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| 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 08/29/2024 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for one (Resident #1) of five residents reviewed for ADL care.</p> <p>The facility failed to remove Resident #1's facial hair.</p> <p>This failure could place residents at risk for social isolation, loss of dignity and self-worth.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, printed on 08/29/24, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE], with diagnoses of other specified myopathies (disease that affects the muscles that control voluntary movement), Type 2 diabetes mellitus with diabetic neuropathy (a serious complication of Type 2 diabetes that occurs when high blood sugar levels over time damage nerves in the body), mixed hyperlipidemia (a genetic condition that causes high levels of cholesterol and fat in the blood), hypokalemia (low potassium levels of the blood), and postprocedural hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormones after a medical procedure).</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 08/19/24, indicated Resident #1 had BIMS score of 09, which indicated Resident #1 had moderate cognitive impairment. Section GG - Functional Abilities and Goals, question GG0130. Self-Care indicated Resident #1 required set-up or clean up assistance with ADLs of eating, bathing, oral hygiene, dressing and personal hygiene.</p> <p>Record review of Resident #1's care plan, revised on 08/27/24, reflected the following:</p> <p>FOCUS: [Resident #1] has an ADL self-care performance deficit r/t Alzheimer's . INTERVENTIONS: PERSONAL HYGIENE: The resident requires assistance by supervision/setup staff with personal hygiene and oral care .</p> <p>Record review of Resident #1's progress notes, from 07/01/24 through 08/29/24, failed to reveal notes indicating the resident refused showers or grooming.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>In an interview and observation on 08/29/24 at 10:57 AM, Resident #1 stated she was well. Resident #1 was observed with several white/gray hairs on her chin, which were roughly 0.25 of an inch in length. Resident #1 stated she did not like the hair on her chin and she wanted it gone. Resident #1 stated she could not recall any facility staff offering to shave her chin, but she would allow them to shave if they had asked.</p> <p>In an interview on 08/29/24 at 3:02 PM, CNA B stated she had been Resident #1's aide for roughly 2 weeks. CNA B stated Resident #1 normally refused her showers, stating she had washed up in the sink and she had not tried to shave her face. CNA B stated she had not really noticed the length of the hairs observed on her face. CNA B stated it was the aide's responsibility to ensure residents were groomed daily, including shaving.</p> <p>In an interview on 08/29/24 at 3:24 PM, LVN C stated she was Resident #1's charge nurse for roughly 5 months. LVN C stated she had not received any complaints from Resident #1 regarding her facial hair. LVN C stated she had not received any reports from aides that Resident #1 refused to be groomed but stated Resident #1 often refused care. LVN C stated all residents should be groomed daily, including shaving and any refusals should be documented on the resident shower sheet and in their electronic health record. LVN C stated women having facial hair could affect their self-esteem.</p> <p>In an interview on 08/29/24 at 3:42 PM, the ADON stated she was not aware of the hair on Resident #1's chin. The ADON stated the hair should have been shaved and any refused attempts should have been documented in the resident's electronic chart. The ADON stated the facility's expectation was for residents to be groomed daily, as not doing so could affect them mentally and they may not want to be seen by others. The ADON stated she would begin an Inservice on ADL care and grooming and will monitor residents to ensure ADL care, including grooming is provided.</p> <p>In an interview on 08/29/24 at 4:43 PM, the Administrator stated residents should be groomed daily and at every shower, unless the resident refused, which should be documented on shower sheets and in the resident's electronic health record. She stated she was not aware of Resident #1's facial hair but would get staff to attempt to shave it, if the resident allowed. She stated having unwanted facial hair could affect residents' self-esteem and was a dignity issue. She stated she would in-service staff on grooming, showers, ADL care and documentation to ensure all grooming needs were met in the future.</p> <p>Review of the facility's undated policy entitled Activities of Daily Living (ADLs), Supporting, reflected the following:</p> <p>Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Policy Interpretation and Implementation: . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .</p> | | |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>42214</p> <p>Post nurse staffing information every day.</p> <p>Based on observation, interview and record review the facility failed to ensure the nurse staffing information was posted on a daily basis for one of twenty-nine days (08/29/24) reviewed for nursing services and postings.</p> <p>The facility failed to update the posting of the daily staffing information on 08/29/24.</p> <p>This failure could place residents at risk of not having access to information regarding staffing data and facility census.</p> <p>Findings included:</p> <p>Observation on 08/29/24 at 9:51 AM of the building revealed the daily nursing staff posting was posted near the facility's entrance with a date of 08/28/24.</p> <p>Observation on 08/29/24 at 11:46 AM of the building revealed the daily nursing staff posting was posted near the facility's entrance with a date of 08/28/24.</p> <p>Observation on 08/29/24 at 3:08 PM of the building revealed the daily nursing staff posting was posted near the facility's entrance with a date of 08/28/24.</p> <p>In an interview on 08/29/24 at 3:42 PM, the ADON stated DON was responsible for updating the daily nursing staff posting, but the DON packed her belongings at the end of her shift on 08/28/24 and did not return on 08/29/24. She stated she may have been responsible for updating the post in the absence of the DON but had not had a chance to update the posting as of yet. She stated if the staffing posting was not updated daily, residents would not be aware of the staffing for the day.</p> <p>In an interview on 08/29/24 at 4:43 PM, the Administrator stated the nurse staffing posting should be updated daily. She stated it was the responsibility of the DON to ensure the posting was updated daily. She stated she did not know why the post was not updated for 08/29/24's staffing. She stated residents would know the day's staffing ratio or availability if the staff posting was updated daily. She stated she would designate a facility employee, more than likely the receptionist to ensure the posting was updated daily and in-service staff on the facility's posting policy to ensure the post is updated appropriately in the future.</p> <p>Review of the facility's undated policy entitled Posting Direct Care Daily Staffing Numbers reflected the following:</p> <p>Policy Statement</p> <p>Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.</p> <p>Policy Interpretation and Implementation</p> <p>(continued on next page)</p> | | |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .</p> | | |