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	02/06/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 3 of 16 rooms (Rooms #118, #126, and #147) and 2 of 14 residents (Resident #37 and Resident #66) reviewed for clean, comfortable, and homelike environment and clean bed and bath linens that are in good condition. 1. The facility failed to replace stained ceiling tiles in room [ROOM NUMBER] 2. The facility failed to repair a ceiling HVAC vent in room [ROOM NUMBER]. 3. The facility failed to maintain a clean environment for Resident #37. 4. The facility failed to ensure there was an adequate supply of linens to meet resident needs. 5. The facility failed to repair the room door for Resident #66. This failure placed residents at risk of decreased feelings of self-worth and possible infections. Findings included: 1. Observation on 02/04/25 at 9:35 AM revealed the ceiling tiles above the Resident #48's bed had multiple brown stains on three ceiling tiles. The resident stated the tiles had been stained for over a month. The resident stated he notified nursing staff about them, but no one ever did anything about it. 2. Observation on 02/04/25 at 9:41 AM revealed the ceiling vent in Resident #9's room was missing one screw and was hanging down, only one screw was preventing it from falling. The vent was not directly above the resident's bed. The resident was non-verbal and could not state how long the vent had been like that. (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

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 02/06/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation and interview on 02/04/25 at 11:00 AM with Resident #37 revealed the resident's fitted sheets had multiple large, dark yellow stains. Resident #37 stated that his sheets had not been changed in approximately six days. Resident #37 also said that staff told him that there was no clean linen available. Resident #37 could not recall the names of the aides that told him no clean linen was available. Observation on 02/04/25 at 11:10 AM of linen closet A revealed 14 resident hospital gowns were available. No other linen was available in the closet. Observation on 02/04/25 at 11:30 AM of linen closet B revealed 13 hospital gowns and 6 fitted sheets were available. No other linen was available. Observation on 02/04/25 at 3:04 PM of the laundry facilities revealed there was no clean linen for residents' beds. No clean fitted sheets or clean top sheets were observed. Interview and observation on 02/04/25 at 11:24 AM CNA K revealed linens should be changed when residents were showered and when they were dirty. CNA K stated that she had not changed Resident #37's linens because she had been busy providing patient care to other residents. CNA K stated she was PRN; therefore, she did not know how long Resident #37's sheets had been on his bed. CNA K then went to linen closet A, and there was no clean linen was available. CNA K and surveyor then went to linen closet B. Only six fitted sheets were available. CNA K revealed that when clean linen was not available in the linen closets, she would go to the laundry facilities to locate clean linen. CNA K stated that it was her responsibility to ensure that residents had clean linen on their beds. Interview on 02/04/25 at 3:02 PM with the Laundry Supervisor revealed that she was aware that the facility had a shortage of linen. The Laundry Supervisor stated that she knew that the Administrator had purchased new linen. However, the Laundry Supervisor revealed that she believed that staff were throwing dirty linens in the garbage instead of sending them to the laundry. The Laundry Supervisor stated that the facility had one functioning residential washing machine. The Laundry Supervisor stated that the laundry department ran two shifts per day to attempt to keep up with the facility's laundry. The Laundry Supervisor said that the first shift was 6:00 AM to 2:00 PM and the second shift was 4:00 PM to 12:00 AM. The Laundry Supervisor stated that it was her responsibility to ensure that the linens in the facility were clean so that staff could change the residents' bed linens in a timely manner. The Laundry Supervisor revealed that she had notified the Administrator of the shortage of linen in the facility but did not say the specific date or time. The Laundry Supervisor did not have access to the facility to the facility policy on linen. Interview on 02/04/25 at 3:06 PM with the Administrator revealed that he was aware of the shortage of linen at the facility. The Administrator stated that he had made multiple orders of linen since his employment at the facility beginning at the end of December 2024. The Administrator said that he believed staff were throwing the linen in the thrash instead of rinsing them off and taking them to the laundry room. The Administrator revealed that part of reason for the shortage of linen in the facility was because the facility had only one working residential washing machine. The Administrator stated that corporate had not approved a commercial washing machine within his allowed budget to purchase for the facility. The Administrator stated that it was his responsibility to ensure enough linen was available to meet the daily needs of the residents. The Administrator revealed he was aware that there was not enough linen in the facility to meet the daily needs of the residents. The Administrator did not know the facility policy on linen. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation and interview on 02/04/25 at 11:15 AM, of Resident #66 room door to be broken, an attempt was made to enter; however, Resident #66 had a wheelchair behind the door that made it difficult to open. Resident #66 moved her wheelchair and gave permission to enter. Observed Resident #66 door to not latch and would keep the door open. Resident #66 stated her door had been broken for a couple of months, unknown of the exact time. She stated she kept her wheelchair by the door so that other residents do not come in her room. She stated her restroom had another door where she could enter and exit her room. Interview on 02/06/25 at 11:01 AM, with CNA B revealed she was aware of Resident #66's door not closing; she does not know how it broke. CNA B stated she had Resident #66 usually puts her wheelchair by the door to close it. She stated she does not know how long the door had been broken. CNA B stated she had notified the maintenance staff about it, but it had not been fixed. She stated she could not recall when she notified the maintenance staff. Interview on 02/06/25 at 11:09 AM, with LVN M revealed she had not noticed Resident #66's door did not close. She stated usually Resident #66 kept her door closed by using the wheelchair. LVN M stated Resident #66 would use the bathroom door to enter and exit her room. She stated she was unsure if the maintenance staff was aware that it needed to be fixed. She stated it was the responsibility of the nurses to notify maintenance staff if any maintenance was needed in a room. Interview on 02/06/25 at 3:25 PM, with Maintenance Director revealed he was aware Resident #66 room door was broken, it would not close. He stated he was told a resident had kicked it and it broke the latch and would not close. Maintenance Director stated he was told about a week ago, unknown of the exact date. He stated Resident #66 liked her door closed and would usually keep her wheelchair by the door to close it. He stated it was the resident rights to have a door that closes and opens properly. Review of the facility's undated policy Quality of Life- Homelike Environment reflected the following: Residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. . 2. The facility staff and management shall maximize, the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. Clean, sanitary, and orderly environment e. Clean bed and bath linens that were in good condition. 44140 48236

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure residents had the to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, for 1 of 4 residents (Resident #9) reviewed for restraints. The facility failed to care plan for Reisdent #9's half bedrails. This failure could place the resident at risk of entrapment or restraint. Findings included: Record review of Resident #9's undated Admission Record reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included muscle weakness, personal care assistance, and diabetes. Record review of Resident #9's annual MDS reflected a BIMS score of 5 indicating she had severe cognitive impairment. Her Functional Status indicated she required assistance with all her ADLs. Record review of Resident #9's care plan dated 12/05/25 reflected she was at risk for falls and required assitance with transfers, she was at risk for skin breakdown related to decreased mobility and she had short term memory issues. The resident was not care planned for bedrail use. Observation and interview on 02/04/25 at 1:42 PM Resident #9 was in bed, bed was not in low position, and the bed had half bedrails in place on both sides of the bed. Resident #9 was unable to follow requests to use the bedrails to reposition herself. Record review of Resident #9's EHR reflected she had a physician order for bedrails for mobility. Resident was not assessed for bedrail safety, and there was no consent for bedrail use signed by her Responsible Party. Interview on 02/06/25 at 1:55 PM CNA I stated Resident #9 did not use the bedrails for mobility. Residnt #9 would grab onto the rail when she was being turned for incontient care. She stated the resident did not get out of bed on her own because she would fall. Interview on 02/06/25 at 2:00 PM the DON stated bedrails could only be used for mobility, not for keeping the resident in bed. She stated she was unaware Resident #9's bedrails were half rails instead of mobility bars. The DON stated the resident needed a physician order for moblity bars, then needed to have consent to use them, and be assessed for safety related to the bars. Record review of the facility's undated Proper Use of Side Rails policy reflected: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed). (Note: The side rails may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed ' s dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48236 Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and of exploitation of residents and misappropriation of resident property for 1 of 8 employees (CNA D) reviewed for employment registry screenings. The facility failed to ensure a search of the EMR/NAR was completed for CNA D prior to employment and before providing direct patient care. This failure could place residents at risk for abuse, neglect, exploitation and misappropriation of property. Record review of CNA D's personnel file reflected a hire date of 07/07/23 and no EMR/NAR check was completed prior to this date. Interview on 02/06/22 at 12:12 PM with the HR Manager revealed she began working at the facility in March of 2024. The HR Manager stated that CNA D had no EMR/NAR checks completed prior to her employment and hire date of 07/07/2023 nor the annual EMR/NAR check. The HR Manager stated that she discovered this when she was asked by this surveyor for the documentation. The HR Manager said that it was her responsibility to complete the annual EMR/NAR background checks for staff as well as upon hire. The HR Manager revealed that the staff member was suspended immediately until the EMR/NAR check was completed. The HR Manager stated that EMR/NAR checks were important to prevent abuse and neglect to residents. Interview on 02/06/25 at 1:12 PM with the Administrator revealed EMR/NAR checks were supposed to be completed upon hire and annually by the HR Manager. The Administrator stated it was his responsibility to monitor that EMR/NAR checks were completed annually and upon hire. The Administrator revealed the importance of EMR/NAR checks were to prevent potential harm to a resident. Record review of the facility's current, undated Abuse Prevention Program reflected the following: .2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 3 of 14 residents (Residents #29, #48, and #57) reviewed for ADLs. The facility failed to ensure Resident #29, #48, and #57 received showers as scheduled. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. Findings included: Record review of Resident #29's Quarterly MDS Assessment, dated 01/23/25, reflected the resident was a [AGE] year-old female who was first admitted to the facility on [DATE], readmitted on [DATE], and then readmitted again on 11/20/24. Resident #29 had a BIMS score of 15, which indicated her cognition was intact. Her diagnosis included quadriplegia (paralysis of all four limbs), neurogenic bladder (urinary problems caused by nerve problems affecting bladder control), and osteomyelitis of vertebra, sacral and sacrococcygeal region (spinal infection in the sacrum). The MDS further review reflected Resident #29 was dependent on staff regarding bathing. Record review of Resident #29's Care Plan, dated 02/05/25, reflected Focus: Resident #29 has an ADL Self Care Performance Deficit r/t quadriplegia. Goal: The resident will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, mobility through the review date. Interventions: Eating-The resident requires max staff participation to eat. Bed Mobility- The resident requires max X 2 staff participation to reposition and turn in bed. Transfer- The resident requires total dependence X 2 staff participation with transfers. Toilet use- The resident requires total staff participation to use toilet. The care plan did not address Bathing/Showering. Record review of Resident #29's POC Response History for 01/24/25 to 02/06/25 under Task - ADL- Bathing reflected no showers or bed baths provided during the time period and no indications of refusals. Record review of Resident #29's Shower Sheets completed by the facility CNAs reflected Resident #29 refused showers on: 01/14/25 twice, 01/30/25, 01/18/25, and 02/01/25 and received showers on 01/07/25 and 01/16/25. Record review of Resident # 48's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included total paralysis related to multiple sclerosis. Record review of Resident #48's quarterly MDS, dated [DATE], reflected a BIMS score of 14 indicating he was cognitively intact. His Functional Status reflected he was totally dependent on staff for his ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #48's care plan, dated 12/08/24, reflected it was not individualized to the resident, he had a pressure ulcer, and had a self-care deficit. Record review of Resident #48's shower sheets for December 2024 and January 2025 reflected he had a bed bath on 01/13/25, and 01/26/25. Record review of Resident #57's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes, morbid obesity, heart failure, and high blood pressure. Record review of Resident #57's quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicated he required substantial assistance with his bathing and ADLs. Record review of Resident #57's care plan, dated 11/29/24, reflected he refused care, becoming verbally abusive towards staff. He also had an ADL self-care deficit requiring mas staff participation with hygiene. Record review of Resident #57's shower sheets for December 2024 and January 2025 reflected a bed bath on 12/30/24, 1/13/25, 1/15/25, and 1/22/25. He refused a bed bath on 1/1/25 and 1/8/25. Observation and interview on 02/04/25 at 11:33 AM revealed Resident #48 was in bed. His sheets had brown stains surrounding his body, his blanket had red stains on it. Resident #48's hair was unkempt and appeared greasy. There was a strong odor of body odor about the resident. Resident #48 stated he did not recall his last bath, and his sheets had not been changed in a long time. Resident #48 stated the red stain on his blanket was from a spilled drink from three days prior. Observation and interview on 02/04/25 at 12:05 PM revealed Resident #29 had not been bathed in three weeks. Resident #29's shower days were Tuesday, Thursday, and Saturdays Resident #29 stated she had not been showered because she was told by staff that there were no clean linen and no clean towels. Resident #29 said that she could not recall the name of staff that told her she could not be showered. Resident #29 stated she did not feel like a lady. Resident #29 also stated she had more than one wound on her that required wound care treatment. Observation and interview on 02/04/25 at 12:27 PM revealed Resident #57's linen had large brown stains outlining his body, a heavy smell of body odor. Resident #57 stated his sheets had not been changed in over a week, he stated he had heard from staff the washing machine was broken and there was not enough linen. Resident #57 stated he did refuse a bed bath if the staff did not have clean linen for his bed, Why wash up just to get back into filthy bed?. Interview on 02/05/25 at 11:41 AM CNA I revealed Resident #29 was a Tuesday, Thursday, and Saturday shower. CNA I stated it was the CNA's responsibility to offer showers and document refused showers. CNA I said that if a resident refuses a shower, she would report it to her nurse. CNA I also stated Resident #29 often refused showers and other personal care like wound care. When asked if Resident #29 was offered more than seven showers in the last 30 days, CNA I stated she was. CNA I stated she did not know where more shower sheets showing Resident #29's refusals were located. CNA I said that showers were important because it could increase bed sores and smells. CNA I did not recall her last in-service on ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/05/25 at 11:48 AM LVN J revealed showers were supposed to be offered three times per week, three times per shift, and as needed or requested. LVN J stated Resident #29 being offered seven showers during the last 30 days was not sufficient. LVN J said that if a resident refused a shower, the aide was supposed to notify the nurse. LVN stated the nurse should educate Resident #29 about the importance of showers. LVN J stated the nurse should offer to shower the resident again at this time. LVN J stated the resident's skin was best assessed when the resident was showered, and the resident was more comfortable when they were clean. LVN J also said that if a resident did not receive regular showers, it could lead to skin breakdown. LVN J stated Resident J often refused showers for an entire week. LVN J stated the shower sheets could not be located, and it was not documented in the facility POC Response History, Task-ADL-Bathing portion of the facility EHR. LVN J revealed if a resident refused a shower, the family and DON should be notified. Interview on 02/06/25 at 3:31 PM the ADON revealed residents should be offered showers three times per week and three times per shift. The ADON stated if the resident refused a shower, then the nurse should be notified by the aide. Then the nurse should alert the family, ADON, and the DON about the shower refusal. The ADON said that if a resident continued to decline a shower, she would notify the DON and the family. The ADON stated the importance of showers was for infection control, dignity, resident rights, skin issues, and so that the resident feels comfortable. The ADON revealed she would also educate the resident on the importance of showers when she was notified about shower refusals. The ADON stated Resident #29 was offered showers and refused them, but she could not locate shower sheets, and it was not documented in the EHR. The ADON said that it was the nurse's responsibility to document the resident shower refusals and that she would notify the DON and Administrator if she saw refusals not documented. Interview on 02/07/25 at 9:55 AM the DON revealed residents should be offered showers three times per week by the aides. And if the resident refuses, the nurse should go and offer another shower during that shift after the aide notifies the nurse of the refusal. If the resident refuses the shower, the nurse will educate the resident on the importance of a shower. The DON stated if the resident continued to refuse a shower, then the resident's family would be notified. The DON said that refusals should be documented by both the aide and the charge nurse. The DON revealed showers were important because without them there was a risk of skin breakdown and infection and a loss of dignity. Record Review of facility undated policy Activities of Daily Living (ADLs), Supporting reflected the following: 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 were unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.2. Appropriate care and services will be provided for residents who were 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); 48236 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 3 of 14 residents (Residents #29, #48, and #57) reviewed for ADLs. The facility failed to ensure Resident #29, #48, and #57 received showers as scheduled. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. The findings include: Record Review of Resident #29's Quarterly MDS Assessment, dated 01/23/25, reflected a [AGE] year-old female who was first admitted to the facility on [DATE], readmitted on [DATE], and then readmitted again on 11/20/24. Resident #29 had a BIMS score of 15, which indicated her cognition was intact. Her diagnosis included quadriplegia (paralysis of all four limbs), neurogenic bladder (urinary problems caused by nerve problems affecting bladder control), and osteomyelitis of vertebra, sacral and sacrococcygeal region (spinal infection in the sacrum). MDS further review reflected Resident #29 was dependent on staff regarding bathing. Record Review of Resident #29's Care Plan, dated 02/05/25, reflected Focus: Resident #29 has an ADL Self Care Performance Deficit r/t quadriplegia. Goal: The resident will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, mobility through the review date. Interventions: Eating-The resident requires max staff participation to eat. Bed Mobility- The resident requires max X 2 staff participation to reposition and turn in bed. Transfer- The resident requires total dependence X 2 staff participation with transfers. Toilet use- The resident requires total staff participation to use toilet. The care plan did not address Bathing/Showering. Record Review of Resident #29's POC Response History for 01/24/25 to 02/06/25 under Task - ADL-Bathing reflected no showers or bed baths provided during the time period and no indications of refusals. Record Review of Resident #29's Shower Sheets completed by the facility CNA's reflected Resident #29 refused showers on:1/14/25 X 2, 1/30/25, 1/18/25, and 02/01/25 and received showers on 1/7/25 and 1/16/25. Record review of Resident # 48's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included total paralysis related to multiple sclerosis. Record review of Resident #48's quarterly MDS, dated [DATE], reflected a BIMS score of 14 indicating he was cognitively intact. His Functional Status reflected he was totally dependent on staff for his ADLs. Record review of Resident #48's care plan, dated 12/08/24, reflected it was not individualized to the resident, he had a pressure ulcer, and had a self-care deficit. (continued on next page)

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 02/06/2025
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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #48's shower sheets for December and January reflected he had a bed bath on 1/13/25, and 1/26/25. Record review of Resident #57's undated Admission Record reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes, morbid obesity, heart failure, and high blood pressure. Record review of Resident #57's quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicated he required substantial assistance with his bathing and ADLs. Record review of Resident #57's care plan, dated 11/29/24, reflected he refused care, becoming verbally abusive towards staff. He also had an ADL self-care deficit requiring mas staff participation with hygiene. Record review of Resident #57's shower sheets for December and January reflected a bed bath on 12/30/24, 1/13/25, 1/15/25, and 1/22/25. He refused a bed bath on 1/1/25 and 1/8/25. Observation and interview on 02/04/25 at 11:33 AM Resident #48 was in bed. His sheets had brown stains surrounding his body, his blanket had red stains on it. Resident #48's hair was unkempt and appeared greasy. There was a strong odor of body odor about the resident. Resident #48 stated he did not recall his last bath, and his sheets had not been changed in a long time. Resident #48 stated the red stain on his blanket was from a spilled drink from three days prior. Observation and interview on 02/04/25 at 12:05 PM with Resident #29 revealed she had not been bathed in three weeks. Resident #29's shower days were Tuesday, Thursday, and Saturdays Resident #29 stated she had not been showered because she was told by staff that there were no clean linen and no clean towels. Resident #29 said that she could not recall the name of staff that told her she could not be showered. Resident #29 stated she did not feel like a lady. Resident #29 also stated she had more than one wound on her that required wound care treatment. Observation and interview on 2/4/25 at 12:27 PM Resident #57 reflected the resident's linen had large brown stains outlining his body, a heavy odor of body odor. Resident #57 stated his sheets had not been changed in over a week, he stated he had heard from staff the washing machine was broken and there was not enough linen. Resident #57 stated he did refuse a bed bath if the staff did not have clean linen for his bed, Why wash up just to get back into filthy bed?. Interview on 02/05/25 at 11:41 AM with CNA I revealed Resident #29 was a Tuesday, Thursday, and Saturday shower. CNA I stated it was the CNA's responsibility to offer showers and document refused showers. CNA I said that if a resident refuses a shower, she would report it to her nurse. CNA I also stated Resident #29 often refused showers and other personal care like wound care. When asked if Resident #29 was offered more than seven showers in the last 30 days, CNA I stated she was. CNA I stated she did not know where more shower sheets showing Resident #29's refusals were located. CNA I said that showers were important because it could increase bed sores and smells. CNA I did not recall her last in-service on ADL's. (continued on next page)

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 02/06/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/05/25 at 11:48 AM with LVN J revealed showers were supposed to be offered three times per week, three times per shift, and as needed or requested. LVN J stated Resident #29 being offered seven showers during the last 30 days was not sufficient. LVN J said that if a resident refused a shower, the aide was supposed to notify the nurse. LVN stated the nurse should educate the resident about the importance of showers. LVN J stated the nurse will offer to shower the resident again at this time. LVN J stated the resident's skin was best assessed when the resident was showered, and the resident was more comfortable when they were clean. LVN J also said that if a resident did not receive regular showers, it could lead to skin breakdown. LVN J stated Resident J often refused showers for an entire week. LVN J stated the shower sheets could not be located, and it was not documented in the facility POC Response History, Task-ADL-Bathing portion of the facility EHR. LVN J revealed if a resident refused a shower, the family and DON should be notified. Interview on 02/06/25 at 3:31 PM with the ADON revealed residents should be offered showers three times per week and three times per shift. The ADON stated if the resident refused a shower, then the nurse should be notified by the aide. Then the nurse should alert the family, ADON, and the DON about the shower refusal. The ADON said that if a resident continued to decline a shower, she would notify the DON and the family. The ADON stated the importance of showers was for infection control, dignity, resident rights, skin issues, and so that the resident feels comfortable. The ADON revealed she would also educate the resident on the importance of showers when she was notified about shower refusals. The ADON stated Resident #29 was offered showers and refused them, but she could not locate shower sheets, and it was not documented in the EHR. The ADON said that it was the nurse's responsibility to document the resident shower refusals and that she would notify the DON and Administrator if she saw refusals not documented. Interview on 02/07/25 at 9:55 AM with the DON revealed residents should be offered showers three times per week by the aides. And if the resident refuses, the nurse should go and offer another shower during that shift after the aide notifies the nurse of the refusal. If the resident refuses the shower, the nurse will educate the resident on the importance of a shower. The DON stated if the resident continued to refuse a shower, then the resident's family would be notified. The DON said that refusals should be documented by both the aide and the charge nurse. The DON revealed showers were important because without them there was a risk of skin breakdown and infection and a loss of dignity. Record review of the facility's current, undated Activities of Daily Living (ADLs), Supporting reflected the following: 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 were unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene 2. Appropriate care and services will be provided for residents who were 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) .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 32227 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being for 1 secure unit reviewed for activities. The facility failed to ensure there were organized activities provided to the residents in the secure unit . The failure placed residents at risk for a diminished quality of life, isolation, lack of stimulation. Findings included: Review of the facility's current February 2025 Activities Calendar for the secure unit reflected the following: 02/04/24 10:30 AM - Pretty Nails 2:00 PM - National Homemade Soup Day 3:00 PM - Table Games 02/05/24 10:00 AM - Exercise/Movie 10:30 AM - Arts and Crafts 2:00 PM - Resident Birthday Party 3:00 PM - Cookie and Apple Cider Social 02/06/24 10:00 AM - Exercise/Movie 2:00 PM Bingo 3:00 PM Senior Trivia (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/04/25 at 10:22 AM, of the secure unit revealed there were 7 residents in the dining room and the TV was on and there were no activities going on at the time. At 12:04 PM staff began to gather the residents for lunch and surveyor exited the secure unit and not activities were noted during the continuous observation. Observation on 02/05/25 at 10:37 AM, revealed there were 6 residents in the dining area and the TV was on and the radio was playing music in the background. Residents were noted to be wandering to and from their rooms and no activities were observed. Observation on 02/06/25 from 10:42 AM to 12:20 PM, revealed some residents were sitting in the dining room and others were wandering in and out of the dining room and there was a staff member in the dining room monitoring the residents. No activities were observed during that time. Interview on 02/06/25 at 1:45 PM, LVN M revealed she had been working at the facility on the secure unit for about 2 weeks and during her 6AM to 6PM shift, she had never seen any activities in the secure unit. LVN M said one of those days she did see the Activity Director paint a resident's nails. Interview on 02/06/25 at 1:45 PM, the Activity Director revealed none of the activities that were on the calendar during 02/04/25 to 02/06/25 had been done on the secure unit. The Activity Director said it was difficult to try and do activities both on and off the unit and at times she would try to do some room rounds and paint their nails or comb their hair. Interview on 02/06/25 at 4:02 PM, the Administrator revealed he thought there was some discrepancy in the amount of activities that were being done in the secure unit but was not aware none of them had been done during the last few days. The Administrator said they would need to review the schedule and ensure activities were being done on the secure unit. The Administrator further stated activities were important because lack of could lead to resident boredom which could increase resident behaviors. Review of the facility's undated policy titled Activity Programs reflected the following: Activity programs designed to meet the needs of each resident are available daily. .1. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to ensure an environment that was free of accident hazards and that each resident received adequate supervision to prevent elopement for one (Residents #323) of three residents reviewed for elopement. 1. The facility failed to ensure Resident #323 was provided with adequate supervision to prevent him from eloping from the facility on 12/24/24 and 01/06/25. The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 12/24/24 and ended on 01/06/25. The facility corrected the non-compliance before surveyor's entrance. This failure placed residents at risk of harm and/or serious injury. Findings included: Review of Resident #323's Admission MDS dated [DATE] reflected the resident was an [AGE] year-old resident admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure). Resident #323 had a BIMS of 1 indicating his cognition was severely impaired. The MDS further reflected the resident did not have impairment to his upper and lower extremities and ambulated with no assistance. Review of Resident #323's care plan initiated on 12/24/24 reflected the resident was at risk for elopement/wandering related to dementia and required placement on the secure unit to provide a secure environment due to risk of elopement. Interventions included to frequent monitor and identified a pattern of wandering and assess reason for wandering and provide redirection as needed . Review of Resident #323's hospital records dated 12/01/24 reflected the following: Patient is a [AGE] year-old male who presents to [emergency room] primarily for pneumonia and neurology was consulted for patient's recent history of elopement and getting lost concerning for newly diagnosed dementia. On chart review is noted that patient had eloped and gotten lost 5 times and family found him after he had fled Observation on 02/04/25 at 11:19 PM, revealed there was wooden privacy fence around the outside of the building of the secure unit with three rails inside of the fence, one at the bottom, one in the middle and one towards the top of the fence. Review of the facility's PIR dated 01/02/25 reflected that on 12/24/24 Resident #323 had left the facility without signing out and was found by the police department and was returned to his family. The resident was on enhanced supervision until the window of his room was repaired and installation of a fence on the side of the building with potential exiting windows was completed. Review of Resident #323 progress notes dated 12/24/24 documented by LVN J reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident was up from breakfast in the dining area. Resident ate 100% of meal. Resident showed no signs of pain or discomfort. At 1145, the patient was last observed entering his room. During routine rounds at approximately 12:45 PM, the patient was found to be absent from their room. A code white was initiated promptly, and the search for the patient is currently ongoing [Police] notified the facility that resident had be [sic] found by [Police] 2 hours ago and told resident to [family]. Interview on 02/05/25 at 10:45 AM, with CNA N revealed she was working the morning of 12/24/24 and sometime after breakfast they staff noticed Resident #323 was not in the secure unit. The CNA N said after breakfast the resident would normally go back to his room and only come out for meals. When they staff realized the resident could not be located, they all began to search the rooms and the bathrooms. After a while, they discovered the window to Resident #323's room was broken and that is how the resident had gotten out. CNA N described Resident #323 as being independent with his ADL's and very pleasant. There were times the resident was seen carrying his bag with his belongings and stand at the exit doors but he was usually easily redirected to go back to his room. Interview on 02/05/25 at 11:29 AM, with LVN M revealed she was working during the elopement on 12/24/24 and during her morning rounds during breakfast all residents were accounted for in the secure unit and Resident #323 had gone to the dining room to eat. The LVN M said after breakfast she sat in the hall monitoring and around 11:30 AM she noticed the resident was not in his room so they began to look for him room by room and alerted the rest of the staff the resident was missing. They checked the secure unit doors and they remained locked and after that they noticed the window to his room was broke. They alerted management staff and 911 was also called and later found out he had been found by the police and taken to his family's home. LVN M said she normally did not work the secure unit and had been filling in for someone else. She said Resident #323 did not appear to be exit seeking that day and had not been carrying a packed bag stating he wanted to go home. Interview on 02/05/25 at 12:40 PM, with MA O revealed he was working on 12/24/24 he was assisting other staff gather residents in the secure unit into the dining room for lunch. MA O said they realized Resident #323 was not in his room and they began to check every room and around the facility when they realized the window to his room was broken and appeared that is how he had eloped. Management was notified and 911 was also called. MA O said he was told the resident had been found by the police and take to his family's home. MA O further stated Resident #323 was very mobile, independent, with confusion and would only come out of his room for meals. The MA said he never recalled the resident to be exit seeking or saying he wanted to leave the facility. Review of the facility's PIR dated 01/10/25 reflected on 01/06/25: This resident had previously broken a window and left the facility. As the facility response, we built a wooden fence around the windows on this area of the secured unit. The resident broke a window on the same section and scaled the fence. Staff witnessed the resident scaling and because of the location of the exit had to respond by going around the building. Once they were on the other side of the fence the resident was gone. Staff initiated searchs [sic] for the resident and contacted the police and the police were able to find him two hours later (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/06/25 at 10:25 PM, with LVN Q revealed she worked on 01/04/25 and Resident #323 had dinner in the dining room and had gone back to his new room he was placed in after he was brought back by his family after his first elopement. LVN Q said she was she was sitting in the hallway and during her rounds, sometime after dinner, did not recall the time, she went to Resident #323's room to check on him and did not find him. She happened to glance down the hall and noticed he was headed into his old room, the room he first eloped from, and as she went into that room she did not see Resident #323. LVN Q noticed the window had been forced open and as she went to look outside, she saw Resident #323 on top of the fence, that had been built after his first elopement, but she was not able to get to the resident fast enough even after calling after him. LVN Q alerted staff and by the time they went outside to look for the resident, he was nowhere to be found. LVN Q further stated she alerted management and 911 was called and she was later told the resident had been found by the police and again take to his family's home. Interview on 02/05/25 at 3:50 PM, with CNA R revealed he was working on 01/04/25 outside of the secure unit when he was alerted that Resident #323 had eloped from the facility through a window. CNA R said all of the staff began to look for the resident but he was not found. CNA R further stated he did work on the secure unit but has assisted in looking for Resident #323. Interview on 02/04/25 at 10:54 AM, with CNA L revealed she was not at the facility during incidents where Resident #323 eloped. CNA L said Resident #323 was independent and very nice. She said the resident was able to communicate his needs and at times he would pack his bag and stand next to the exit doors but was easily redirected back to his room. CNA L stated after his first elopement, the staff had put up a fence around the outside rooms. Resident #323 was taken back to the facility and was put in another room, facing the enclosed courtyard. Interview on 02/05/25 at 1:08 PM, with LVN P revealed she worked with Resident #323 and he was usually anxious to be picked up by his family so they could take him home and had a cell phone he would use to call his family. Resident #323 was cooperative and very pleasant with everyone and would stay in room and only come out for meals. LVN P further stated one day she noticed Resident #323 has packed his bag and said he wanted to leave but he had never tried to open the doors or leave and was easily redirected to his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/05/25 at 1:26 PM, with the DON revealed on 12/24/24 staff alerted her that Resident #323 could not be located and they had noticed the window to the resident's room had been broken out. The DON said all the staff were searching for the resident and 911 had been called. The facility later got a call from the police about 4:30 PM stating Resident #323 has been found and take to his family's home. The DON said she was not told how far from the facility he had been found. After that elopement Resident #323's family kept the resident over the holidays and had been taken back the facility on 12/31/24 and placed in another room that did not face the outside of the facility. The DON said while the resident was gone they had fixed the window to his previous room, and they had put up a wooden fence around the perimeter of the secure unit. On 01/04/25 she again was alerted that while making rounds they noticed Resident #323 was not in his room and the window to his old room had been opened and the resident had been seen jumping over the wooden fence. The staff immediately ran outside to look for the resident but he was not found so they called 911. The DON further stated that the police had found Resident #323 and again had been taken back to his family's home. The DON did not know how far from the facility he had been located. Resident #323 did to return to the facility and the family decided to keep him at home. The DON said after each of Resident #323's elopement all the staff were re-in serviced on their elopement policy. Staff participated in an elopement drill to ensure they were competent during a resident elopement. All resident in the secure unit were put on 15-minute checks to make sure there were no other resident that were exit seeking. Interview on 02/05/25 at 11:06 AM, with the Director of Maintenance revealed he had built the wooden fence around the outside of the secure unit and was not aware the fence rails should have faced the outside of the fence and not the inside due to the safety of someone being able to climb the fence. The Director of Maintenance further stated that would be a fast and easy fix and he would just have to turn the fence around by sections. A Past Non-Compliance Immediate Jeopardy/Immediate Threat was identified on 02/05/25. The Administrator, the Regional Consultant were notified of the Past Non-Compliance Immediate Jeopardy on 02/05/25 at 4:04 PM. The IJ template was provided to the facility on [DATE] at 4:10 PM. Review of the facility's policy titled Elopements dated 2018 reflected the following: Staff shall investigate and report all cases of missing residents. .1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing/designee .c. if a resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative the Attending Physician, law enforcement officials Observation on 02/04/25 at 10:27 AM revealed there was a staff member sitting in the hallway with a bedside table charting on a laptop. The staff member had visual of the hall where the resident rooms were located and the dining room where other resident were. Observation of the secure unit at various times from 02/04/25 to 02/06/25 revealed there were no residents that appeared to have the physical and mental capabilities of climbing the fence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Enhanced Supervision Monitoring Tool dated 12/24/24 and 12/25/24 revealed all the residents in the secure unit has been put on 15-minute checks by staff to ensure no other residents were exit seeking or showing signs of wanting to leave the secure unit. Further review of the Enhanced Supervision Monitoring Tool revealed there were no other residents identified as being exit seeking. Review of the Elopement Drill/Actual Event Participation dated 12/27/24 and 12/28/24 revealed staff members actively participated in a drill on what to do when and if a resident went missing. Review of the in-services dated 12/24/24 and 01/06/25 revealed staff were in-serviced on the facility's elopement and wandering policy. Interview on from 02/04/25 to 02/06/25 at various times with LVN J, LVN P, LVN Q, LVN V, MA O, CNA S, CNA N, CNA T, CNA U, CNA I, and CNA R revealed residents were checked on at the beginning of their shift to ensure all resident were accounted for frequent round were made to monitor all resident for signs of exit seeking. They all said if they were to notice a resident was missing, they were to alert all staff working and begin to look for the resident. If the resident was not located in the building, they would notify management and call 911.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure it received registry verification for 2 (CNA D and CNA E) of 5 employees reviewed for registry verification prior to allowing an applicant to serve as a nurse aide. The facility failed to ensure CNA D and CNA E had a current nurse aide certification while employed at the facility, while actively providing care for residents. This failure could result in residents being provided care by staff who have not provided documentation of training and competency in providing care. Findings included: Record review of CNA D's personnel file reflected a date of hire of [DATE]. The facility did not complete an EMR/NAR check upon hire or annually. Record review of CNA E's personnel file reflected a date of hire of [DATE]. The last Employability Stats Check Search that was completed on [DATE] reflected CNA E's NAR status would expire on [DATE]. Record review of the daily nursing staff schedule, for [DATE] reflected CNA D worked on [DATE] on shift 6:00 PM - 6:00 AM under the CNA Assignments section. Interview on [DATE] at 12:12 PM with the HR Manager revealed that she had been the HR Manager since March of 2024. The HR Manager stated that EMR/NAR should be completed annually. The HR Manager stated that she was told by regional on [DATE] that if a staff had both a CNA and a MA, then both certifications must be updated annually. The HR Manager said that until she was told this by regional, she was unaware of the regulation. The HR Manager stated that she had spoken to CNA D last May when she reviewed her personnel file. The HR Manager said CNA D was instructed to renew her CNA certification by her. The HR Manager said she thought CNA D had renewed her license. The HR Manager said that she discovered CNA D's certification had not been renewed when she was asked by the surveyor for evidence of the renewed certification. The HR Manager revealed that she notified the aide that she was suspended immediately. The HR Manager stated that she was notified on [DATE] CNA E's certification was expired. The HR Manager said that she spoke with CNA E on [DATE]. The HR Manager stated that CNA E told her she was unaware her CNA certification had to be renewed. CNA E said she thought if her MA certification was renewed, her CNA certification was automatically renewed. The HR Manager stated she was now aware that CNA E's certification was expired and had notified CNA E that she was suspended immediately. The HR Manager revealed it was her responsibility to ensure that EMR/ENR checks were conducted annually to ensure that all staff working have updated certifications. The HR Manager stated that it was the staff's responsibility to keep their own certifications current. The HR Manager said that if staff did not keep their certifications updated, it could lead to increased falls, accidents, abuse allegations, and infection control issues. (continued on next page)

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	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Residence and Rehabilitation Center	405 Duncan Perry Rd Arlington, TX 76011

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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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 12:30 PM with the DON revealed that it was the HR Manager's responsibility to ensure that the EMR/NAR check were conducted annually for all cna's and medication aides. The DON stated that there was no one that monitored this system to ensure that all certified nurse's aides and medication aides' certifications were active. The DON said that if certified nurse's aides and medication aides' certifications were not active, it could lead to falls, fractures, incorrect transfers and other incorrect procedures. Interview on [DATE] at 1:12 PM with the Administrator revealed that EMR/NAR is supposed to be checked by the HR Manager annually and upon hire. The administrator said that it was his responsibility to monitor the process. The Administrator also stated that there was potential for harm to a resident when no EMR/NAR checks are completed on hire or annually. Record review of the facility's current, undated Competency of Nursing Staff reflected the following: Policy statement 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 7 residents (Residents #8) reviewed for pharmacy services. Facility failed to ensure Ranolazine 1000 mg ER (extended release) used for chest pain was administered on 02/03/25, 02/04/25 and 02/05/25 as ordered for Resident #8. This failure could place residents at risk of not receiving the therapeutic value of the ordered medications and leading to potential hospitalization . The findings were: Record review of Resident #8's entry MDS assessment, dated 11/27/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses which included: chest pain. Resident #8 had moderate cognition with a BIMS(Brief Interview for Mental Status) score of 11. Record review of Resident #18's care plan initiated 01/06/25 reflected: Focus: Resident has altered cardiovascular status rule out Angina. Goal: Resident will be free from signs and symptoms of complications of cardiac problems through the review date. Interventions: Assess for chest pain. Enforce the need to call for assistance if pain starts. Record review of Resident #8's physician orders dated 11/15/24, revealed, Ranolazine ER oral tablet extended release 12 Hour 1000MG. Give 1 tablet by mouth every 12 hours for ANGINA (chest pain). Record review of Resident #8's February 2025 Medication Administration Record (MAR) reflected; the resident was not administered Ranolazine ER 1000mgs on: 02/03/25 at 09:00 PM 02/04/25 at 09:00 AM and 09:00 PM 02/05/25 at 09:00 AM it was documented see nurses notes . Observation and interview on 02/04/25 at 10:52 AM revealed Resident #8 in her room. Resident#8 stated she had been out of Ranolazine for 2 days. She stated she uses the medication for her heart. She denied pains. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/05/25 at 07:48 AM revealed MA E administering medication to Resident #8. She checked the blood pressure sanitized and popped the following morning medications for Resident#8:. -Entacapone 200 mg 1 tablet three times daily p.o -Escitalopram 5 mg 1 tablet daily p.o -Plavix 75mgs 1 tablet daily p.o -Pantoprazole 40 mg 1 tablet twice daily p.o -Carbodo/levodopa 25-100 mg 2 tablet three times a day p.o -Lidocaine patch 4%- apply to the lower back daily p.o -Potassium cl 10 meq 1 tablet daily p.o. -Metoprolol succinate ER 25 mg 1 tablet daily p.o. -Gabapentin Oral Capsule 300 mg three times a day p.o -Candesartan Cilexetil Oral Tablet 4 mg 1 tablet daily p.o. -MA failed to administer Ranolazine extended release 1000mgs. Interview with MA E on 02/05/25 at 10:21 AM revealed, she administered the last tablet of Ranolazine extended release on 02/04/25 in the morning. MA E stated she had ordered the medication from the pharmacy twice and the pharmacy had not sent the medication to facility. She stated she was aware the resident had missed the medication on 02/03/24,02/04/24 and 02/05/24 and she had notified the nurse . She stated she was supposed to order the medication when she had 7 left on the bubble pack. She stated she had notified the nurse her medications were missing, but she did not notify the management. She stated the risk of missing those doses was Resident #8 having chest pains. She stated she had done training on medication administration. She stated she was checking with the resident for changes of condition while administering other medications and checking vitals. Interview with LVN L on 02/05/25 at 10:35 AM revealed he was the charge nurse for Resident #8 from 02/03/25 to 02/05/25. He stated MA E had not notified him of Resident#8 missing her Ranolazine ER 1000 mg until a few minutes ago and he was to call pharmacy. He stated the MA was supposed to notify him when they order medication from pharmacy, and they fail to receive refills, or the medication has finished so that he can check from the emergency kit and follow up with pharmacy. He stated the risk of Resident#8 missing the doses was having increased heart rate and having shortness of breath. She stated he had done training on medication administration and ordering. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/05/25 at 12:34 PM with the ADON revealed, she was not aware Resident#8 was missing her Ranolazine ER 1000 MG. She was notified on the morning of 02/5/25 by MA E and she stated she had reported it to the charge nurse. The ADON stated her expectation was the MA to order medication when she had 7 tablets remaining on the bubble pack and they had done training on their staffs. She stated she called the pharmacy, and they were waiting for the insurance clearance. She stated the risk of missing the doses was Resident #8 experiencing chest pain. Interview on 02/05/25 at 01:38 PM with DON revealed, she was not aware Residentt#8 was missing her Ranolazine ER 1000 MG. She stated her expectation was the MA to notify the nurses once they order medication from pharmacy and do not receive the refills and they nurses should notify her. She stated she expected the staffs to order medication for refills when they have 7 remaining on the bubble. She stated it was her responsibility to check the Medication administration record every day for holes and missing tablets, but she had not checked until 02/04/25, when she saw she had not been receiving and she was to address the issue when the MA came and notified her that the surveyor was asking about the missing doses. She stated the risk of Resident #8 missing the doses was delay in treatment. She stated she called the physician assistant on 02/05/25 and she was told to hold the medication until when available. She stated she had done training on medication refills and administration. The last training was on 1/31/25 and [NAME] was in attendance. Interview with the chief Nursing Officer on 02/06/25 at 12:57PM revealed her expectation was MA to report to the nurse on the medication that were not refilled by pharmacy and nurse to call pharmacy, know what was delaying delivery. The nurse should contact the doctor for alternate medication and decision making. She stated per state regulations they have enough medication for 72 hours always remaining. She stated there were no risk since she could see Resident #8 up and about and medications were delivered on the night of 02/05/25. Interview on 02/06/25 at 03:10 PM with Pharmacist consultant revealed, the records show that Resident#7 had missed 4 doses and she was not able to tell the history of when the medication was last ordered by checking on the records. She stated it was her expectation the facility should order for refills a week before the supply finishes because of insurance or any other issue that could delay refilling. She stated facility was supposed to follow up with pharmacy 24 hours after ordering and she fills there was issue with communication because any time the pharmacy note something they communicate through writing or call the facility. She stated the facility was supposed to have notified the doctor for a substitute. She stated the risk of missing those doses for extended-release medication Resident #8 would lack sustainability of therapy. Interview with on 02/10/25 at 01:38 PM with physician assistant while returning a missed call for 2/6/25 revealed, she was not aware Resident#8 was missing her Ranolazine ER 1000 MG. She was notified on the morning of 02/5/25 and she told them to hold until available. She stated her expectation was the facility to ensure all medication are available and ordered timely and if there were issues with pharmacy she should be notified. She stated the risks are there for Resident missing those does but she had not complained of chest pain, and she had other extended-release medications. Review of the facility training records revealed training on medication ordering dated 1/31/25 and MA E was in attendance. (continued on next page)

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	455872	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility undated policy on medication administration revealed the following . 3. Medications must be administered in accordance with the orders, including any required time 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44140 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 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food items were kept away from potential airborne contaminants (dust and fuzz) on the ceiling vents. The facility failed to ensure stove backsplash was kept clean from buildup grease. This failure could place residents at risk for food contamination and food-borne illness. Findings included: Observation on 02/04/25 at 9:00 AM revealed three air conditioning vents over the food preparation area and two air conditioning vents by the dishwasher in the kitchen were observed to have built-up fuzz and dust stuck to them. Observed stove backsplash to have build-up grease stuck to it. Observation on 02/05/25 at 10:30 AM revealed three air conditioning vents over the food preparation area and two air conditioning vents by the dishwasher in the kitchen were observed to have built-up fuzz and dust stuck to them. Observed stove backsplash to have build-up grease stuck to it. Food was on the stove. Interview on 02/05/25 at 12:48 PM with [NAME] revealed she was unsure who was responsible for cleaning the stove backsplash. She stated she could not recall when the last time it was cleaned. She stated the potential risk of not cleaning the grease off could lead to it getting in the food and safety concerns. She stated the air vents were cleaned by maintenance staff; she stated the air vents were last cleaned about 3 months ago. The [NAME] stated the risk of air vents not being cleaned could lead to build-up falling in the food. Interview on 02/05/25 at 12:51 PM with the Dietary Manager revealed the kitchen staff was responsible for cleaning kitchen equipment. She stated the cooks were responsible for cleaning the stove. She stated the last time the stove was cleaned was about a month ago. She stated she had a daily log of items that needed to be cleaned, and that is how she oversees to ensure it was being done. She stated the air vents should be cleaned by maintenance staff. She stated she could not recall when was last time the air vents were last cleaned. She stated the risk of stove backsplash not being clean could be a hazard and the risk of not cleaning the air vents could lead into dust falling in the food. Interview on 02/06/25 at 3:28 PM with the Maintenance Supervisor revealed he was unsure who was responsible for cleaning the air vents in the kitchen. He stated he had not been told it was his responsibility to clean them. He stated the potential risk would be dust falling in the food and bacteria build up. Record review of the facility's current, undated Sanitation policy reflected the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The food service area shall be maintained in a clean and sanitary manner. .2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. .11. For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: Equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; Removable components will be scraped to remove food particle accumulation and washed according to manual or dishwashing procedures. Record review of the Federal Food Code 2022 reflected the following: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48236 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 2 washing machines (Washer A) reviewed for essential equipment. The facility failed to maintain a laundry washing machine (Washer A) in operating condition. This failure could place residents at risk of not having clean linen for their beds or personal clothing. Findings included: Observation and interview on 02/04/2025 at 11:00 AM with Resident #37 revealed Resident #37 had sheets on his bed with large brown stains on them. Resident #37 stated his sheets had been like that for about six days. Resident #37 also said he had asked two times in the past week to shower but was told by staff that there were no clean towels. Observation on 02/04/2025 at 2:45 PM of the facility laundry area revealed the facility had one commercial washing machine and one residential washing machine. The commercial washing machine appeared broken because parts were removed from it and lying on top of it. The only washing machine running in the laundry area was the residential washing machine. Interview on 02/06/2025 at 12:56 PM with the Laundry Aide revealed she had been the Laundry Aide about three months. The Laundry Aide stated for the past month there had only been one working residential washing machine. The Laundry Aide said that she works the first shift from 6:00 AM to 2:00 PM. The Laundry Aide revealed another Laundry Aide worked a second shift from 4:00 PM to 12:00 AM to assist with the laundry. The Laundry Aide stated sometimes the laundry was backed up because of how dirty the laundry became. The Laundry Aide revealed when the surveyors entered the facility laundry area on 02/04/2025 that the laundry was backed up due to excessive personals and blankets. The Laundry Aide did not know the facility policy regarding facility essential equipment. The Laundry Aide stated when laundry was behind, she notified the Laundry Supervisor. The Laundry Aide revealed it was important for residents to have clean linen and clothes to help prevent wounds and infections. The Laundry Aide also stated residents should feel like they were at home with clean laundry. Interview on 02/06/2025 at 1:19 PM with the Laundry Supervisor revealed she had two shifts of full-time laundry aides. The Laundry Supervisor stated she was aware that there was only one functioning washing machine. She also said it was the Administrator's responsibility to ensure there was sufficient equipment for the facility including the washing machines. The Laundry Supervisor also revealed sometimes staff threw dirty linen in the trash because they did not think it could get cleaned. (continued on next page)

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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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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/06/2025 at 2:22 PM with the Administrator revealed he was aware that the facility had one residential washing machine. The Administrator stated one residential washing machine was not sufficient to keep up with the population of the facility. The Administrator said it was his responsibility to ensure that the facility had sufficient equipment to meet the residents' needs. The Administrator stated he was unaware of the length of time that the facility had only had one washing machine. The Administrator also said that the facility had only had one washer since he started on 12/26/2024. The Administrator revealed he requested a new washing machine from corporate at a minimum of three times in the past 30 days. The Administrator stated the dryers worked properly. The Administrator also revealed he had the laundry sent out to the for cleaning once or twice since starting to work at the facility. The Administrator also said if residents did not have clean linen and clothes, it could affect their emotional well-being. The Administrator stated a new washing machine had just been delivered a few minutes prior to the interview. Record review of the facility's current, undated Quality of Life-Homelike Environment policy reflected the following: Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observations, interviews, and record reviews, the facility failed to ensure each bed had ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains for 7 rooms (room [ROOM NUMBER], #117, #118, #120, #122, # 127, and #144) of 30 rooms reviewed for privacy. The facility failed to provide full privacy for residents of rooms #110, #117, #118, #120, #122, # 127, and #144 This failure could place residents at risk of no privacy. Findings included: Observations on 2/04/25 from 11:10 AM to 12:34 PM revealed room [ROOM NUMBER]-2 had no privacy curtain for the end of the bed; room [ROOM NUMBER]-2 had no privacy curtain for the end of the bed, curtain clips were present; room [ROOM NUMBER]-2 had no privacy curtain for the end of the bed; room [ROOM NUMBER]-2 had no privacy curtain for the end of the bed and had several missing slats in the window blinds; rooms # 122-2 and #127-2 had no privacy curtains at all; and room [ROOM NUMBER]-2 had no privacy curtain for the end of the bed. Interview on 02/06/25 at 4:15 PM the HR Manager stated each resident needed privacy curtains to protect their privacy and to give them their own space. She stated her floor tech was responsible for changing out curtains but he had quit one week ago and had not been replaced. She stated she was ultimately responsible for the privacy curtains. Interview on 2/06/25 at 3:45 PM with the Administrator revealed there was no policy addressing privacy curtains specifically but they fell under Resident Dignity and provided the facility's undated policy Quality of Life-Dignity, which reflected: 6. Residents ' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents ' rooms. b. Staff will not handle or move a resident ' s personal belongings (including radios and televisions) without the resident ' s permission.

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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 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. 48236 Based on observation, interview, and record review, the facility failed to establish procedures to ensure that enough water was available in the facility in the event of a loss of normal water supply, for 1 of 1 facility. The facility's emergency water supply consisted of 0 gallons of water on hand for a census of 68 residents. This failure could place all residents in the facility at serious risk for complications from dehydration and sanitation. Findings included: Observation on 02/06/25 beginning at 12:50 PM of the facility revealed no emergency water in the facility. The kitchen was observed and the dietary manager was interviewed. No emergency was located. Two additional closets in the facility were observed and no emergency was located. Interview on 02/06/25 at 1:10 PM with the Dietary Manager revealed that the Dietary Manager was unaware of any placement of emergency water. The Dietary Manager stated that she had never ordered emergency water for the facility and had no knowledge of emergency water stored in the facility. The Dietary Manager said that she was unaware of any policy of emergency water storage for the facility and had never been assigned the task of keeping emergency water for the facility on hand. The Dietary Manager also said that she had never been in-serviced on emergency water for the facility. Interview on 02/06/25 at 2:22 PM with the Administrator revealed that he was unaware of any emergency water on site at the facility. The Administrator stated that he had asked the facility staff if they knew where emergency water was stored, and staff had told him they were not aware of any stored emergency water. The Administrator stated that the facility should have three days of water for each resident population of water on hand. The Administrator stated that there is a method of estimating the amount of emergency water required for a facility. But the Administrator stated he did not have the policy and would have corporate send it to him. The Administrator said that it was his responsibility to ensure that sufficient emergency water was on the premises for residents and staff. The Administrator also revealed that not having an adequate supply of water during an emergency could lead to dehydration for residents. Interview on 02/06/25 at 2:41 PM with the Chief Nursing Officer revealed that the facility should have at least one gallon per resident for three days. The Chief Nursing Officer stated the facility should have 204 gallons of emergency water on hand at a minimum. The Chief Nursing Officer said that if residents do not get enough water, it could cause residents to need additional emergency medical interventions. The Chief Nursing Officer also stated that it was a combination of the Dietary Manager's responsibility and the Administrator's responsibility to ensure emergency water is kept at the facility. The Chief Nursing Officer placed an order for emergency water following this conversation. Record review of the facility's current, undated Water/Dietary Considerations for Residents reflected: (continued on next page)

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 02/06/2025
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)
F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	:Policy Statement This facility has planned for the dietary needs of its residents in the case of an emergency situation. .4. A minimum of food and water to last for three days shall be maintained at the facility in a specific location. This minimal amount of food and water should be determined based on the number of residents, employees and visitors during a crisis or disaster situation. Record review of the facillity's Emergency Preparedness; Loss of Water Supply revised October 2021, reflected: Under procedure; Preparation, 1. Each center maintains a supply of drinking water based on state-specific requirements (see OP6 1511.00, state emergency water requirements). It is recommended that, at minimum, the center have on hand two gallons of water per resident (2 gallons per resident x 68 residents = 136 gallons needed per day) and per employee (2 gallons x 105 employees = 210 gallons per day) per day for at least three days (136 gallons for residents + 210 gallons for employees = 346 gallons x 3 days = 1,038 gallons needed for residents and employees for 3 days), or more, for patients who are on medications or who are at risk for dehydration. Record review of the facility's State emergency water requirements for Texas policy, revised June 2015, reflected: Keep at least a three-day supply of water per person; each person will need a gallon per day. (68 residents + 105 employees = 173 gallons x 3 days = 519 gallons)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48236 Based on interview and record review, the facility failed to develop, implement, and maintain and effective training program for 8 of 11 staff (CNA A, CNA B, CNA, C, CNA D, CNA E, LVN G, LVN H,) reviewed for training. The facility failed to ensure CNA A, CNA B, CNA, C, CNA D, CNA E, LVN G, and LVN H were provided with training on dementia and abuse, neglect and exploitation. These failures could place residents at-risk for abuse and neglect due to lack of training. Findings included: 1. Record review of the facility's current, undated Staff Roster reflected CNA A was hired on 06/07/23. Record review of CNA A's training history revealed CNA A's training transcript did not indicate when last previous ANE training had been completed. 2. Record review of the facility's current, undated Staff Roster reflected CNA B was hired on 12/12/23. Record review of CNA B's training history revealed CNA B's training transcript did not indicate when last previous ANE training had been completed. 3. Record review of the facility's current, undated Staff Roster reflected CNA C was hired on 10/17/23. Record review of CNA C's training history revealed CNA C's training transcript did not indicate when last previous ANE training had been completed. 4. Record review of the facility's current, undated Staff Roster reflected CNA D was hired on 07/7/23. Record review of CNA D's new hire history revealed CNA D's training transcript did not indicate when last previous Dementia and ANE trainings had been completed. 5. Record review of the facility's current, undated Staff Roster reflected CNA E was hired on 6/12/23. Record review of CNA E's new hire history revealed CNA E's training transcript did not indicate when last previous Dementia and ANE trainings had been completed. 6. Record review of the facility's current, undated Staff Roster reflected LVN G was hired on 11/14/23. (continued on next page)

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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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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of LVN G's required annual training history revealed LVN G's training transcript did not indicate when last previous Dementia and ANE trainings had been completed. 7. Record review of the facility's current, undated Staff Roster reflected LVN H was hired on 10/10/23. Record review of LVN H's required annual training history revealed LVN H's training transcript did not indicate when last previous Dementia training had been completed. Interview on 02/06/25 at 12:12 PM with the HR Manager revealed the facility policy stated that all required trainings were to be completed every two years. HR Manager stated that the facility directed their staff to complete their required trainings online. The HR Manager said that she instructed staff to bring their completion certificates of each course completed to the DON. The HR Manager also revealed that it was the DON's responsibility to monitor all staff's trainings and ensure that they were completed. The HR Manager stated that trainings were imported because fall training led to decreased falls. The HR Manager said that dementia training was crucial because it can decrease abuse allegations as well as falls. Interview on 02/06/25 at 12:30 PM with the DON revealed that annual trainings and on hire trainings were her responsibility. The DON said that she conducted some in-service trainings in person with staff like abuse and hand washing using quizzes to ensure staff understanding of the topic. The DON also stated that some trainings were on-line. The DON revealed that some in-services were completed for staff, but she could not locate them during the survey. The DON stated that there was no monitoring system in place to ensure that required trainings were completed and documented in the staff's employee file. The DON said that lack of education can lead to falls, fractures, and other dangerous situations for residents. Interview on 02/06/25 at 1:12 PM with the Administrator revealed that he would have to review the facility policy to determine what the required trainings were for appropriate facility staff. The Administrator stated that it was the DON's responsibility to ensure annual and on hire trainings are completed for facility staff. The Administrator said that there was no monitoring system in place to ensure trainings were completed. The Administrator stated that there is potential for harm when staff are not properly trained. Record review of facility undated policy titled Competency of Nursing Staff, revealed, .Policy Interpretation and Implementation 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. 2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and (continued on next page)

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	455872	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. .4. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: a. Preventing abuse, neglect and exploitation of resident property; b. Dementia manager; c. Resident rights; d. Percent centered care; e. Communication; f. Basic nursing skills; g. Basic restorative skills;