

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  The Arbors Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1884 Loop 343 West Rusk, TX 75785	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and records review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 5 residents (Resident #1) reviewed for Resident Rights. The facility failed to ensure Resident #1 was treated with respect and dignity on 9/22/25 from approximately 9:00 a.m. to 1:00 p.m. when there was a brown substance that looked and smelled like feces smeared on the floor in her bathroom. The facility failed to ensure Resident #1 was treated with respect and dignity on 9/21/25 at approximately 6:00 p.m. when staff failed to provide assistance with ADLs. These failures could place residents at risk of psychosocial harm, self-isolation, and diminished quality of life. Findings included: 1. Review of an admission Record for Resident #1 dated 9/22/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of type 2 diabetes, vascular dementia (altered cognition), and muscle wasting and atrophy (muscle weakness). Review of a quarterly admission MDS for Resident #1 dated 8/16/25 indicated she had intact cognition with a BIMS score of 13. She required maximum staff assistance with putting on/taking off footwear, lower body dressing, showers/bathing, and toileting hygiene; she required supervision with personal hygiene; she required cleanup/setup assistance with eating and oral hygiene. She was occasionally incontinent of bladder and frequently incontinent of bowel. Review of the care plan for Resident #1 dated 8/15/24 indicated she had an ADL self-care performance deficit, and appropriate interventions were in place including encouraging resident to use bell to call for assistance. During an interview on 9/22/25 at 10:40 a.m., CNA A said she was working on Resident #1's hall and she rounded on every resident at least once every 2 hours. CNA A said she asked each resident if they needed any assistance and addressed their needs as part of routine rounding. She said she typically rounded at 7:30 a.m. when she came in to work and then she rounded again after breakfast at around 9:00 a.m. During an observation and interview on 9/22/25 at 10:50 a.m., Resident #1 was observed in her room sitting in a wheelchair. She appeared poorly groomed; she had stains on her shirt, a soiled wound-dressing on her right wrist, and a brown smear on her right leg which she identified as feces. Resident #1 said she had IBS and sometimes had episodes of bowel incontinence. Resident #1 said she had an episode of bowel incontinence this morning after breakfast. Resident #1 said she accidentally got feces on the floor and herself and activated her call light for assistance to clean up. Resident #1 said CNA A answered her call light but told her she could clean up the mess herself and did not offer any assistance. Resident #1 said staff did not like to help clean her up when she had bowel incontinence and it made her feel small, like I wanted to hide in my shell, it was humiliating, and it kept her from socializing with other residents because of embarrassment. During an interview on 9/22/25 at 11:00 a.m., a private sitter for Resident #1 said she comes daily to sit with Resident #1 on weekdays. The sitter said there was feces smeared in Resident #1's bathroom, on the floor in front of the toilet. The sitter said CNA A brought a shower chair into the bathroom at approximately 10:30 a.m. for Resident #1's shower and did not offer any assistance with cleaning the bathroom floor. During an interview on 9/22/25 at 3:30 p.m., CNA A said she answered Resident #1's call light after breakfast, at around 9:00 a.m. CNA A said Resident #1 was in the bathroom and had an episode of bowel incontinence. CNA A said she saw feces on the trash can in the bathroom and dirty clothes/towels on the floor. CNA A said Resident #1 told her she did not want any assistance. CNA A said Resident #1 does not usually require assistance for ADLs. During an interview on 9/22/25 at 4:00 p.m., LVN B said CNAs were expected to round on every resident a minimum of once every 2 hours. LVN B said CNAs were expected to ask residents if they had any needs and to address them. LVN B said if the CNA cannot address the need or the resident refused care the CNA was expected to alert the charge nurse. LVN B said she monitored compliance with resident care plans by maintaining good communication with staff and frequent rounding. LVN B said Resident #1 required staff assistance for ADLs. During an interview on 9/22/25 at 5:20 p.m., Resident #1's RP said on 9/21/25 at approximately 6:00 p.m. Resident #1 called him from the facility because she had an episode of bowel incontinence and the CNA staff would not help her clean up. RP said he drove approximately 20 minutes to the facility and Resident #1 was still sitting on the toilet and had not been assisted yet. RP said he asked the charge nurse why no one had assisted Resident #1. RP said he was told Resident #1 was team care (required 2 staff when providing care) and she asked for a different CNA. RP said after approximately 10 minutes the charge nurse and a CNA whose names he could not recall went to assist Resident #1. RP</p>		