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	06/14/2024

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 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** 42824 Based observation, interview, and record review, the facility failed to 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 (Resident #2) of 6 residents observed for infection control. The facility failed to ensure Resident #2's urinary catheter was positioned safely off the floor. This failure could place the residents at risk of cross-contamination and the development of infection. Findings included: Review of Resident # 2 face sheet dated 06/03/2024 revealed she was a [AGE] year-old resident admitted to the facility 06/10/2023 from an acute care hospital. Relevant diagnoses included encephalopathy (changes in brain that lead to brain damage,) heart disease, hypertension (high blood pressure,) cerebrovascular disease (condition that affects blood flow and vessels in the brain,) hemiplegia (one sided paralysis) following cerebral infarction (brain lesion in which a cluster of brain cells die when they do not get enough blood) affecting the right side, and dementia (group of symptoms that affects memory, thinking, and interferes with daily life.) Review of Resident #2's Physician Orders revealed she had orders for the care and maintenance of a urinary catheter with a start date of 05/30/2024. In observation and interview of Resident #2 on 06/03/2024 at 12:40 PM revealed her resting in her bed. Her urinary catheter was located on the floor to the resident's right side. The resident stated she was not aware her urinary catheter was on the floor and was not aware of the significance of maintaining her urinary device off the floor. She was not aware of how long it had been located on the floor. In interview and observation with Resident #2's nurse for the day, LVN B, on 06/03/2024 at 12:50 PM, after prompting from surveyor, she stated she observed Resident #2's urinary catheter on the floor. LVN B then repositioned Resident #2's urinary catheter off the floor and hooked it to the side of her bed. She stated Resident #2's urinary device should not be located on the floor but could not say how long it was on the floor. She stated it was a potential infection control risk if resident urinary catheters were touching the floor. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the DON on 06/03/2024 at 2:07 PM, she stated she did rounds on Resident #2 this morning and her urinary catheter was not on the floor at that time. She stated she expected frequent rounding for Resident #2 and for all care staff to ensure that her urinary catheter device was positioned off the floor. She stated that it was ultimately the nurse's responsibility to ensure resident urinary catheter devices were kept off the floor for infection control purposes. In interview with the facility Administrator on 06/03/2024 at 1:20 PM, she stated she expected all resident urinary catheter devices be positioned off the floor for infection control purposes. She stated that the charge nurse should be rounding on her residents frequently as well as the staff nurses to ensure resident urinary catheters are positioned appropriately. Record review of facility policy Catheter- Care/Insertion, dated 02/17/2020 revealed 16 . Properly position bag below level of bladder (must not touch floor) and secure to bed frame .

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on observation, interview, and record review, the facility failed to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 resident (Resident #1) of five residents reviewed for environment. The facility failed to ensure Resident #1 had a functional call light. This failure placed residents at risk of not being able to get staff assistance when they need it. Findings included: Review of Resident #1'S Face Sheet dated 06/03/2024 revealed she was a [AGE] year-old resident admitted to the facility on [DATE] from another skilled nursing home. Relevant diagnoses included fibroblastic disorder (connective tissue dysfunction,) diabetes type 2 (insulin resistance,) major depressive disorder (clinical depression where one feels sad, low, or worthless,) and insomnia (inability to sleep at night.) Review of Resident #1's Admission MDS dated [DATE] revealed she was cognitively intact with a BIMS score of 15. She was occasionally incontinent of bladder and always continent of bowel. She required a wheelchair for mobility and partial/moderate assistance for shower/baths. Review of Resident #1's Comprehensive Care Plan dated 05/07/2024 revealed Resident #1 had acute pain related to fibroblastic disorder and intervention included for the resident to call for assistance when in pain. In interview with Resident #1 on 06/03/2024 at 12:35 PM she stated her call light had not worked for a while. She could not specify how long her call light was not functioning; but she stated when she needed anything, she had to self-propel herself in her wheelchair to the nurse's station. She stated that was inconvenient for her. She stated that the facility staff was aware, but it had not been repaired yet. In interview and observation with LVN A on 06/03/2024 at 12:36 PM, Resident #1's call light was activated, and the light located outside the door did not light up. LVN A was then interviewed at the nurse's station, and she confirmed that Resident #1's call light was not signaling at the nurse's station. She stated she was not aware that Resident #1's call light was not functioning . When LVN A was asked to provide a maintenance log for review, she was not able to provide it for review and stated that she thought the maintenance man was around the facility, but she did not know what his name was. She stated it was important for the facility's call light system to function so when resident's need the staff, they can let the staff know when they need something. Facility maintenance staff was not available for interview at the time of the investigation. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the facility's Corporate Maintenance Director on 06/03/2024 at 1:21 PM he stated his expectations were for the facility's call lights to be functioning at all times. Stated he expected for staff to perform routine inspections and document any call light concerns on the facility's maintenance log. He stated he was not aware of Resident #1's call light not functioning but stated he was not the facility's on-site maintenance director and was not aware of all the specifics of this particular building. He stated it was important for the facility call lights to function properly so residents can get immediate service and if not, it would compromise care. In interview with facility Administrator on 06/03/2024 at 1:41 PM, she stated that Resident #1 never complained to her about her call light; but stated staff should be rounding daily to check resident call light functionality. She stated it was not acceptable for Resident #1 to not have a working call light. She stated her expectations were for all residents have a call light that functioned as it was extremely important for resident care concerns. Review of Facility Maintenance Log provide by the Corporate Maintenance Director on 06/03/2024 at 1:34 PM revealed no evidence of Resident #1's room call light not functioning. Review of facility policy, "Answering the Call Light, undated, provided by the Administrator on 06/03/2024 at 1:53 PM revealed The facility maintains a functional call light system . the staff shall complete routine rounds to maintain resident safety and well-being . General Guidelines . 4. Report all defective call lights to the nurse supervisor promptly. 5. Call light system that needs repair shall be reported to the maintenance staff promptly.