

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  09/12/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32227</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for two (Residents #1 and #2) of four residents reviewed for dignity.</p> <ol style="list-style-type: none"> <li>The Maintenance Director on 09/10/24 recorded Resident #1 with his personal cell phone while Resident #1 yelled and cursed at the facility staff.</li> <li>CNA A took Resident #2's cell phone away when Resident #1 stated he was going to call 911 on 06/20/24.</li> </ol> <p>This failure could place residents at risk for a loss of dignity, decreased self-worth and decreased self-esteem.</p> <p>Findings included:</p> <p>Review of Resident #1's quarterly MDS assessment dated [DATE] reflected the resident was [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included stroke, hemiplegia (paralysis to one side of the body), history of traumatic brain injury, muscle weakness, abnormal gait and mobility and depression. Resident #1 had a BIMS of 8, which indicated his cognition was moderately impaired. The MDS further indicated Resident #1 used a wheelchair for mobility.</p> <p>Review of Resident #1's care plan initiated on 06/14/24 reflected he had the potential to demonstrate verbally abusive behaviors related to ineffective coping skills, mental/emotional illness and poor impulse control. Interventions included to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document.</p> <p>On 09/10/24 at 12:02 PM revealed, while in the secure unit, there was a resident heard yelling and cursing. While in the secure unit's dining room the Maintenance Director was seen thru clear locked double doors, on the other hall. The Maintenance Director was holding a cell phone and appeared to be recording Resident #1 while he (Resident #1) yelled and cursed.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 09/10/24 at 12:11 PM of Resident #1 revealed he was wheeling himself backwards in his wheelchair towards the front of the facility. Resident #1 was asked what happened, but the resident just kept repeating butthole repeatedly. Resident #1 was asked if the Maintenance Director was recording him, but the resident did not appear to comprehend what was being asked.</p> <p>Interview on 09/10/24 at 1:19 PM with the Maintenance Director revealed Resident #1 had been calling him racial names and cursed at him and even threatened to burn the Maintenance Director's house down, from the time he hired at the facility two months prior. The Maintenance Director said, during the incident, he walked past Resident #1 in the hall and the Resident #1 hit him and began to yell and curse at him so the Maintenance Director said he began to record the resident with his cell phone to show management how the resident treated him. The Maintenance Director said after he recorded the resident's outburst, he went to the Administrator's office to show her, and he was told what he had done was not right and was told to immediately delete the video. The Maintenance Director further stated he did not know he was not supposed to record residents with his cell phone.</p> <p>Review of the Maintenance Director's personnel file reflected he had been trained on how to manage residents with behaviors on 07/30/24.</p> <p>Interview on 09/11/24 at 4:14 PM with the Administrator revealed after the incident, 09/10/24, the Maintenance Director went to her office and showed her a video of Resident #1 yelling and cursing at him. The Administrator said she told the Maintenance Director that recording the resident had not been right because he had violated the resident's right. The Administrator further stated a while back the Maintenance Director took a fan that belonged to the facility from Resident #1's room and the resident became upset therefore each time the resident saw the Maintenance Director he believed he would be taking his personal belongings.</p> <p>Review of the facility's undated employee handbook reflected the following:</p> <p>.Handheld Electronic Devices</p> <p>The presence or use of camera, camera-enabled mobile phones, and other handheld electronic devices in the workplace may interfere with productivity, create privacy concerns, and lead to problems, including privacy violations and the unauthorized disclosure of confidential business and personal health information</p> <p>2. Review of Resident #2's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included multiple sclerosis, cognitive communication deficit, and muscle weakness. The resident had a BIMS of 13 which indicated his cognition was moderately impaired.</p> <p>Review of Resident #2's care plan initiated on 06/20/24 reflected the resident refused care and could verbally and physically aggressive towards staff during care. Interventions included if the resident became combative, aggressive or refuse care, provide for safety, offer alternative time for care, back away, seek assistance as needed and notify the nurse of behaviors or refusal.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Provider Investigation Report dated 06/30/24 reflected the following: Nurse in charge reported that This writer arrived at the nurse station [sic] find iPhone cellphone at the desk which was taken away by the CNA on duty so that the resident can not call 911, charge nurse [sic]take the phone immediately back to the [Resident #2] and put it back in his room by the bed side and reported immediately to administrator/DON.</p> <p>Observation and interview on 09/10/24 at 10:22 AM with Resident #2 revealed he was in bed scrolling through his phone. He had a lot of food and food particles all over his bed and his draw sheet was soiled. The resident stated he did not staff change his linens and said he was fine. Resident #2 was asked about the incident when his phone was taken away and he said a staff, did not recall her name, had taken his phone when he tried to call the police and she had been fired. The resident did not go into details of incident and said he called the police often, but they would never press charges and would only talk to him. Resident #2 stated he felt safe at the facility and his phone had never been taken away again.</p> <p>Interview on 09/09/24 at 4:45 PM with CNA Q revealed Resident #2 had called the police multiple times during the days around 06/30/24 for various of non-emergency reasons. The resident had called the police on Friday (06/28/24) and when they showed up the DON appeared as though she was frustrated and while the police were there she made the comment to take Resident #2's phone if he tried to call again 911 again. On Sunday (06/30/24) she assisted CNA A to try to change Resident #2 because he had BM all over himself and he had been refusing to be changed. When CNA Q entered the room they began to change the resident and halfway through the care, he began to get upset, yell and curse and knocked his bedside table over on the floor. CNA Q said she left the room and a while later she saw CNA A come out of Resident #1's room with his cell phone, put it at the nurse's station and said she had to take it away because he tried to call 911. The charge nurse for the next shift arrived to work at that time and asked about the cell phone and when she was told what happened, the charge nurse stated they needed to take the cell phone back to the resident.</p> <p>Interview on 09/11/24 at 11:56 AM with CNA A revealed the days around the incident, 06/30/24, Resident #2 called the police many times and kept pressing his call light over and over from the time she arrived to work at 6:00 AM. On Friday, 06/28/24, Resident #2 called the police and while they were at the nurse's station, the DON said, if he tries to calls the police, take his phone away. On 06/30/24, she noticed Resident #2 had BM on himself and she explained to the resident that he needed to be changed and cleaned up. She and CNA B began to provide care to the resident and before they were done the resident began to resist and punched her in the stomach as she began to put his items on the bedside table. Resident #2 told her he was going to call the police, so she took his cell phone and put it at that nurse's station and explained to the charge nurse, did not recall which one, what had occurred and how she had been told to take the resident's phone away. CNA A was later told by the charge nurse to give the phone back to the resident. CNA A further stated she knew it was the resident's right to have his cell phone and call 911, but she said she had just followed the DON's orders and took the cell phone away.</p> <p>Interview on 09/12/24 at 10:24 AM with LVN S revealed CNA A told her Resident #2 was combative during care on, 06/30/24, and the resident wanted to call 911 so the CNA had taken the resident's phone away. LVN S said she told CNA A she needed to take the phone back to the resident and at that time RN R arrived at the facility for her shift and took over the situation.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 09/12/24 at 9:28 AM with RN R revealed on 06/30/24 she arrived at her shift at the facility and noticed there was a cell phone at the nurse's station. LVN S told her it belonged to Resident #2 and told her CNA A had taken it away from the resident because he tried to call 911. CNA A stated she had been instructed by the DON to take his phone away if he tried to call 911. CNA A was instructed to take the phone back to Resident #2 and she then called the DON. The DON told RN R she had never instructed CNA A to take the resident's phone away. RN R said she went to Resident #2 to ask what had occurred and he kept repeating over and over that his phone had been taken away. The resident would not let her assess him, but she did not notice any injuries at the time.</p> <p>Interview on 09/12/24 at 1:42 PM with the DON revealed Resident #2 had increased behaviors around the days of 06/30/24 where he was constantly calling 911 and the police showed up to the facility frequently. On Friday, 06/28/24, she told staff to monitor Resident #2 and redirect as needed but denied she told the staff to take his cell phone away. The day of the incident, 06/30/24, RN R called her to let her know CNA A had taken Resident #2's phone and RN C was instructed to return the cell phone to the resident immediately. The DON said it was a violation of the resident's right to have taken the phone away and it was his right to call 911 whenever he wanted.</p> <p>Interview on 09/12/24 at 2:37 PM with the Administrator revealed she was called by RN S and told CNA A had taken Resident #2's phone so he would not call 911. RN C told her she had returned the cell phone back to Resident #2. The Administrator said staff were not allowed to take the resident's personal belongings because it was a violation of their rights.</p> <p>Review of the Resident Rights provided by the facility on 09/10/24 reflected the following:</p> <p>Resident Rights</p> <p>Policy Statement</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>a. a dignified existence;</p> <p>.e. self-determination;</p> <p>f. communication with and access to people and services, both inside and outside the facility;</p> <p>.i. exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility;</p> <p>.x communicate with outside agencies (e.g., local, state, or federal officials )regarding any matter</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41781</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Resident #4) reviewed for accidents.</p> <p>The facility failed to ensure Resident #4 was provided with adequate supervision to prevent him from eloping from the facility's secured unit that was not in proper working condition on 07/24/24.</p> <p>The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 07/24/24 and ended on 07/26/24. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk of harm, severe injury, and possible death to residents who require supervision.</p> <p>Findings included:</p> <p>Review of Resident #4's Admission Record, dated 09/11/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included parkinsonism (not a single disease, but a term for a group of conditions that affect movement and mimic Parkinson's disease), schizoaffective disorder (A mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), and anxiety disorder (persistent and excessive distress that affects daily life).</p> <p>Review of Resident #4's Optional State Assessment MDS Assessment, dated 06/27/24, reflected he had a BIMS score of 11 indicating moderate cognitive impairment. Review of the section regarding behavior reflected there was no wandering behavior exhibited. There were no active diagnoses listed on Resident #4's MDS Assessment.</p> <p>Review of Resident #4's physician's orders reflected an order to admit the resident 0to the secured unit of the facility on 06/18/24.</p> <p>Review of Resident #4's care plan, revised 07/26/24 reflected the following: Focus: The resident is at risk for elopement/wandering r/t History of attempts to leave facility unattended, Impaired safety awareness, Resident wanders aimlessly .Goal: The resident will not leave facility unattended through the next review date .Interventions: Exit and stairwell alarms, Frequent Monitoring, 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. Staff aware of resident's wander risk.</p> <p>Review of Resident #4's July 2024 progress notes reflected staff documented the frequent monitoring of him from 07/26/24 to 07/29/24.</p> <p>Review of Resident #4's Elopement Risk Evaluation, dated 06/18/24, reflected a score of 3 putting him at risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #4's Elopement Risk Evaluation, dated 07/26/24, reflected a score of putting him at risk.</p> <p>Interview on 09/11/24 at 10:00 AM with Resident #4 revealed he remembered leaving the facility because the back door was open so he walked through it. Resident #4 said he did not hear an alarm going off when the door was open. Resident #4 said he wanted to go to the store and was by himself walking down the road and no one was with him. Resident #4 said he did not make it to the store because staff eventually caught up with him and put him in a car to take him back to the facility.</p> <p>Review of a provider investigation report reflected the following under the Investigation Summary section: On 07-24-2024 around 8 pm, [Resident #4] exited the back unit door and door alarm went off, staff promptly responded and ran after the resident and never losses sight off of the resident and returned him back to the facility safely, upon asking resident state that he wanted to walk to the convenience store. Head to toe assessment done no injury noted .elopement assessments completed .Facility checked the functioning of the back door and adjusted the door to ensure it closed completely and locked, additionally facility maintenance director changed the self closing hinge of the unit back door and started q 30 checking exit door by charge nurse and maintenance director daily. Staff were in serviced on elopement and an elopement drill was completed on all 3 shifts including weekends shift. Staff were in serviced on exit doors checking,proper functioning and reporting to maintenance director promptly in case of any technical error. Facility updated care plan of the resident,facility contacted residents rp but no one answered the call [sic].</p> <p>Review of the facility's maintenance log reflected the following: 7/26 and 7/27: Exit door by unit not properly latched/door frame sets loose/must be reset twice to ensure door is locked behind all exit doors must be checked daily for proper latching and closure reset [sic].</p> <p>Review of an invoice dated 08/09/24, from an Electronic Engineering company reflected the following: Description Service Call: Maglock on secure unit is going into delayed egress and needs to be adjusted .The second set of doors were located in the rear of the secured unit. Found that these doors were not locking and found no power present at the Maglock. Troubleshoot the XDT board and found no issues &amp; then traced the power wire to determine where it was receiving power from. While tracing the wire found an area that had been compacted near an AC duct. Cut and spliced the wire &amp; then reconnected all wires. After reconnecting the wires, tested the Maglock and the keypad and everything is now working as designed. Job complete.</p> <p>Attempted telephone interview on 09/10/24 at 3:31 PM with CNA F was unsuccessful as there was no answer or return call.</p> <p>A witness statement, dated 07/24/24, written and signed by CNA F reflected the following: I was in the room taking care of residence the I saw one resident through the window running then I first called the memory nurse that one of you resident is out side I then came back and call other staffs [sic].</p> <p>Attempted telephone interview on 09/10/24 at 3:33 PM to MA H was unsuccessful as there was no answer or return call.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An undated witness statement signed by MA H reflected the following: On Wednesday July 24th when I was about to pass the bedtime meds on bluebonnet the charge nurse came to me and ask me to check all rooms on bluebonnet if everyone was there. Before my charge nurse instruct me one of the nurse came on [the hall] call the CNA and say to him help him because she is looking for somebody [sic].</p> <p>Telephone interview on 09/10/24 at 3:38 PM with CNA K revealed she was in a room helping a resident and heard the nurse calling out for help. CNA K said she stayed behind to care for the residents while the other CNA left with the nurse to run after the resident. CNA K said the door alarm did not go off and the back door to the secured unit was wide open. CNA K explained that she had been trained on what do when a resident eloped from the facility.</p> <p>Telephone interview on 09/11/24 at 9:16 AM with CNA I revealed it was around 8:30 PM when she was in a room assisting a resident to bed and changing them. CNA I said she heard the nurse said a resident was out of the facility so she left to help the nurse. CNA I said the resident left through the back door of the secured unit and the door alarm did not go off. CNA I explained that she had been trained on what do when a resident eloped from the facility.</p> <p>Attempted telephone interview on 09/11/24 at 3:37 PM to LVN J was unsuccessful as there was no answer or return call.</p> <p>An undated witness statement reflected the following: I [LVN J], charge nurse on 7/24/24, [the facility's] Memory Care [unit], while admitting a new resident the alarm was sounded off. I checked around and noted [Resident #4] had gotten out of the building. I immediately went after the resident. [CNA F] also noted resident coming around the building headed toward [a street near the facility]. CNA made this nurse aware that she would notify other staff to assist getting [Resident #4] back in the building. We were able to safely get resident back on unit. I never lost sight of resident and made sure he was safe resident verbalized I'm ok, 'I just wanted to take a walk' [sic].</p> <p>Telephone interview on 09/11/24 at 9:45 AM with RN L revealed he was not working on the unit the day a resident eloped. RN L said he was helping to send a resident to the hospital and heard someone shout that a resident had eloped. RN L said he stayed in the facility to be with the other residents while the aide and nurse went to find the resident. RN L explained that she had been trained on what do when a resident eloped from the facility.</p> <p>Telephone interview on 09/11/24 at 9:37 AM with CNA M revealed he was doing rounds when the nurse (LVN G) called and said a resident ran outside and she needed help bringing him back to the facility. CNA M said he and LVN G found the resident before the stop light before the railroad down the street from the facility. CNA M said the laundry lady had put the resident in her car to drive him back to the facility. CNA M said it was very late at night and were worried about walking him back to the facility. CNA M explained that she had been trained on what do when a resident eloped from the facility.</p> <p>Interview on 09/11/24 at 10:37 AM with LVN N revealed she was not there the day Resident #4 eloped. LVN N said afterwards she continued to monitor him and completed every 15-minute checks on him for a week to make sure he was safe in the facility. LVN N said she was also told to check the exit door to the secured unit every shift to make sure it was working properly. LVN N said if the exit door was not working she was supposed to notify the Administrator and Maintenance Director immediately. LVN N explained that she had been trained on what do when a resident eloped from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 09/11/24 at 11:30 AM of the secured unit's exit door revealed it was locked and the keypad next to it had the light on indicating it was working. An attempt to push on the door to open it was unsuccessful, the door stayed closed and never opened. A piece of paper posted next to the door reflected: In case if alarm goes off, ensure that door is properly closed after resetting the password,if not than immediety inform Administrator/Maintenance Director and log it in Maintenance log book. Please ensure that residents are safely back in the unit and follow P/P of elopement. Thank you, management. [sic]</p> <p>Interview on 09/11/24 at 11:33 AM with the Maintenance Director revealed he had only been at the facility for two months. The Maintenance Director said he has had to fix the back door to the secured unit a few times. The Maintenance Director said the facility called an engineering company to come out and permanently fix the door. The Maintenance Director said since the repair no other residents have eloped from the secured unit. The Maintenance Director said the door used to be able to be opened after pushing on it for so long but now it would not open unless the fire alarm went off or the staff entered the code to unlock it. The Maintenance Director said this change was made because residents were setting the door alarm off too many times at night, and it would not lock back so he would have to go to the facility to fix it to secure the door. The Maintenance Director said he checked the secured unit exit door regularly and completed a log for it.</p> <p>Interview on 09/11/24 at 11:57 AM with the DON revealed she was told Resident #4 pushed through the secured unit's exit door and started running away from the facility. The DON said staff told her they ran after him, but he was running very fast. The DON said staff brought him back to the facility and he was not harmed but he did make it off the facility property. The DON said afterwards they in-serviced all their staff regarding elopements. The DON said they also completed elopement drills and completed an elopement assessment on Resident #4. The DON said the Administrator had a company come out to fix the door as well. The DON said the facility knew Resident #4 was at risk of elopement because he came from another facility that did not have a secured unit where he was trying to elope from there. The DON said a lot can happen when a resident elopes from the facility such as they can be out of food and be hungry, become dehydrated, could be hit by a car, or could die. The DON said all staff were responsible for making sure residents do not elope.</p> <p>Interview on 09/11/24 at 12:20 PM with the Administrator revealed the DON told her that Resident #4 had eloped from the facility. The Administrator said Resident #4 had opened the door and the door alarm went off the nurse saw him and left after him, but he was very fast. The Administrator said multiple staff left to find Resident #4 and they found him on a road near the facility. The Administrator said staff got Resident #4 in one of their cars to bring him back to the facility. The Administrator said Resident #4 was not harmed and told staff he was going to the convenient store to get something. The Administrator said staff were in-serviced on elopements after the incident occurred. The Administrator said the nurse completed multiple assessments on Resident #4 such as skin, pain, and a head to toe which resulted in no findings. The Administrator said an elopement risk evaluation was also completed on Resident #4. The Administrator said the Maintenance Director checked the door and thought there was a glitch in the door alarm or something. The Administrator said they monitored the door for functionality for the next 72 hours and called an engineering company to fix it. The Administrator said two elopement drills were completed, one on 07/25/24 and one on 07/27/24. The Administrator said they knew Resident #4 was an elopement risk when he admitted because he was from another nursing facility where he wandered a lot and was at risk of eloping. The Administrator said anything can happen to a resident when they elope, and all staff were responsible for ensuring they did not.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 09/11/24 at 2:22 PM with CNA D revealed she had been trained on what do when a resident eloped from the facility.</p> <p>Telephone interview on 09/12/24 at 8:52 AM with LVN G revealed an aide called that a resident had left the building. LVN G said she went out of the facility and tried to follow that aide and saw another aide also trying to find the resident. LVN G said she saw one of the laundry ladies take her car and drive off to find the resident. LVN G said she went out to road and off to the side she saw a nurse and an aide with the resident. LVN G said they found the resident around [street name] before the train tracks. LVN G explained that she had been trained on what do when a resident eloped from the facility.</p> <p>Interview on 09/12/24 at 9:16 AM with LVN B revealed she had been trained on what do when a resident eloped from the facility.</p> <p>Interview on 09/12/24 at 10:34 AM with LVN O revealed she had been trained on what do when a resident eloped from the facility.</p> <p>Interview on 09/12/24 at 10:55 AM with CNA P revealed she had been trained on what do when a resident eloped from the facility.</p> <p>The Administrator was notified on 09/11/24 at 4:05 PM, that a past non-compliance IJ situation had been identified due to the above failures.</p> <p>It was determined this failure placed Resident #4 in an IJ situation on 07/24/24.</p> <p>The facility implemented the following interventions:</p> <p>Review of an Elopement Tool worksheet reflected the facility held an elopement drill on 07/27/24.</p> <p>Review of an Elopement Drill/Actual Event Participation Log reflected a date of 07/25/24.</p> <p>Review of an Elopement Drill/Actual Event Participation Log reflected a date of 07/26/24.</p> <p>Review of an Elopement Prevention and Management Program Evaluation worksheet reflected it had been completed.</p> <p>Review of an Exit Doors Check worksheet reflected the secured unit door was checked daily from 07/01/24 to 07/25/24.</p> <p>Review of Enhanced Supervision Monitoring Tools reflect staff were signing off that they had monitored the secured unit exit door on the following dates: 07/26/24, 07/27/24, 07/28/24, 07/29/24, 07/30/24, 08/01/24, 08/02/24, 08/03/24, 08/04/24, 08/05/24, 08/06/24, 08/07/24, 08/08/24, 08/10/24, and 08/11/24.</p> <p>Review of a sheet of paper titled Facility Personal Safety Device and Exit Door Alarm Testing Log for July 2024 reflected there were checks on all the doors, including the secured unit exit door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an in-service titled Elopement and wandering policy and procedure aims to prevent and manage situations where individuals, particularly those with cognitive impairment, leave a designated safe area without authorization or supervision dated 07/26/24 reflected staff had been trained on the facility's policy and procedures.</p> <p>Review of an in-service titled Abuse and neglect, reporting abuse and neglect, forms of abuse, rounding Q 30 minutes in unit, rounding Q hour on the floor dated 07/26/24 reflected staff had been trained on the facility's policy and procedures.</p> <p>Review of an in-service titled Door exits/alarms ringing, all staff must ensure after resetting the password the exit doors are latched/closed and properly functioning dated 07/26/24 reflected staff had been trained on the facility's policy and procedures.</p> <p>Review of the facility's undated policy, titled Elopement reflected: .2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary .4. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41781</p> <p>Based on observation, interview, and record review, the facility failed to ensure that menus were followed for 1 of 3 meals (lunch on 09/10/24) reviewed for meal accuracy.</p> <p>The facility failed to serve pureed bread during the lunch meal on 09/10/24 to all eight residents (Residents #5, #8, #9, #10, #11, #12, #13, and #14) who required a pureed diet.</p> <p>This failure could place residents at risk for poor intake and weight loss.</p> <p>Findings included:</p> <p>Review of Resident #5's admission record, dated 09/11/24, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident #5's Quarterly MDS Assessment, dated 08/26/24, reflected he had a BIMS score of 99 indicating he was unable to complete the interview. His active diagnoses included non-alzheimer's dementia and malnutrition. Further review reflected Resident #5 received a therapeutic diet.</p> <p>Review of Resident #5's physician's orders reflected an order for pureed diet with a start date of 08/21/24.</p> <p>Observation on 09/10/24 at 12:07 PM of the facility's dining room revealed the steamtables with the lunch meal on it.</p> <p>Interview on 09/10/24 at 12:09 PM with [NAME] C revealed he listed off the following items that were to be served to residents for the lunch meal: baked pork chops, mixed vegetables, rice, and a roll. [NAME] C said he had the same items for the mechanical soft and pureed diets.</p> <p>Observation and interview on 09/10/24 at 12:10 PM with [NAME] C plating Resident #5's lunch meal revealed there were three scoops on the plate. [NAME] C said there was a scoop of meat, a scoop of potatoes, and a scoop of vegetables on the plate for Resident #5 who required a pureed diet.</p> <p>Observation on 09/10/24 at 1:10 PM of a sample tray provided by the facility's kitchen revealed a plate of pureed food consisting of mashed potatoes, meat, and vegetables.</p> <p>Interview on 09/10/24 at 1:23 PM with the DM revealed the pureed bread was not served during the lunch meal service earlier in the day because [NAME] C forgot to make it. The DM said [NAME] C was responsible for making the pureed bread and she normally followed up to make sure all components were made and ready to be served but she was busy with something else. The DM said she expected all residents to receive the same meal for each diet they required. The DM said the purpose of that was to make sure every resident got what they were supposed to on their plate. The DM said if a meal component was missing often from a resident's plate they would have nutrition values missing from their diet.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 09/10/24 at 1:37 PM with [NAME] C revealed he cooked all the food for the lunch meal earlier in the day. [NAME] C said he forgot to make the pureed bread, so it was not served to the residents.</p> <p>Review of a list of residents who required a pureed diet reflected there were eight total residents, including Residents #5, #8, #9, #10, #11, #12, #13, and #14.</p> <p>Review of the facility's Spring/Summer 24- Week 3 menu for Tuesday reflected: smother pork chop, confetti rice, braised red and green cabbage, and cornbread.</p> <p>Review of the facility's undated policy, titled Menus, reflected: 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences).</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41781</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for one of three staff (Cook C) and one of one kitchen reviewed for kitchen sanitation.</p> <p>Cook C failed to wear a beard restraint on 09/10/2024 while in the food preparation area and while serving the lunch meal service.</p> <p>This failure could place residents at risk for food contamination and foodborne illness.</p> <p>Findings included:</p> <p>Observation on 09/10/24 at 9:46 AM of the kitchen revealed [NAME] C had facial hair on his chin, and he was not wearing a beard restraint. [NAME] C was observed using the blender to make the pureed meat for the lunch service.</p> <p>Observation on 09/10/24 at 12:07 PM of the dining room revealed the facility's kitchen steamtables with the food being served to residents for the lunch meal service. [NAME] C had facial hair on his chin but was not wearing a beard restraint. [NAME] C began plating resident's meals.</p> <p>Interview on 09/10/24 at 1:23 PM with the DM revealed [NAME] C had facial hair but she had never heard of a beard restraint before. The DM said she did not have any beard restraints available in the kitchen for staff to use if they did have facial hair. The DM said the purpose of wearing a beard restraint was to catch hair so it would not fall into the resident's food. The DM said if that were to happen it could contaminate the food.</p> <p>Interview on 09/10/24 at 1:37 PM with [NAME] C revealed he did have facial hair but was not wearing a beard restraint because there were not any available in the kitchen.</p> <p>Review of the undated facility's policy, titled Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices reflected: 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.</p> <p>Record review of the Federal Food Code 2022 reflected: 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (1) Wearing outer garments suitable to the operation (4) Removing all unsecured jewelry (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints (8) Confining .eating food, chewing gum, drinking beverages or using tobacco and (9) Taking other necessary precautions</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>41781</p> <p>Based on observations, interviews, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests 1 of 5 (Resident #6) resident rooms, and 1 of 3 (Sunflower hallway) dining areas reviewed for environment.</p> <p>The facility failed to ensure Resident #6's room and Sunflower hallway were free of small brown bugs on 09/10/24 and 09/11/24.</p> <p>This failure could place residents at risk for insect borne illness, not having a home free of pests and a comfortable environment in which to live.</p> <p>Findings included:</p> <p>Interview on 09/10/24 at 3:15 PM with Resident #3 revealed he found cockroaches and bugs in his room every night. Resident #3 said the bugs crawled in his shoes, so he always had to check them before he put his feet in them.</p> <p>Interview on 09/10/24 at 3:50 PM with Resident #7 revealed she saw bugs in her room every day and all throughout the facility. Resident #7 said she told staff about the bugs, and they never did anything about them.</p> <p>Observation and interview on 09/11/24 at 8:54 AM in Resident #6's room revealed there were two small brown bugs crawling across the room. The Admissions Coordinator was also in the room and said they were moving Resident #6 across the hallway while he was at dialysis. The Admissions Coordinator stepped on both bugs to squish them.</p> <p>Observation on 09/11/24 at 1:47 PM of the Sunflower hallway revealed there was one small brown bug crawling up the wall. There was also another small brown bug crawling on the floor and into the shower room.</p> <p>Interview on 09/11/24 at 2:22 PM with CNA D revealed they saw bugs in some resident rooms and in the hallways of the facility often. CNA D said they saw a bug earlier today on the memory care unit. CNA D said when they saw bugs anywhere in the facility they let the nurse know.</p> <p>Interview on 09/11/24 at 11:33 AM with the Maintenance Director revealed he had heard from 3 staff that there were pests in the facility. The Maintenance Director said when staff saw the bugs, they put the information in the maintenance logbook. The Maintenance Director said he had the pest control company coming out regularly but there was only so much he could do about the bugs in the facility.</p> <p>Interview on 09/12/24 at 9:47 AM with LVN E revealed they saw bugs everywhere in the facility, and they always told the department heads about them.</p> <p>Interview on 09/12/24 at 10:34 AM with LVN F revealed they saw bugs all over the facility. LVN F said when they saw the bugs they would log it into the maintenance book and tell the Maintenance Director.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 09/12/24 at 2:15 PM with the Administrator revealed she had heard from staff that there were pests in the facility. The Administrator said the pest control company came to spray every two weeks and as needed when staff reported seeing pests. The Administrator said when staff saw pests, they were supposed to write that information into the maintenance logbook. The Administrator said the purpose of having a pest-free environment was that it could cause a sanitation or contamination problem.</p> <p>Review of the facility's Maintenance Request Logs reflected the following:</p> <ul style="list-style-type: none"> <li>- 09/11/24 Pest control Rm 137</li> <li>- 7/25/24 136 pt. said roaches in rm</li> <li>- 8/22 bluebonnet roach in hall</li> </ul> <p>Review of the facility's policy, revised 04/11/24, and titled Pest Control reflected: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Any pest sightings are to be communicated to facility management: Administrator and Director of Nursing and written in the Maintenance Work Order Binder immediately.</p>