STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455840	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Arbors Healthcare and Rehabilitation Center	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record 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, recognizing each resident's individuality for 1 of 7 residents (Resident #1) reviewed for resident rights in that: Resident #1 was not offered water after he asked repeatedly for water. Resident #1 was left lying on the bed in only a brief with no blanket covering resident. This failure could place all residents at risk for poor hydration and diminished quality of life.Findings included: During a review of an admission record dated 7/1/26 indicated Resident #1 was a [AGE] year-old man admitted to the facility on [DATE] with diagnoses of unspecified dementia (altered cognition), restlessness and agitation, and muscle wasting and atrophy(loss of muscle mass due to disuse). During a review of an admission MDS dated [DATE] for Resident #1 indicated he had severely impaired cognition indicated by a BIMS score of 1. He required supervision or touching assistance with eating; he required substantial to maximum assistance with toileting hygiene; all other ADLs were not attempted and the resident did not perform the activities prior to the current illness, exacerbation, or injury. During a review of the care plan dated 6/3/26 indicated Resident #1 had an ADL self-care performance deficit. Interventions in place included eating required staff assistance. During an interview on 6/29/26 at 11:45 a.m., FM A said on 6/13/26 at approximately 10:28 p.m., a nurse entered Resident #1's room to provide care. Resident #1 said the nurse did not provide Resident #1 with water, even though resident asked repeatedly for water. FM A said the nurse told Resident #1 I just gave you water and the nurse left the room and left the resident in bed, uncovered, wearing only a brief. FM A said Resident #1 continued to yell for water. FM A said Resident #1 had fluids available on his bedside table, but the nurse did not assist the resident to get a drink. FM A said CNA B had to come from another hallway to bring Resident #1 water. During record review of a video on 7/1/26 at 2:14 p.m., Resident #1 was observed lying in his bed in his room, uncovered, and wearing only a brief. Resident #1 had no clothing on. Resident #1 was heard calling out for water multiple times throughout the 1-minute-long video clip. LVN D was observed on video and heard to say what sounded like I already gave you water. LVN D then proceeded to open and re-tape down Resident's brief and exit the room. Resident #1 was left in the room still calling out for water, uncovered by blankets, and wearing no clothing. During an interview on 7/1/26 at approximately 2:30 p.m., the ADM was shown the video and identified the nurse as LVN D. The ADM said she had a problem with the video which included the resident wasn't offered water or covered up by the nurse. The ADM said she planned to move forward with an internal investigation. During an interview on 7/1/26 at 3:00 p.m., LVN D said she frequently took care of Resident #1. LVN D said resident asked for water frequently and she provided water to him anytime he asked. LVN D said there was never an incident where she failed to offer Resident #1 water when he asked for it. LVN D said she had never left the room while resident requested water to delegate that task to any other staff member, she always assisted the resident with water herself. LVN D said Resident #1 had no aversion to being covered by blankets but frequently wriggled out of his blankets. LVN D said she (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would always cover Resident #1 if he was uncovered before leaving the room. LVN D said if there was a video of her not giving Resident #1 water or not covering him up before leaving the room it's because she must have forgotten to do so. During an interview on 7/1/26 at 3:18 p.m., the DON said she was responsible for supervising all nursing staff in the facility. The DON said she expected rounding to be completed every 2 hours minimum and all resident needs should be addressed. The DON said Resident #1 did ask for water and fluids frequently. The DON said there was no clinical reason not to provide Resident #1 with water when he asked for it. The DON said Resident #1 did not like to wear clothes and should have been covered up with blanket(s) when staff left his room. Review of an undated facility policy titled Resident Rights indicated .The resident has a right to be treated with respect and dignity including.the right to receive the services and/or items included in the plan of care. Review of a Resident Grievance received on 6/7/26 filed by FM A indicated several complaints including resident needed assistance with all meals and fluid intakes. Corrective action that would be taken included staff informed that Resident #1 was an assisted diner for all meals. The grievance was signed on 6/7/26 by the DON.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 7 residents reviewed for dietary services. Resident #1's dietary card was not brought to the kitchen staff in a timely manner causing Resident #1 to miss meal service. This failure could place all newly admitted residents at risk for poor nutrition/hydration and reduced quality of life.Findings included: During a review of an admission record dated 7/1/26 indicated Resident #1 was a [AGE] year-old man admitted to the facility on [DATE] with diagnoses of unspecified dementia (altered cognition), restlessness and agitation, and muscle wasting and atrophy (loss of muscle mass from disuse). During a review of an admission MDS dated [DATE] for Resident #1 indicated he had severely impaired cognition indicated by a BIMS score of 1. He required supervision or touching assistance with eating; he required substantial to maximum assistance with toileting hygiene; all other ADLs were not attempted and the resident did not perform the activities prior to the current illness, exacerbation, or injury. During a review of the care plan dated 6/3/26 indicated Resident #1 had an ADL self-care performance deficit. Interventions in place included eating required staff assistance. During an interview on 06/29/26 at 12:45 p.m., the DM said there had been issues with getting dietary orders delivered timely to the kitchen staff from nursing. The DM said the kitchen cannot serve a resident if they do not have a dietary card because they would be unaware of any safety restrictions on the diet order. The DM said she was aware of two instances in which a resident's dietary card was not turned in timely, only one resulted in a missed meal. The DM said Resident #1 was admitted at approximately 7:30 p.m. and the dietary order from his admission was not communicated to the kitchen. The DM said the resident did not receive a lunch tray on 6/2/26 due to the dietary card not being turned in, but he did receive a tray later after a family member asked about the missing tray. The DM said she was unsure if Resident #1 had been served breakfast, but without a dietary order, he shouldn't have been served. During an interview on 6/30/26 at 9:15 a.m., [NAME] A said if a resident does not have a dietary card turned into the kitchen they can't be served due to not knowing their dietary restrictions. [NAME] A said the dietary cards are printed by nursing department during admission and are delivered to the kitchen. [NAME] A said if a resident did not have a dietary card the DM could attempt to look in the resident's electronic record for a dietary order, if one was entered. During an interview on 6/30/26 at 9:25 a.m., [NAME] B said she knew Resident #1. [NAME] B said Resident #1 was admitted in the afternoon once the kitchen staff had gone home. [NAME] B said the kitchen did not know Resident #1 was in the facility until a family member voiced concerns during lunch service that the resident had not received a tray. [NAME] B said Resident #1 was served lunch on 6/2/26 after the error was brought to the kitchen's attention. [NAME] B said Resident #1 was not served breakfast on 6/2/26. During an interview on 6/30/26 at 9:35 a.m., LVN C said the charge nurse working the floor when the resident was admitted was responsible for completing the admission. LVN C said part of the admission process is to enter the dietary order and to call the physician if there is no order entered. LVN C said part of the admission process was to then print out and deliver the dietary order to the kitchen. LVN C said the order was to be printed out and hand-delivered to the kitchen. During an interview on 6/23/26 at 10:32 a.m., the ADM said she was responsible for supervision of all staff in the facility and the DM was responsible for supervision of the kitchen staff. The ADM said it was her expectation that dietary cards would be delivered to the kitchen staff promptly to ensure all residents received appropriate meals. The DM said the facility was upgrading their software soon, which would make the process more streamlined, but until then she planned to discuss new admissions in morning meetings with the DM to ensure all new admits had their dietary orders communicated timely to the kitchen. The ADM (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said risks to residents who did not have their dietary orders turned in timely could lead to dehydration, lack of nutrition, diabetic concerns, and incorrect dietary restrictions. Review of a facility policy titled Diet Orders / Diet Manual indicated .Upon admission, Nursing Service transcribes the diet order as it is written by the physician on the diet transmittal form. Forms are sent to Dietary Service prior to meal service.