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	06/27/2024

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review, the facility failed to permit a resident to return to the facility after being hospitalized or placed on therapeutic leave for 1 of 3 residents (Resident #1) reviewed for bed hold. The facility failed to re-admit Resident #1 after he was treated at a behavioral health hospital, when his discharge back to the facility was anticipated on 06/26/24. This failure could place residents at risk of not getting the care and services required. Findings included: Review of Resident #1's Face Sheet reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] to the secure unit. Resident #1 had the following diagnosis: schizoaffective disorder (mental disorder with abnormal thought processes and unstable mood), heart failure, hyperlipidemia (high cholesterol), mild cognitive impairment (memory and thinking problems), and hypertension (high blood pressure). Record review of Resident #1's nursing home discharge MDS, dated [DATE], revealed Resident #1's BIMS, to assess his cognition was blank. Section E of the MDS reflected - Behavior indicated no potential indicators of psychosis; other behavioral symptoms not directed towards others. The MDS reflected Resident #1 required setup or clean-up assistance with all activities of daily living skills. Also, the MDS Discharge Assessment reflected return anticipated. Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1's cognition was intact with a BIMS score of 14. Section E of the MDS reflected - Behavior indicated no potential indicators of psychosis; other behavioral symptoms not directed towards others. The MDS reflected Resident #1 required setup or clean-up assistance with all activities of daily living skills. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's current care plan reflected Resident #1 had a behavioral problem related to banging on the door displaying aggressive behavior. The care plan reflected: Goal .resident will have no evidence of behavior problems or aggressive behaviors. Interventions included administer medications as ordered. Monitor for side effects and effectiveness, anticipate and meet resident needs, caregivers to provide opportunity for positive interaction, if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate, intervene as necessary, divert attention. Record review of Resident #1's progress notes reflected the notes ended on 06/12/24, and the progress notes did not document Resident #1 was transferred to the hospital on 06/14/24. There was also no documentation of a discharge summary. Record review of the facility's current resident roster, dated 06/27/24, reflected Resident #1 was out on leave to the hospital. Interview on 06/27/24 at 12:32 PM with RN A revealed he worked in the facility's memory care unit. He stated Resident #1 had unusual behaviors compared to other memory care residents, and he was younger and more alert. RN A stated Resident #1 walked and paced the floor a lot, write on the walls, try to intimidate other residents. RN A stated it was on Thursday June 14, 2024, Resident #1 kept pacing the floor and was passing a residents on the halls, entered his room and hit the sink, Resident #1 then came out saying he hit his head on the sink and wanted to kill himself. According to RN A, Resident #1 had small amount of blood in the middle of his forehead. RN A stated this was during shift change, so he and the oncoming nurse cleaned Resident #1's wound and administered pain medication. RN A stated he then tried to calm Resident #1 down, offered him snacks, and completed one on one monitoring while LVN B investigated the sink, room and contacted the doctor, DON and Administrator. RN A stated he stayed with Resident #1 until emergency services transferred Resident #1 to hospital for evaluation and further treatment. RN A stated Resident #1 had not returned. Interview on 06/27/24 at 12:57 PM with LVN B revealed at the beginning of her shift on 06/14/24, Resident #1 came out of his room and reported that he hit his head on the restroom sink and wanted to kill himself. LVN B stated she assisted the resident with treatment and gave him pain medication. She stated she then conducted a full assessment for Resident #1. LVN B stated she contacted the doctor, DON, and Administrator which resulted in Resident #1 being transferred to the hospital for evaluation and treatment. LVN B stated Resident #1 had not returned to the facility. Interview on 06/27/24 at 1:09 PM with the DON revealed on 06/26/24 she received a call from the behavioral health hospital, where Resident #1 had been sent, wanting to know if Resident #1 had transferred from the facility. The DON stated she confirmed he was a resident of the facility. She stated she was asked about the resident's return to the facility, and she responded that an assessment would need to be completed to see if he was able to return. The DON stated she informed the behavioral health hospital she was unsure when the assessment could take place. The DON stated she then referred the hospital to the Administrator. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/24 at 1:55 PM with the Administrator revealed she received a call from the behavioral health hospital and informed them that Resident #1 would not be able to return to the facility. The Administrator stated she expressed to the behavioral health hospital that the facility was possibly not the right place for Resident #1. The Administrator stated said she expressed that Resident #1 could only live on the memory care unit due to being an elopement risk; however, with his behaviors it was not safe for himself or other residents. The Administrator stated, The moment the facility sent a resident out to any hospital they are discharged from our system. She stated she told the hospital Resident #1 was not expected to return to the facility because his needs could not be met. The Administrator stated, discharge documents were not sent with Resident #1 when he transferred to the hospital. The Administrator stated, We wait until we get a call from the hospital to discuss discharge at that time. The Administrator stated the behavioral health hospital had been calling her throughout the day on 06/27/24, but she had not answered their call due to a surveyor being in the building. According to the Administrator, there was no risk to Resident #1 not being able to return to the facility at this time because he was currently at the behavioral health hospital. The Administrator stated she would follow-up with the hospital to give them referrals. Interview on 06/28/24 at 12:07 PM with the Program Director at the behavioral health hospital revealed there was no paperwork that followed Resident #1 to the behavioral health hospital, so they had to work backwards to identify which facility he transferred from. The Program Director stated several failed attempts were made to contact the facility about Resident #1's return. The Program Director stated when they finally were able to speak with someone, they were told by the DON Resident #1 required an assessment to see if he was able to return to the facility. The Program Director stated she was then referred to the Administrator, who advised her that Resident #1 was not allowed to return due to property damage. The Program Director stated she asked if there was a formal discharge and requested discharge documents. The Administrator then stated there were no discharge documents sent with him, and he would not be able to return to the facility. The Program Director stated it was the responsibility of the facility to allow him to return since there was no discharge anticipated prior to exiting the facility. The Program Director stated Resident #1 was placed at risk of an unsafe discharge. Review of the facility's current, undated Discharging the Resident policy reflected: .5. If the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed, and telephone report is called to the receiving facility. Prepare transfer documents Record review of the facility's current Bed Holds and Return Policy policy, dated March 2017, reflected: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. 1. Residents may return to and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. (continued on next page)

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