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	10/09/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review the facility failed to ensure the right to resident and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 10 residents (Resident #3 and Resident #18) reviewed for call lights. The facility failed to ensure the emergency call light in Resident #3's and #18's shared bathroom was accessible from the floor on 10/7/24. These failures could affect residents who used their call lights or desire to use the call lights and place them at risk of not being able to notify staff of their needs. Findings include: Record review of a facility face sheet dated 10/7/24 for Resident #3 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: type 2 diabetes (uncontrolled blood sugar) and muscle wasting and atrophy (the loss of muscle mass and shortening of muscle fibers). Record review of a comprehensive MDS assessment dated [DATE] for Resident #3 indicated that she had a BIMS score of 11, indicating that she had moderately impaired cognition. She required moderate to maximal assistance with toileting hygiene and personal hygiene. She required partial/moderate assistance with toileting transfers. She was frequently incontinent of bladder and bowel. Record review of a comprehensive care plan dated 7/30/24 for Resident #3 indicated that she was at risk for falls and had an intervention that read: .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed . Record review of a facility face sheet dated 10/7/24 for Resident #18 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: anemia (a condition where your blood produces a lower-than-normal amount of healthy red blood cells, leading to a lack of oxygen in the body), hypertension (high blood pressure), and myocardial infarction (heart attack). (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a comprehensive MDS assessment dated [DATE] for Resident #18 indicated that she had a BIMS score of 9, indicating that she had moderately impaired cognition. She required moderate to partial assistance with toileting and supervision/touching assistance with personal hygiene. She required partial/moderate assist with toilet transfers. She was occasionally incontinent of bladder and frequently incontinent of bowel. Record review of a comprehensive care plan dated 8/13/24 for Resident #18 indicated that she was at risk for falls and had an intervention that read .be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed . During an observation and interview on 10/7/24 at 11:01 am the emergency call light in Resident #3's and #18's shared bathroom was observed with no string on the emergency call light. Resident #18 said that she did use the restroom independently and had not had any falls in the restroom. When exiting room, Resident #18 was observed ambulating into the restroom independently. CNA C was observed entering the room to assist the resident. During an observation on 10/7/24 at 11:28 am Resident #3 was observed ambulating independently into the restroom. During an interview on 10/7/24 at 10:38 am CNA C said that she had been employed here about a month. She said she would have maintenance fix the call light string. She said if a resident were to fall in the restroom, they would need to be able to reach the light to call for help. If they could not reach the light, they would be unable to call for help. During an interview on 10/9/24 at 11:28 am the Administrator said all staff were responsible for checking for bathroom call lights during their rounds. He said maintenance was responsible for installing the call light strings. He said residents could be at risk of a number of things and if they were in distress, the distress could escalate if they were not able to call for help. He said going forward they would be in-servicing the staff and making sure that administrative staff checked the call lights during their Champion Rounds and discuss the findings in the daily morning meetings. During an interview on 10/9/24 at 11:39 am the DON said all staff would be responsible to check the call lights during their Champion Rounds. She said a resident could potentially fall and not be able to call for help. She said they could possibly lay there for a long time. She said going forward they would be holding in-services and checking during their rounds. During an interview on 10/9/24 at 11:45 am the Maintenance Man said that he was responsible for ensuring the call lights were installed and functional. He said a resident could lay there a while without being able to call for help if they fell . He said he would be in-servicing staff and checking lights to ensure strings were there. Record review of a facility policy titled Resident Rights undated, read .the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observations, interviews, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 3 residents (Resident # 9 and Resident # 25) reviewed for quality of care. The facility failed to ensure Residents # 9 and Resident # 25's indwelling catheters (drains urine from your bladder into a bag outside your body) had a securement device to anchor their catheters. This failure could place residents at risk for urinary tract infections and catheter related injuries. Findings: 1.Record review of a facility face sheet dated 10/7/24 for Resident # 9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: type 2 diabetes (uncontrolled blood sugar), hypertension (high blood pressure), and chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure). Record review of a Quarterly MDS assessment dated [DATE] for Resident # 9 indicated that she had a BIMS score of 9, indicating that she had moderately impaired cognition. Section H (Bladder and Bowel) indicated that she had an indwelling catheter. Record review of a comprehensive care plan dated 9/17/24 for Resident # 9 indicated that she had an indwelling catheter and had an intervention that read: .ensure tubing is anchored to the resident's leg or linens so that tubing is not pulling on the urethra . Record review of a physician's order summary report dated 10/7/24 for Resident # 9 indicated that she had the following order dated 3/15/24: .Ensure catheter strap in place and holding every shift . During an observation and interview on 10/7/24 at 3:46 pm Resident # 9 was observed lying in bed. She had no strap or anchor on the catheter tubing. She said she could not remember the last time she had one on it. She said it felt a little uncomfortable when moving because it felt like it was pulling on her bladder. 2. Record review of facility face sheet dated 10/07/2024 revealed Resident # 25 was an [AGE] year-old male that admitted on [DATE] with diagnoses of encephalopathy (a brain disease that alters brain function or structure), diabetes (high blood glucose), and urinary retention (difficulty emptying bladder). Record review of admission MDS assessment dated [DATE] revealed Resident # 25 had a BIMS score of 04, indicating severe impairment in thinking. Section H (bladder and bowel) indicated indwelling catheter was present at the time of MDS. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of comprehensive care plan initiated on 09/26/2024 and revised 10/01/24 revealed Resident # 25 had an indwelling catheter at the time the care plan was initiated with intervention to ensure tubing was anchored to the resident's leg or linens so that the tubing was not pulling on the urethra. Record review of the physician order summary, indicated an order dated 09/26/24 that read: Resident # 25 may have an indwelling catheter and had an order to . Ensure catheter strap in place and holding, every shift change as needed . Resident #25 had an order with a revision date of 10/07/2024 to . ensure catheter strap in place and holding every shift until 10/11/24. Record review of nurses note dated 09/27/24 revealed Resident # 25 admitted from the hospital on 09/26/24 with an indwelling catheter due to urinary retention. Record review of a Treatment Administration Record (TAR) for Resident #25 for 10/01/24 to 10/07/24 had no indication for monitoring placement of a catheter strap. Record review of nurses note dated 10/08/224 read: Urology faxed orders for foley catheter to be discontinued 10/11/24 @0800. Resident has appointment with urology that same day AT 1515. NP notified; family aware . During an observation and interview on 10/07/24 at 10:15 am, Resident # 25 had an indwelling catheter present in a privacy bag and the tubing was not secured with a securement device. Resident # 25's family representative stated he was at the hospital a few weeks ago and they put the catheter in due to retention caused by an enlarged prostate. During on observation on 10/07/2024 at 10:30 am, Resident # 25 received catheter care by CNA B. Resident # 25 did not have a catheter tubing securement device in place. During an observation on 10/07/24 at 3:35 pm, Resident # 25 had his arm looped around the foley catheter drain line and draped across his shoulder, the catheter was not secured with a securement strap as ordered. During an observation and interview on 10/08/24 at 8:00 am, CNA A said that Resident #25 had a strap applied to secure his foley catheter earlier this morning by the nurse. CNA A said that not having a securement strap could cause harm or pain to the resident from the pulling or weight of the drainage bag pulling on the urethra. During an interview on 10/09/24 at 09:05 am, the DON said the nurses were responsible for assessing residents with indwelling catheters to ensure there was a securement device in place. She stated the charge nurse should also assess the securement device on each shift to ensure the resident was not having any discomfort from tension or pulling of the tubing. The DON stated she expected every resident with an indwelling catheter to have a securement device. The DON said she would be in servicing the staff. During an interview on 10/09/2024 at 11:35 am, the Administrator stated the nursing staff were responsible for ensuring catheters were secured and in place. He stated by not having a device it could cause discomfort, infections, and dislodgement. He stated he expected each resident with a catheter to have a securement device. He stated all physician orders should be followed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Nursing Policy and Procedure Manual for Catheter Care General Guidelines revised 2/13/2007 had no indication for application of a urinary securement strap. 46273

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observations, interviews, and record review the facility failed to 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 1 of 2 residents (Resident #15) reviewed for infection control. CNA D did not wash or sanitize her hands when changing gloves while performing foley catheter care for Resident #15. CNA D wiped down the catheter tubing and without changing the washcloth picked up the washcloth and started at the top of the catheter and wiped down again while performing catheter care for Resident #15. These failures could place residents at risk of exposure to communicable diseases and infections. Findings included: 1. Record review of a Face Sheet dated 10/08/2024 for Resident # 15 indicated he admitted to the facility on [DATE] and was [AGE] years old. His diagnoses included dementia (a decline in cognitive abilities), acute cystitis with hematuria (irritation of the bladder with blood in the urine), and encephalopathy (brain dysfunction). Record review of a Care Plan dated 2/20/2022 for Resident # 15 indicated he had an indwelling suprapubic urinary cathete r with interventions to position catheter bag and tubing below the level of the bladder and in a privacy bag. Record review of a Quarterly MDS dated [DATE] for Resident # 15 indicated a BIMS score of 12 which indicated moderate cognitive impairment. He required substantial to maximal assistance with dressing, toileting hygiene, and showering. He was always incontinent of bowel and bladder. During an observation on 10/8/2024 at 2:02 pm in Resident # 15's room revealed, CNA D and LVN E were present to provide foley catheter care. Both staff washed their hands in the bathroom of Resident # 15's room and donned gloves. CNA D and LVN E positioned Resident # 15 in supine position to perform his foley catheter care. CNA D removed the blanket from Resident # 15. CNA D removed a washcloth from a basin on the over the bed table and began cleaning around the foley catheter insertion site working in a downward motion. CNA D after wiping downward on the catheter tubing picked up the washcloth and without turning the washcloth started back at the top of the catheter tubing wiping in a downward motion again. CNA D doffed gloves and without washing hands or sanitizing donned new gloves. CNA D then began drying the catheter tubing wiping in a downward motion and without turning the towel started back at the top of the catheter again wiped in a downward motion. CNA D then applied barrier cream around the catheter insertion site and on the catheter tubing. CNA D then retrieved trash bag with dirty linens and removed them from Resident #15's room. Both CNA D and LVN E went to the hall shower room across from Resident # 15's room and washed hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/08/2024 at 2:31 PM, LVN E said when asked if CNA D should have done anything differently with the foley catheter care provided to Resident #15, she said she should not have put barrier cream around the foley catheter insertion site and catheter tubing. She said CNA D had wiped down the catheter tubing without changing to a clean portion of the washcloth. She said while drying the catheter she wiped in a downward motion and without changing to a clean portion of the towel and started back at the top of the catheter tubing and wiped down again. She said she did notice that CNA D did not wash or sanitize her hands between glove changes . LVN E said CNA D's failures could cause the resident to get an infection. During an interview on 10/08/2024 at 2:37 PM, CNA D said after the catheter care while her and LVN E were washing their hands in the shower room, LVN E told her she should not have put barrier cream around the foley catheter insertion site and catheter tubing. She said she was nervous and had hand sanitizer in her pocket but had forgotten to use it in between glove changes. She said she always got confused when she tried to fold the washcloth to use it multiple times and must have forgotten to fold the washcloth to a clean area when she was wiping the catheter tubing . CNA D said by not using the correct procedure could cause the resident to get an infection. Record review of C.N.A Proficiency Audit dated 9/16/2024 for CNA D indicated she had been trained and had demonstrated handwashing and male foley catheter care procedure in accordance with the facility's standard of practice. During an interview on 10/09/2024 at 11:32 AM, the Administrator said the nurse managers were responsible for training CNA's in performing catheter care. He said going forward there would be a plan in place for training CNA's to properly perform catheter care. He said the potential risk if catheter care was not performed correctly was a possible infection for the resident. During an interview on 10/09/2024 at 11:35 AM, the DON said the nurse managers were responsible for making sure CNAs are trained properly to perform catheter care. She said if catheter care was not done properly the resident would be put at risk for infection at the catheter insertion site and internally. She said all nursing staff would be educated on infection control and catheter care with check offs. Record review of a facility policy titled Catheter Care with a revised date of February 13, 2007, indicated, .16. Gently wash, rinse and dry around the juncture of the catheter and meatus . 17. Then wash the catheter from the meatus down the tube about 3 inches. 18. Dispose of wash cloths. 19. Remove gloves. 20. Straiten clothing and bedding. 21. Wash Hands .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 47339 Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 of 1 smoking area reviewed for smoking. The facility failed to follow their policy on smoking on 10/08/24 when an empty cigarette package and paper towels were observed in an ashtray in smoking area. These failures could place residents at risk of injury, burns, and an unsafe smoking environment. Findings included: During an observation on 10/08/24 at 9:35 am a tall silver and black metal ashtray with a push button that emptieds the contents of the upper portion of the ashtray to the lower portion of the ashtray was observed in smoking area. When the lid to the trash can was opened, an empty cigarette package and paper towels were observed in the bottom of the ashtray with multiple used cigarette butts. There was a separate red metal trash can with a pad lock securing it closed. During an interview on 10/08/24 at 9:40 am the Maintenance Director said the previous housekeeping supervisor had the key to the red metal trash can and usually emptied the red trash can. He said the previous housekeeping supervisor had not worked at the facility for the last 3 to 4 weeks therefore it had not been emptied. He said he was looking for the key but had not been able to locate it. He said starting that day he would be emptying the ashtray and the red metal trash can. He said there should not have been an empty cigarette pack or paper towels in the ashtray because it was a fire hazard. During an interview on 10/09/24 at 11:28 am the Administrator said the previous housekeeping supervisor was responsible for emptying the ashtray and red metal trash can. He said they were going to have to figure out a plan because the administrator had the only key to the red metal trash can. He said he talked to housekeeping yesterday and they would be taking responsibility for that task. He said the potential risk for an empty cigarette package and paper towels being in the ashtray was that it could have caused a fire. Record review of a facility policy titled Smoking Policy dated 11/1/17 read . ashtrays on noncombustible materials and safe design will be provided in all areas where smoking is permitted. Ashtrays will be a metal container with a self-closing cover device into which ash trays may be emptied. Ashtrays will be readily available in all areas where smoking is permitted .