STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455872	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Residence and Rehabilitation Center	405 Duncan Perry Rd Arlington, TX 76011

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 3 of 11 residents (Residents #1, #2, and #3) reviewed for accidents. 1. The facility failed to ensure Resident #1 was provided with adequate supervision to prevent an unwitnessed fall with injury (non-displaced sacrum ring fracture) on 03/18/24. 2. The facility failed to ensure Resident #2 was provided with adequate supervision to prevent him from eloping from the facility's secured unit on 01/31/24. 3. The facility failed to ensure the staff break room was locked at all times and residents did not have access to the microwave. Resident #3 sustained burns on his left foot first toe and second toe. An Immediate Jeopardy (IJ) situation was identified on 03/28/24 at 1:41 PM. While the IJ was removed on 03/29/2024, the facility remained out of compliance at a scope of pattern for a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm, severe injury, and possible death to residents who require supervision. Findings included: 1. Review of Resident #1's face sheet, dated 03/28/24 revealed the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included epilepsy (a brain condition that causes recurring seizures), seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (a stroke) affecting right dominant side. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Arlington Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Duncan Perry Rd Arlington, TX 76011	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's quarterly MDS assessment, dated 01/31/24, reflected he had a BIMS score of 06, which indicated severe cognitive impairment. His functional abilities for toileting hygiene and personal hygiene indicated he required substantial/maximal assistance meaning the helper did more than half of the effort. He was also substantial/maximal assistance for rolling left and right, sit to lying, lying to sitting on side of the bed, sit to stand, and chair/bed-to-chair transfer. Review of Resident #1's care plan, dated 11/01/23 , reflected the following: Focus: [Resident #1] [was] at risk for fall due to: unsteady gait, decreased balance and poor safety awareness .01/17/24 fall with no injury . Goal: Resident will have no reports of injuries that requires hospitalization or fractures related fall through next review date .Interventions: 01/17/24 Resident re-educated on the importance of calling for help for safety .Focus: [Resident #1] [had] an ADL Self Care Performance Deficit r/t Hemiplegia, Impaired balance, Limited Mobility .Goal: the resident will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, mobility through the review date .Interventions: Personal Hygiene: The resident requires total assistance with personal hygiene care. Bed Mobility: The resident requires (X1) staff participation to reposition and turn in bed. Toilet Use: The resident is totally dependent on staff for toilet use. Review of Resident #1's progress notes for March 2024 reflected the following: - On 03/18/24 at 05:04 AM, LVN Z wrote: This nurse was alerted by resident yelling. The CNA explained that she went to gather more wipes as they run out during cleaning session, resident was found at the foot of the bed. Resident was assessed for external injuries, helped back in bed and assessed some more, he denied any pain for the moment being, V/S = 132/71 mmHg, P=74 bpm. R= 17, T=97.9, O2 SAT= 98% room air. Teachings were provided to resident on importance of safety, and how he needed help to move out of bed. DON was made aware, a message has been left for the on-call number, resident family was informed. Neuro ongoing. [sic]. - On 03/18/24 at 11:08 AM, LVN Y wrote: On continue follow up post fall Res complained of pain to right ankle. On Assessment, red area noted to right ankle with Rest of VS WNL. Tylenol 325mg 2 tabs given as ordered and was effective. NP [NP X] notified and X-ray proposed which she accepted. X-ray to right ankle called in STAT. RP [RP V] notified. [sic]. - On 03/18/24 at 5:52 PM, LVN Y wrote: X-ray to right ankle done and results pending with RP at bed side. - On 03/18/24 at 6:00 PM, LVN Y wrote: Res Transfer to ER for further evaluation post fall as decided by RP [RP V] who called 911 herself. [sic]. - On 03/20/24 at 2:53 PM, LVN Y wrote: Res arrived the building via a stretcher AAOX3 and denies any pain. VS WNL with no discomfort reported. DX of sacral fracture .[sic]. Review of an incident report for Resident #1, dated 03/18/24, prepared by LVN Z reflected the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Incident Description: Nurse Description: Nurse was alerted by resident yelling, the nurse headed to resident's room where she found him next to bed, yelling 'wipes, wipes'. The cna explained to the nurse that they run out of wipes during the cleaning session, she explained to resident that she will go get some more wipes from the supply room. [sic] .Resident Description: Resident kept screaming 'wipes, wipes' [sic]. - Immediate Action Taken: Resident was assessed for any external injuries, helped back in bed and assessed some more, he denied any pain for the moment being, V/S = 132/71 mmHG, P=74 bpm. R= 17, T= 97.9, o2 SAT= 98% room air. Teachings were provided to resident on importance of safety, and how he needed help to move out of bed. Review of Resident #1's hospital records, dated 03/18/24, reflected the following: History of present illness: . presents to the ED after falling out of bed while undergoing changing at his extended care facility yesterday. All HPI and past medical history have been obtained from patient's [RP] who is POA and states that while the patient was being changed/turned at the extended care facility yesterday afternoon, the patient accidentally rolled off the bed, hitting his entire right side .Assessment and Plan: 1: Sacral fracture, 2: Pelvic ring fracture .History: Additional Comments: CT scan of the pelvis was reviewed which shows very subtle sacral S2 fracture without significant displacement Review of Resident #1's x-ray results for his right ankle, dated 03/18/24, reflected there was no acute fracture or dislocation. Review of a form titled Extended Care Employee Termination Form, dated 03/27/24, reflected CNA T was terminated for negligence and was not eligible for rehire. Observation and interview on 03/26/24 at 10:45 AM with Resident #1 revealed he was sitting in his wheelchair in the activity room drinking coffee. Resident #1 was dressed, groomed, and appeared content; there were no obvious signs or symptoms of pain noted. Resident #1 replied with no to each question the State Surveyor asked so it was difficult to ascertain if he understood what he was being asked based on how he was answering. Observation on 03/28/24 at 9:59 AM of CNA JJ and CNA R providing incontinent care for a resident revealed they gathered all supplies and did not leave the resident alone. Interview on 03/26/24 at 2:30 PM with LVN Y revealed he came in on Monday (03/18/24) morning and the outgoing nurse said the resident fell at about 3:00 AM. LVN Y said he made his rounds and saw Resident #1 laying in bed and he was fine. LVN Y said he contacted RP #4 because the outgoing nurse was unable to contact her earlier. LVN Y said he completed an assessment on Resident #1 and noted he complained of pain to his right ankle and he administered Tylenol. LVN Y said he called Resident #1's doctor and got an order for an x-ray. LVN Y said the X-ray company took a few hours to get to the facility, but they came during his shift and so did RP V. LVN Y said RP V wanted Resident #1 to go to the hospital for further evaluation and called 911 herself. LVN Y said the ankle X-ray results came in the next day when Resident #1 was already at the hospital, but the results were negative, which indicated no injury. Attempted interview via phone on 03/27/24 at 10:02 AM with LVN Z was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/27/24 at 11:50 AM with CNA W revealed when she came in for her shift on 03/18/24, she was informed Resident #1 had a fall on the night shift. CNA W said Resident #1 was a two-person assist and he only complained of pain to his ankle where there was a bruise. Attempted interview via phone on 03/27/24 at 1:23 PM with NP X was unsuccessful. Interview on 03/27/24 at 1:54 PM with ADON U revealed Resident #1 had a fall on 03/18/24 and during the initial assessment there was no complaints of pain. ADON U said an X-ray was done after Resident #1 started to complain of pain and the results were negative. ADON U said Resident #1's RP wanted him to go to the hospital and they found a fracture of some sort on his sacrum. ADON U said CNA T was providing care and in midst of this service ran out of material so she told the resident she would be back. ADON U said she left to go and get more wipes and by the time she came back Resident #1 had fallen out of the bed. ADON U said Resident #1 was total care meaning staff providing all care for his incontinent needs. ADON U said at the time of the fall Resident #1 was a one-person assist but after the fall he was changed to be a two-person assist. ADON U said CNA T should have called for help to ask another co-worker or nurse to retrieve what she needed and stayed with Resident #1. ADON U said CNA T should not have left Resident #1 alone in the condition he was in being in the middle of providing him incontinent care. ADON U said CNA T was suspended pending the investigation and staff were in-serviced on fall risks and prevention and abuse/neglect. Interview via phone on 03/27/24 at 3:05 PM with CNA T revealed on 03/18/24 she went in to answer Resident #1's call light after her lunch break. CNA T said when she went into his room he wanted to be changed so she got her supplies and started changing him. CNA T said in the middle of care, the wipes finished, and she still needed to keep cleaning him. CNA T said she told him she was going to grab some more wipes and was going to come back and finish cleaning him. CNA T said she stepped out of the room to get wipes and came back to the room, and he was on the floor. CNA T said she could have called someone to come and bring wipes or stay with him before leaving to get more wipes. CNA T said she knew better than to leave a resident alone in the middle of providing care. CNA T said she was informed after the fall on 03/18/24 that Resident #1 was now a two-person assist. Interview on 03/27/24 at 3:25 PM with ADON S revealed on 03/18/24 Resident #1 had his call light on and he needed to be changed. ADON S said Resident #1 was a one-person assist at the time and CNA T was caring for him. ADON S said Resident #1 was very impulsive and didn't understand having to wait and hold on for something or for care. ADON S said if staff were running out of supplies during care, they should ensure the resident was safe and try calling someone else and not leaving the resident alone. ADON S said when Resident #1 was found the nurse assessed him and he had no injuries or pain noted at the time. ADON S said later on in the day he complained of pain to his ankle so an x-ray for his ankle was ordered and was negative. ADON S said Resident #1's RP came to the facility and requested him to be sent to the hospital because she felt as if something was broken. ADON S said the hospital found Resident #1 had a sacrum fracture. ADON S said the risk of leaving a resident in the middle of care was they were at increased risk of falls or injuries. ADON S said all staff were responsible for ensuring residents were always left in a safe and comfortable manner. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/27/24 at 4:23 PM with the DON revealed Resident #1 had a fall on 03/18/24 and she went to go and see him and speak to LVN Y. The DON said LVN Y told her Resident #1 hurt the right side of his leg, that he was going to call the doctor to get an x-ray ordered. The DON said after the x-ray technician came and took the x-ray, Resident #1's RP said she did not want to wait for the results and wanted him to go to the hospital instead. The DON said on 03/20/24 the facility found out Resident #1 had a pelvic fracture. The DON said LVN Z was the one who found him the morning of 03/18/24 around between 4 and 6 AM when she heard a noise and saw him on the floor. The DON said CNA T went into Resident #1's room to answer his call light, began to gather supplies to care for him and realized she did not have enough to complete the job so she assured him she would be right back. The DON said she was not told by CNA T that she had actually started providing care and then ran out of supplies and left the room. The DON said if that was the case, CNA T should have asked someone for help by bringing her the additional items she needed. Interview on 03/27/24 at 5:23 PM with the Administrator revealed she was still investigating what happened on 03/18/24 with Resident #1. The Administrator said in the middle of the night when the CNA was rounding and checking on residents CNA T saw Resident #1's call light on. The Administrator said she went in to turn off the lights and saw Resident #1 wanted her to change his brief. The Administrator said CNA T agreed to change him so she put his bed to a high position to be able to start care, she had wipes and started caring for the resident. The Administrator said CNA T told her the bed was in a low position before she left the room because she ran out of wipes. The Administrator said Resident #1 was very impulsive and when CNA T left the room and returned, he was at the foot of the bed and screaming about wipes. The Administrator said CNA T should not have left Resident #1 in the middle of caring for him. The Administrator said during the initial assessment by LVN Z, Resident #1 did not have any complaints of pain or injuries. The Administrator said later in the day the next nurse checked on Resident #1 and he was noted to have complaints of pain to his ankle, so an x-ray was ordered. The Administrator said Resident #1's RP requested for him to be sent to the hospital where it was found he had a sacral non-displaced fracture. The Administrator said CNA T was suspended for almost 4 days during the investigation and before she was brought back to work a skills check off was completed for peri-care. The Administrator said Resident #1 has one word that someone says to him and he sticks to that word such as wipes so it was hard to understand from him what happened. The Administrator said all staff were in-serviced on abuse/neglect and fall prevention regarding the incident. The Administrator said CNA T should never have left Resident #1 after beginning care and should have ensured she had enough supplies before beginning peri-care. The Administrator said CNA T could have asked for help and stayed with Resident #1 to keep him safe because he has a history of impulsiveness and this incident caused harm to him. Follow-up interview on 03/28/24 at 8:42 AM with the Administrator revealed CNA T was terminated as of 03/27/24 because the facility confirmed her negligence regarding Resident #1's fall on 03/18/24 . The Administrator said CNA T told her last night (03/27/24) via phone she was providing care to Resident #1, ran out of wipes, and then left him to get additional wipes outside of the room and he ended up falling and sustained a fracture. The Administrator said she began an additional in-service regarding providing care to residents but had only been able to re-educate the day shift so far for today (03/28/24). Attempted an interview via phone on 03/28/24 at 9:49 AM with RP #4 was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Follow-up interview on 03/28/24 at 11:02 AM with the DON revealed as of this morning (03/28/24) she had just started an additional in-service with staff regarding following the facility's policy and procedures for peri-care. The DON said she was re-educating staff on making sure they had all supplies gathered and ready before beginning incontinent care for a resident. The DON said she was also completing skills check off competencies with staff regarding incontinent care as well. The DON said this was prompted because her and the Administrator contacted CNA T again last night to discuss what happened with Resident #1's fall on 03/18/24. Interview on 03/28/24 at 11:30 AM with CNA R revealed she knew to get all supplies before providing incontinent care and to not leave a resident alone during incontinent care. CNA R said she would use the call light to get the attention of someone else if she did run out of supplies during care. Interview on 03/28/24 at 11:35 AM with CNA Q revealed she knew to get all supplies before providing incontinent care and to not leave a resident alone during incontinent care. CNA R said she would use the call light to get the attention of someone else if she did run out of supplies during care. Review of the facility's undated policy titled Perineal Care reflected the following: Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. Assemble the equipment and supplies needed. Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure: 1. Disposable wipes, 2. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Review of the facility's undated and blank Peri Care Audit Tool reflected the following actions: 2. Staff must gather supplies, have bags ready for linen and garbage and wash hands 2. Review of Resident #2's face sheet, dated 03/28/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder.) Review of Resident #2's care plan, updated 01/31/24, reflected the following: Focus: [Resident #2] is an elopement risk/wandered has History of attempts to leave facility unattended, Resident wanders aimlessly. [Resident #2] got out of the facility on 01/31/24 .Goal: The resident will not leave facility unattended through the review date. The resident's safety will be maintained through the review date .Interventions: 01/31/24 30 minute checks x 6 days .Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate [sic]. Review of Resident #2's quarterly MDS Assessment, dated 02/29/24, reflected he had a BIMS score of 6, which indicated severe cognitive impairment. Review of an elopement risk evaluation, dated 01/31/24, reflected Resident #2 was at risk of eloping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an incident report, dated 01/31/24, reflected for the Incident Description: Nursing Description: Res. had finished his breakfast and directed to his room. Apparently, able to leave the unit without any alarm sounds noted. Res. was found by another staff coming to work, and brought back resident to the facility. Res. noted holding his Bible and card that he received from his mother recently. Resident Description: Res. Stated that he went to the back door and was trying to get home to his mother. [sic]. Completed by LVN BB. Observation and interview on 03/26/24 at 10:40 AM with Resident #2 revealed he was laying in his bed with a blanket covering him. Resident #2 said he left the facility but could not remember how or why or where he went or when it was. Resident #2 said he felt safe in the facility and did not travel much anymore. Observation on 03/26/24 at 11:00 AM of the secured unit's back door revealed it was secured, locked, and appeared to be functioning properly. Interview on 03/26/24 at 2:30 PM with LVN Y revealed he was aware of the facility's policy and procedures regarding a resident eloping. LVN Y explained that he knew the facility's code color for when a resident has eloped and what steps to take to try and find an eloped resident by searching the entire facility and around the facility. LVN Y said he knew to immediately report any exit door that was not functioning properly to the Maintenance Director so that it could be fixed quickly. Interview on 03/26/24 at 2:50 PM with CNA J revealed she was aware of the facility's policy and procedures regarding a resident eloping. CNA J explained that she knew the facility's code color for when a resident has eloped and what steps to take to try and find an eloped resident by searching the entire facility and around the facility. CNA J said she knew to immediately report any exit door that was not functioning properly to the Maintenance Director so that it could be fixed quickly. Interview on 03/26/24 at 4:08 PM with LVN BB revealed early in the morning on 01/31/24 she was serving breakfast in the dining room on the secured unit. LVN BB said Resident #2 was always the first resident to finish their breakfast and she had to redirect him to his room afterwards. LVN BB said she took Resident #2 to the hallway and then went back to the dining room because she was helping other residents finish their meals. LVN BB said the next thing she knew the front desk was calling saying Resident #2 was seen by Housekeeper KK on her way to work. LVN BB said apparently Resident #2 pushed on the back door of the secured unit and walked around the back and went to the front of the building. LVN BB said she called the DON and Administrator immediately to report what happened. LVN BB was instructed to count all residents and ensure no one else was missing or had eloped. LVN BB said all residents were accounted for and Resident #2 was back in the building . LVN BB said she spoke with Resident #2 and said he was carrying his Bible and a card sent to him by his [family member] so he was trying to get home to her. LVN BB said she checked his skin and he had no injuries. LVN BB said she thought something was wrong with the door to the secured unit at the time since there was not an alarm that went off. LVN BB said usually when someone tried to open that door the alarm would go off letting staff know that someone was trying to leave. LVN BB said the ADON came to check the door as well and she was able to just push the door open, it was not locked and did not require a 15-second release, and the alarm did not sound. LVN BB said the Maintenance Director came and fixed the door right away that day (01/31/24). LVN BB was able to explain the facility's policy and procedures regarding a resident eloping. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/27/24 at 5:20 PM with LVN K revealed she was aware of the facility's policy and procedures regarding a resident eloping. LVN K explained that she knew the facility's code color for when a resident has eloped and what steps to take to try and find an eloped resident by searching the entire facility and around the facility. LVN K said she knew to immediately report any exit door that was not functioning properly to the Maintenance Director so that it could be fixed quickly. Interview on 03/28/24 at 9:58 AM with LVN L revealed he was aware of the facility's policy and procedures regarding a resident eloping.LVN L explained that he knew the facility's code color for when a resident has eloped and what steps to take to try and find an eloped resident by searching the entire facility and around the facility. LVN L said he knew to immediately report any exit door that was not functioning properly to the Maintenance Director so that it could be fixed quickly. Interview via phone on 03/28/24 at 11:35 AM with CNA LL revealed Resident #2 eloped from the secured unit back in January. CNA LL said it happened during breakfast time and she was helping other residents to eat their food. CNA LL said Resident #2 finished his meal and liked to go to his room after so when the nurse saw him finish his food she directed him to his room. CNA LL said all of a sudden she heard Resident #2 was found out of the facility and she was not sure how he got out. CNA LL said she asked Resident #2 how he got out of the facility, and he said he went out the back door, but the alarm did not go off. CNA LL said she never noticed the back door to the secured unit was not working. CNA LL said she no longer worked at the facility. Interview via phone on 03/27/24 at 12:49 PM with the Regional Maintenance Director revealed he did not know anything about the back door to the secured unit not functioning back in January because he was not specifically assigned to this facility. Attempted interview via phone on 03/27/24 at 12:56 PM with the Maintenance Director was unsuccessful. Interview on 03/27/24 at 1:54 PM with ADON U revealed Resident #2 eloped from the secured unit and was found down the street at the stop sign. ADON U said a Housekeeper was driving to work and saw Resident #2 and brought him back to the facility. ADON U said an incident report, pain assessment, and skin assessment were completed on Resident #2 and nothing was found. ADON U said Resident #2 was also placed on 30-minute checks by staff, the doctor, and the RP were also notified of the incident. ADON U said the facility checked the back door to the secured unit and there was something wrong with the door arm that they readjusted to make sure it shut and locked. ADON U said after they readjusted the door arm, they noticed it was closing faster and was now locking. ADON U said after the incident occurred, all staff were educated on the facility's policy and procedures for elopements. ADON U said when residents eloped they were at risk of a lot, including injury or death. Interview via phone on 03/28/24 at 4:02 PM with Housekeeper KK revealed she was driving to work on 01/31/24 and found Resident #2 walking outside. Housekeeper KK said she put Resident #2 in her car and brought him back to the facility. Housekeeper KK said she found Resident #2 down the street from the facility about 5 minutes away . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Arlington Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 405 Duncan Perry Rd Arlington, TX 76011	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/28/24 at 3:25 PM with ADON S revealed Resident #2's (family member) sent him something in the mail with an address on it and that was where he was going to when he eloped. ADON S said Resident #2 was on the secured unit of the facility because he had a history of eloping from previous facilities where he admitted from. ADON S said the facility completed elopement drills, completed in-services for staff, and also put Resident #2 on 30- minute checks. ADON S said the elopement drills were completed on 01/31/24 and 02/06/24. ADON S said the risk of residents eloping from the facility was they could get injured. ADON S said all staff were responsible for making sure residents did not elope. Interview on 03/28/24 at 4:23 PM with the DON revealed a Housekeeper staff member came to the facility and said she thought this person was their resident. The DON said the previous receptionist for the facility told the Housekeeper staff member that it was a resident and identified the person as Resident #2. The DON said she asked where he was going and he was going to the address on the envelope he received from his family member. The DON said Resident #2 was found down at the corner to the left of the facility. The DON said Resident #2 told her he got out of the secured unit through the back door and jumped over the fence. The DON said the nurse had just walked him to his room after eating breakfast when this occurred. The DON said she had the Maintenance Director check on the door to evaluate what happened and why the alarm did not go off. The DON said the Maintenance Director readjusted the door and it was fixed to where the alarm would go off and it was locking. The DON said Resident #2 was assessed and placed on 30-minute checks. The DON said Resident #2 had not eloped again since this incident on 01/31/24. The DON said all staff were educated to know about the facility's elopement policy and procedures. Review of an elopement drill log, dated 02/06/24, indicated the facility completed an elopement drill with staff on this day. Review of an elopement drill log, dated 03/17/24, indicated the facility completed an elopement drill with staff on this day. Review of maintenance logs titled Monthly door Check included a check of the rear exit from the locked unit was checked on the following dates: 01/22/24, 01/29/24, 02/05/24, 02/12/24, and 02/19/24. Review of maintenance logs titled Doors, Locks, and Alarms Inspection Log included a check of the rear memory care exit was checked on the following dates: 02/26/24, 03/01/24, 03/04/24, 03/08/24, 03/11/24, 03/15/24 and 03/25/24. Review of an in-service titled: Code white= missing person policy and procedure, dated 01/31/24, reflected staff were in-serviced on the facility's policy and procedures regarding elopements. Review of an in-service titled: Elopement Monitoring Safety of Residents, dated 03/28/24, reflected staff were in-serviced on the facility's policy and procedures regarding elopements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER: Arlington Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 405 Duncan Perry Rd Arlington, TX 76011	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy, dated July 2017, and titled Wandering and Elopement reflected: Definition: a resident who does not have the capacity who leaves the facility unaccompanied. VIII. Response to Resident Elopement, A. The Facility Staff member who finds that a resident is missing will alert Facility Staff. B. The Charge Nurse will call Code ________ and organize a search. Facility Staff will search areas of the Facility, including common areas, bathrooms, showers, outside areas, etc .F. The Licensed Nurse most familiar with the incident will document in the resident's medical record how the elopement occurred IX. Return of a Resident .H. all facility will receive an inservice on hire and annually regarding the elopement policy [sic]. 3. Record review of Resident #3's face sheet revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: depression (mental health disorder), nasal bone fracture (a break in the bone over the ridge of the nose) and contusion of scalp (a bruise on the scalp). Record review of Resident #3's quarterly MDS assessment, dated 01/8/24, reflected Resident#3's cognitive skills for daily decision making were moderately impaired with a BIMS score of 07. Record review of Resident #3's care plan, revised 02/15/24, reflected: [Residents #3] was at risk for skin breakdown rule out decreased mobility . 1/24/24 burn wound to left dorsal 2nd toe, 1/24/24 burn wound to left dorsal 1st toe resolved on 2/14/24. Goals: Resident will have no reports of skin breakdown through next review date. Interventions: 1/24/24 burn to left dorsal first toe size 1.3 x 1.5 x no measurements. Treatment of hydrogel and bordered gauze dressing daily. 2/14/24 Burn wound to left dorsal 2nd toe size 2.1 x 1.1 x 0. 1cm. Treatment to continue with xeroform and bordered island gauze dressing. 2/21/24 burn to left dorsal 2nd toe size 1.3 x 0.7 x 0.1cm. Treatment to continue with xeroform and bordered gauze dressing and skin prep (A waterproof skin barrier which protects the skin from irritation and trauma resulting from tape or dressing applications.). 3/13/24 Burn to left 2nd toe size 0.7 x 0.2 x 0.1 cm. Treatment skin prep. Record review of Resident #3's skin assessment, dated 01/22/24, reflected skin was intact. Record review of Resident #3's incident report, dated 01/24/24, reflected the resident wound on his second toe. Resident #3 reported his second toe was hurting. Record review of the facility's provider investigation report reflected; staf [TRUNCATED]