue and agitation. RN B stated that she had not seen Resident #5 sleepy or overmedicated. Interview with ADON C on 04/15/2026 at 4:49 PM revealed that she had been employed at the facility for about 5 months and was normally the nursing staff responsible for reviewing the pharmacy recommendations. ADON C stated the Regional Compliance Nurse input the new order into the EHR. ADON C said the incorrect order entry into the EHR caused the Medication Aide to dispense the wrong medication dosage. ADON C stated it was her responsibility to input the correct orders for the Gradual Dosage Reductions into the EHR. ADON C revealed the resident could be over medicated with Melatonin leading to increased falls. ADON C stated that she had not seen Resident #5 fatigued or sleepy. ADON C stated that the residents' doctors were responsible for explaining Gradual Dose Reductions to their residents. ADON C stated that this was a medication error, and the family, DON, and Medical Director would be notified. Interview on 04/15/2026 at 5:07 PM revealed that the Regional Compliance Nurse entered the pharmacy recommendation order into the Resident #5's EHR. The Regional Compliance Nurse stated she decreased the order but did not change the Melatonin 10 mg tablet to a 5 mg tablet. The Regional Compliance Nurse stated she assisted ADON C enter the pharmacy recommendations. The Regional Compliance Nurse revealed that Resident #5 was at risk for continuing to receive a higher dose of Melatonin than recommended. The Regional Compliance Nurse stated that the Gradual Dose Reduction would be effective 04/15/26 when she received her dosage that night. And the nursing staff would report the medication error to the family and the physician. The Regional Compliance Nurse revealed that the nursing department was responsible for ensuring that Gradual Dose Reductions were completed correctly. Interview on 04/15/2026 at 5:13 PM revealed that the DON's first day of employment at the facility was on 04/07/2026. The DON stated she would review the pharmacy recommendations in the future to ensure they are entered correctly into residents' EHR. The DON also stated that she would in-service the nursing staff on following orders and verifying orders and obtaining clarification orders when necessary. Because she was new to the position of DON, she did not know the last date the nursing staff were in-serviced on following orders and verifying orders. Interview on 04/16/2026 at 3:03 PM with the Medical Director revealed she agreed with the pharmacist to attempt a Gradual Dose Reduction for Melatonin from 10 mg hs to 5 mg hs. The Medical Director stated that she did not believe that there was any negative effect on the resident since she was already on 10 mg. The Medical Director stated that the facility would now attempt the 5 mg Gradual Dose Reduction. The Medical Director stated that it was best to reduce polypharmacy when possible. The Medical Director stated that polypharmacy could increase falls, so they would again attempt to decrease the Melatonin to 5 mg. Interview with Resident #5 on 04/17/2026 at 9:33 AM revealed that she slept well the previous night. Resident #5 stated she had not noticed being groggy in the daytime and did not ask to have her medication changed. Resident #5 stated that the Medical<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Director had not spoken with her about a Melatonin Gradual Dose Reduction. Record Review of Medication Administration and General Guidelines policy, dated March 2025, reflected: ProcedureMedications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or personnel authorized by state laws and regulations to administer medications.Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. The interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate. 6. All current medications and dosage schedules, .are listed on the resident's medication administration record (MAR). |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 9 insulin pens with correct open dates. The facility also failed to keep 2 of 5 medication carts locked, in accordance with currently accepted professional principles.Insulin pens in south hall nurse cart and north hall nurse cart were labeled incorrectly.Medication cart on south hall was left unlocked and unattended.Treatment cart on north hall was left unlocked and unattended.These failures could result in adverse reactions to residents, injuries, medication errors.Findings included:In an observation on [DATE] at 9:01 AM, south hall nurses' medication cart was left unlocked. RN A was sitting behind the nurses' station. Medication cart included 4 insulin pens. There was a Novolin R insulin pen for Resident #30 which was labeled [DATE] under exp date line.In an interview on [DATE] at 9:05 AM, RN A stated the date [DATE] was supposed to be an open date of the pen. She stated she did not know why the date was written under expiration date line on the pen. She stated the risk of giving residents potentially expired insulin included ineffectiveness of medication. She stated an opened insulin pen would expire in 28 days after. She also stated medication cart should always be kept locked to prevent unauthorized access. She stated she forgot to lock her medication cart. In an observation of north hall nurses' medication cart on [DATE] at 9:15 AM, five insulin pens were inside the cart. Resident #44's insulin pen was labeled [DATE] on the line that said exp date. In an interview with ADON C on [DATE] at 9:15 AM, she stated nurses should not label insulin pens open date under the line of expiration date. She stated it could cause confusion on when the actual open date was. She stated all nurses should label insulin pens where it said open on date or put an open date on a different spot, but not on the line of expiration date. She stated insulin pens expired after 28 days of opening. In an observation on [DATE] 1:35 PM, nurses' cart in south hall was left unlocked. There was no one at nurses' station. There were no residents around the area at the time. In an interview on [DATE] 1:40 PM, the DON stated all carts should be kept locked always when not in use because residents could get into the cart and get medication out. She stated it's a safety risk. She stated only authorized persons could access the carts. She stated she expected all her staff to be vigilant and practiced locking all carts when they were not in use.In an observation on [DATE] at 8:15 AM, treatment cart was unlocked and unattended. Treatment cart was placed across north hall nurses' station. There were no nurses at the nurses' station at the time of observation. Inside of treatment cart included wound care dressings, wound cleanser, cream, and scissors. In an observation on [DATE] at 8:54 AM, treatment cart was still unlocked and unattended.In an interview on [DATE] 10:16 AM, ADON D stated all carts should stay locked at all times regardless if there were people around the cart or not. She stated for treatment cart, there were biologicals & sharp objects which could put residents at risk for injuries if residents get ahold of those objects. She was not sure who had the treatment cart today because all nurses shared the treatment cart. She stated the treatment cart should not have stayed unlocked when not in use.Record review of facililty's Medication labels:, dated in 2025, revealed the policy stated each prescription medication label includes:. date medication is dispensed, [and] expiration date.Record review of the facility's Medication storage in the facility, dated in 2025, revealed the policy stated that medications and biologicals are stored safely, securely. The medication supply is accessible only to license nursing personnel. or staff members lawfully authorized to administer medications. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure that food stored in the freezer was labeled and dated. 2. The facility failed to remove the food thermometer prior to food service. These failures had the potential to affect residents by placing them at risk for cross-contamination and food borne illnesses. Findings included:Observation on 04/14/2026 at 9:22 A.M. revealed during the initial tour the following items were found in the reach in freezer not labeled or dated: - two bags of frozen pancakes removed from original boxes and placed in plastic freezer bags- two bags of chicken nuggets removed from the original boxes not labeled or dated - one bag of hushpuppies not labeled or dated.Observation on 04/15/2026 at 11:10 A.M. revealed initial service line temperature for puree Broccoli was 137 degrees. This item was removed from service line, placed in facility oven for additional warming. Item was removed from the oven placed back on service line and re-temped at reheated 163 degrees. [NAME] C did not remove the thermometer. Observation on 04/15/2026 at 11:28 A.M. revealed lunch service started. The food thermometer was still laying in the pureed broccoli. Observation on 04/15/2026 at 11:42 A.M. revealed [NAME] C removed the food thermometer from pureed broccoli. Interview on 04/16/2026 at 2:04 A.M. with Dietary Manager revealed the risk of not removing the food thermometer from the food item could cause it to explode in the food. All food should be labeled and dated to ensure food was served by best used by date to reduce food borne contaminations. Interview on 04/17/2026 at 9:06 AM with [NAME] C revealed food should be labeled with date received and used by so that expired food is not cooked also just in case there was a recall on food. The risk is contaminated food being served to the residents. If you leave the thermometer in the food, it could break and contaminate the food. Record Review of policy Food Received and Storage revealed Labeling and dating food items: If food is removed from its original container, it must be labeled to include the name of the food item Date all food items with the date it was received All dates must include the month, the day, and the year If a food manufacture's label states an expiration date, circle it so it is easily noticeable. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's needs related to indwelling catheter for 1 of 5 residents (Resident #38) reviewed for care plans.Resident #38 was not care planned for indwelling catheter.This failure could result in improper care to residents which could lead to infection.Findings included:Record review of Resident #38's face sheet on 04/15/2026 1:19 PM revealed the resident was admitted on [DATE]. One of the listed admitting diagnoses was Present of an indwelling catheter.Record review of Resident #38's admission note, dated 3/30/2026, documented by ADON C, revealed the resident was admitted with a urinary catheter size 16.In an observation on 04/14/2026 10:56 AM, Resident #38 was sleeping in bed. Resident #1 had a catheter bag. Catheter bag and tubing were in clean condition. Record review of Resident #38's provider progress note, dated 3/31/2026, revealed the provider had put in the following orders: Continue Foley catheter care, monitor urine output and characteristics, maintain catheter hygiene, monitor for infection, reassess need for continued catheter use.Record review of Resident #38's care plan, dated 3/31/2026, revealed the resident did not have a comprehensive care plan related to catheter care. In an interview on 04/16/2026 at 11:28 AM, RN B stated there should be a care plan for residents who had indwelling catheters. She stated the nurses should check for urine output, sediments, color, and measure flow rate every shift. She stated the risk of not having a care plan for the resident's catheter was the nurses could give improper care for that catheter. She also stated the nurses would not know to check for specific things including output, color, sediments. She stated the risks to residents included infection, urine obstruction, which could lead to hospital admission. In an interview on 04/16/2026 at 11:48 AM, RN A stated she was assigned to take care of Resident #38 the past 3 days. She stated she was aware that the resident had a urinary catheter. She stated she was not aware that he was not care planned for it. She stated at the end of every shift, she checked for urine output, sediments, urine color. She stated the risk of not having a comprehensive care plan for the resident was infection. She stated the risk of not having a comprehensive care plan could affect continuation of care for the resident because the nurses would not know to take care of the catheter. In an interview with ADON C on 04/16/2026 12:09 PM, she stated residents should be care planned for having an indwelling catheter. She stated the care plan was a way that a new nurse working with a resident knew how to care for the resident, making sure the urine output was documented, sediment was documented. She stated it's the nurse and nurse manager's responsibility to make sure catheters were care planned. She stated in-service on catheter care was provided monthly or when there was an incident. In an interview on 04/16/2026 at 1:05 PM, the DON stated there should be a comprehensive care plan for residents who had catheters. The nurses should make sure the urine was flowing, the site was not irritated, the site had no sign of infection. She stated the risk to residents included infection. She stated the nurse management team was responsible for developing a care plan for residents. She stated she just started at the facility and did not know Resident #38 did not have a care plan for his urinary catheter. Record review of facility's Comprehensive care planning, policy, unknown date, revealed the policy stated the comprehensive care plan will describe. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. Care plans will be person-centered and reflect the resident's goals for admission and desired outcomes.Record review of facility's Catheter care policy, unknown date, revealed the policy stated to review the resident's plan of care daily for changes. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to attempt to use alternatives prior to installing a side or bed rail, obtain informed consent prior to installation, ensure correct installation, use and maintenance of bedrails for 1 (Resident #9) of 5 residents reviewed for bedrails. The facility failed to obtain a bed rail assessment and informed consent prior to the installation of Resident #9's bedrails. These failures could place residents at risk of entrapment or injury.Findings included: Record Review of Resident #9's Nursing Home Comprehensive MDS assessment, dated 03/11/26, reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. His MDS reflected he had a BIMS score of 15, which indicated he had no cognitive impairment. Resident #9's active diagnoses included type 2 Diabetes Mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), cerebrovascular accident (occurs when blood flow to the brain is interrupted or vessel bursts, causing rapid brain death), acquired absence of left and right legs below the knee, and dependence on renal dialysis (relying on regular life-sustaining hemodialysis to remove waste and excess fluid when kidneys fail). His MDS did not address that he utilized bed rails. Record Review of Resident #9's undated care plan, reflected the following: Focus: [Resident #9] has an ADL Self-Care Performance Deficit r/t Bilateral AKA.Interventions: Bed Mobility: requires max assist from staff x1 for assistance. Date initiated: 03/12/26. Record Review of Resident #9's EHR, dated 04/16/26, reflected no Side Rail Evaluation. Observation on 04/14/26 at 1:25 PM revealed that Resident #9 had half bedrails on both sides of his bed. Interview with the Maintenance Supervisor on 04/16/2026 at 10:50 AM revealed that the previous DON told him to place the bedrails on the resident's bed. The Maintenance Supervisor stated that he told her that he needed to see the signed consent. The Maintenance Supervisor stated that he was told by the previous DON that she had it, but he was never shown the signed consent. The Maintenance Supervisor stated that the importance of ensuring that there was a signed consent was to show that the resident had been evaluated for the bedrails and gave consent for them to be placed on the bed. The Maintenance Supervisor stated he should have notified the Administrator before installing the bedrails when he was not shown a signed consent. The Maintenance Supervisor stated that he checks the rails weekly to ensure that they are securely placed. Interview with RN B on 04/16/2026 at 11:33 AM revealed she had been a nurse for five months and was Resident #9's current dayshift nurse. RN B stated that she was not aware that Resident #9 had half bedrails. RN B said that she did not believe that half bedrails were a restraint because it did not prevent Resident #9 from getting out of bed. RN B stated that Resident #9 required a mechanical lift to be transferred into and out of bed, so she did not think the bedrails were a restraint. RN B stated that she did not know what the facility's policy stated about bedrails. RN B said that a resident could get their arm stuck in the bedrail and get hurt. RN B also stated that before bedrails were placed on a bed, an assessment was supposed to be completed for the resident. RN B said that Resident #9 should have bedrails listed on their care plans as well. Interview with ADON C on 04/16/2026 at 12:10 PM revealed that she was not aware that Resident #9 had bedrails. ADON C stated that Resident #9 should have an assessment for the bedrails as well as a care plan, and a consent. ADON C stated that she would notify the resident's POA, DON, and physician. ADON C revealed that bedrails could be a risk to residents because they could get their heads caught in the rails and be injured. ADON C stated that it was the nurses' responsibility to ensure that all documentation was completed for residents with bedrails as well as document any changes that could happen to the resident. ADON C revealed that if changes occurred, nurses should notify their ADON and DON. Interview with the DON on 04/16/2026 at 1:06 PM revealed that residents with half bedrails should have a bedrail assessment, a consent, a care plan intervention, and nurse<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documentation. The DON stated that she was unaware that these were not completed on Resident #9 who had half bedrails on both sides of this bed. The DON stated that she started working at facility on 04/07/26 and has not been able to complete chart audits. The DON revealed that it is all of nursing's responsibility to ensure that all of these are completed on residents with bedrails because they are considered restraints. The DON said that the physician and responsible party should be notified when residents have bedrails. The DON also stated that the facility policy was that every shift should document that the bedrails are used correctly. The DON also stated that quarterly assessments for bedrails should be completed. And if a change in condition occurred, the nurse should notify the ADON, DON, physician, and responsible party. The DON revealed that therapy should work with the resident to show them how to correctly use the bedrail. The DON then stated that after the resident demonstrated to therapy and the nursing department that they correctly know how to use the bedrails, the maintenance supervisor could install the bedrails on the resident's bed. The DON stated she was unsure if other interventions were attempted before the bedrails were placed on the bed. The DON revealed that Resident #9 could get tangled up in the bedrail if not used correctly. Interview with Resident # 9 on 04/17/2026 at 11:36 AM revealed that he did not request the bedrails. Resident #9 stated that no staff member came to speak with him about the bedrails or provide him with a bedrail consent or conduct a bedrail assessment on him. Resident #9 was unaware that therapy should provide training on the proper way to use the bedrail. Record Review of undated Bed Rails policy reflected: .The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements:Assess the resident for risk of entrapment from bed rails prior to installation.Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.Ensure that the bed's dimensions are appropriate for the resident's size and weight. Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.Assessment: Prior to use of a bed rail the resident will be assessed to ensure the proper rail is utilized for the resident's need.The facility will re-evaluate the use of the rail on a periodic basisBased on the resident assessment, the interdisciplinary team (IDT) will make the determination for the plan of care as it relates to bed rails.Consent - The resident and/or resident representative will provide consent for the use of rails prior to installation.Follow the manufacturers' recommendations and specifications for installing and maintaining bed railsThe facility will conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment and ensure rails are installed according to manufacturer recommendations. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.The facility will ensure that all bed rails in service will meet this criteria. Any bed rail determined to be out of compliance will be removed from service. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675018 | A. Building<br>B. Wing | 04/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Oaks Health and Rehabilitation Center | 2416 NW 18th St<br>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.

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|---|---|
| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to help family and visitors understand safe food handling practices reviewed for Resident #8 personal refrigerator. The facility failed to ensure that Resident # 8's in room refrigerator was at a safe cooling/reheating processes meeting food safety temperature standards.These failures had the potential to affect the residents by placing them at risk for cross-contamination and foodborne intoxication.Findings Included:Record review of Resident #8's admission Record revealed an [AGE] year-old female admitted on [DATE] with a primary diagnosis of Parkinson's Disease without Dyskinesia, and secondary Dementia in other diseases classified elsewhere. Record review of Resident #8's Care Plan dated 04/06/2026 revealed; on a Regular diet and chooses to eat all meals in her room. Interventions monitor and document meal intake.Record review of Resident # 8's MDS Nursing Home Quarterly assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Section GG- Functional Abilities: A. Eating- the ability to use suitable utensils to bring food and /or liquid to the mouth and swallow food and /or liquid once the meal is placed before the resident. Setup or clean-up assistance-helper sets up on cleans up; Helper assists only prior to or following the activity. Observation on 04/14/2026 at 11:00 AM revealed Resident #8 had a personal refrigerator in her room. When opened, the interior of the refrigerator did not feel cool. There was no inside thermometer or temperature log. Observation and interview on 04/14/2026 at 1:59 PM with Maintenance Supervisor revealed Resident #8's personal refrigerator temperature was taken by Maintenance Supervisor and showed 48.9 degrees. The temperature control was turned to 1. Interview on 04/16/2026 at 10:41 AM with Maintenance Supervisor revealed the family member or responsible party was responsible for maintaining personal refrigerators. Interview on 04/16/2026 at 1:20 PM with DON revealed residents monitor their own refrigerators. Nursing should help with the content. The risk of having content in the refrigerator was she could get sick. Direct care staff should throw away spoiled food.Interview on 04/16/2026 at 1:46 PM with Housekeeper Supervisor revealed personal refrigerators were cleaned by a member of housekeeping when alerted by the DON. Housekeeping will go in and remove items from the refrigerator that are expired with the resident in the room (resident rights). Review of policy Personal Refrigerator dated 2022 revealed; Housekeeping can assist the resident and/or family member by inspecting the refrigerators at least weekly and assist with removal of outdated food items and cleanliness. The refrigerator compartment should be maintained at temperature of 35-41 degrees. The freezer compartment should be maintained at zero degrees or less, or food frozen to a solid state. Temperatures can monitored by the use of a thermometer designed for a refrigerator/freezer that can be purchased from a department store. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675018 | A. Building<br>B. Wing | 04/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| River Oaks Health and Rehabilitation Center | 2416 NW 18th St<br>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.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for catheter care for 1 of 6 residents (Resident #38) reviewed for infection control.RN A picked up Resident #38's catheter bag on the floor and hung it back on the resident's bed, failing to replace the catheter bag. This failure could place residents at risk for infection. Findings included:Record review of Resident #38's face sheet on 04/15/2026 1:19 PM revealed the resident was admitted on [DATE]. One of the listed admitting diagnoses was Present of an indwelling catheter.Observation on 04/14/2026 at 1:52 PM revealed the catheter bag and catheter tubing of Resident #38 was on the floor next to the resident's bed. The resident was sleeping. The DON was walking by the room at the same time as surveyor. The DON saw the bag on the floor and she informed RN A of the situation and walked to the other hall. RN A performed hand hygiene, donned PPE and went in the room, picked up the catheter bag & hung it back on the bed. RN A then removed her PPE, performed hand hygiene and left the room. In an interview on 04/14/2026 at 1:55 PM, RN A stated the risk to the residents if catheter bag and tubing were on the floor included infection. When she was asked why she did not remove the bag and tubing that were on the floor in Resident #38's room, she stated she should have done that. She could not give a clear answer why she did not change the catheter bag out. She stated the bag was already contaminated because it was on the floor.In an interview on 04/14/2026 at 2:00 PM with ADON D, she stated if she saw a catheter bag on the floor, she would immediately remove it because it was already contaminated. She stated the bag should not be used anymore and she would get another bag to change it. She stated it's an infection risk to the resident. She expected her nursing staff to follow the facility's policy when providing catheter care for residents. She stated in-services on catheter care was being done monthly or as needed.In an observation on 04/14/2026 at 2:15 PM, a new catheter bag was hanging above the floor, to the side of the bed of Resident #38. Record review of Resident #38's care plan, dated 3/31/2026, revealed the resident was not care planned for urinary catheter. Record review of Resident #38's provider progress note, dated 3/31/2026, revealed the provider had put in the following orders: Continue Foley catheter care, monitor urine output and characteristics, maintain catheter hygiene, monitor for infection, reassess need for continued catheter use.Record review of the facility's Catheter care policy, unknown date, revealed the policy stated be sure the catheter tubing and drainage bag are kept off the floor. |