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	12/13/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurate in accordance with accepted professional standards and practices for 1 of 7 residents (Resident #1) whose clinical records were reviewed. The facility failed to ensure Resident #1's MAR was accurately and completely documented in their permanent clinical record on [DATE]. This failure could place all the residents, who resided in the facility, at risk for inaccurate or incomplete clinical records. Findings included: Record review of Resident #1's Face Sheet dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses which included acute combines systolic and diastolic heart failure (congestive heart failure), Type 2 diabetes (body does not produce insulin to maintain normal glucose levels), Stage 4 chronic kidney disease (advanced kidney damage requiring dialysis), and morbid (severe) obesity. The resident discharged from the facility on [DATE] to the hospital. Record review of Resident #1's last quarterly MDS dated [DATE] reflected the resident had severe cognitive impairment with a BIMS score of 3 (a score of ,d+[DATE] indicated severe cognitive impairment). She required substantial of one staff for dressing, toilet use, personal hygiene, and transfers. She required only supervision for her other activities of daily living. She was frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #1's SBAR Change of Condition Form dated [DATE] at 6:39 AM reflected Resident #1 was sent to hospital due to a fall. Record review of Resident #1's Progress Note dated [DATE] at 3:49 PM and signed by the DON reflected: [Resident #1's] family member and family came to the facility to get [Resident #1's] belongings and stated [Resident #1] expired early this morning at the hospital. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Resident #1's EHR reflected the following vitals recorded for Resident #1 on [DATE]: Blood pressure, ,d+[DATE] mmHg at 5:27 PM; and blood sugar, 100 mg/dL at 5:28 PM and pulse, 70 bpm at 5:27 PM signed by LVN A. Pulse, 78 bpm at 6:14 PM and O2 saturation, 97% at 6:14 PM signed by LVN B. Record review of Resident #1's eMAR Medical Administration Notes dated [DATE] and signed by LVN A reflected at 5:26 PM the resident refused Apixaban and at 5:27 PM the resident refused Carvedilol. Record review of Resident #1's eMAR Medical Administration Notes dated [DATE] and signed by LVN B reflected the resident refused Reglan at 6:15 PM, at 6:16 PM refused Apixaban, at 6:17 PM refused Caltrate, at 6:18 PM refused Carvedilol and at 6:19 PM refused insulin. In an interview on [DATE] at 10:45 AM, LVN B said she did not work on [DATE]. She said she called in and LVN A was working. She said it was possible for another nurse to document under her name because she had her password saved in the computer. She said the documentation should reflect Resident #1 was in the hospital, and it would be impossible for anyone to take vitals since Resident #1 was not in the facility at the time the vitals were recorded. In an interview on [DATE] at 11:02 AM, the DON and ADON said they thought the nurses had saved their passwords in the computer and did not pay attention when entering documentation. The DON said she entered in the nurse noted on [DATE] when Resident #1's family came to the facility to retrieve her things and informed her that Resident #1 had passed at the hospital that morning. She stated based on that information, it was impossible to take Resident #1's vitals or for her to refuse medications because Resident #1 was not in the facility and had already passed by the time the documentation was entered. She stated documenting incorrectly in the EMR placed residents at risk of not getting appropriate treatment or follow up. She said she had completed an in-service on securing passwords and documentation in the past but will start another one. She said she did not want anyone having access to another staff's password for documentation. In a telephone interview on [DATE] at 11:21 AM, LVN A stated she did work on [DATE]. She said she did recall Resident #1 was sent to the hospital on [DATE]. LVN A said she did document that Resident #1 refused her medications on [DATE]. She said she was not sure if she documented under LVN B's password but said it could have been possible because when she got busy, she did not always check. LVN A said she did not recall that Resident #1 was not in the facility when she documented Resident #1's vitals and medication refusals. She said if the resident was not in the facility, they should be removed from the MAR so mistakes could not occur. When asked how she ensured residents were in the facility, she said she rounded at the beginning of the shift. She said when she administered medications, she checked to see that she had the right medication and the right resident before administration. LVN A did not have an explanation for documenting Resident #1's vitals or medication refusals on [DATE] when Resident #1 was not in the facility. She said doing that could place residents at risk of not getting appropriate care. Record review of the facility's, Daily Position Sheet, reflected LVN B was scheduled to work; however. LVN B's name was crossed out and replaced with LVN A on [DATE]. Record review of the facility's in-service record dated [DATE] and titled, POC Documentation, charting and documentation, reflected it was delivered by the ADON. The sign-in sheet included LVN A. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled, Charting and documentation, reflected: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy .