| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455872 | A. Building<br>B. Wing | 04/09/2026 |

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment for seven of twelve Resident rooms (Rooms #1, #2, #3, #4, #5, #6, and #7) on the Sunflower Hall, and one of three shower rooms observed for cleanliness. The facility failed to ensure Resident Rooms #1, #2, #3, #4, #5, #6, and #7 on the Sunflower Hall were thoroughly cleaned and sanitized.The facility failed to ensure the shower room on the Sunflower Hall was thoroughly cleaned and sanitized.These failures could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.Findings included:During an observation on 04/07/26 at 10:39 a.m., a shower room on the Sunflower hall had a tub in it. The tub was observed with brownish and grayish stains near the drain hole and on the front panel of the tub. During an observation on 04/07/26 at 10:39 a.m., of room [ROOM NUMBER] reflected the bathroom floor had dark stains in the corners of the floor, and behind the toilet. The bathroom floor had white shredded little pieces of tissue near a wall. The wall near the handrail had brownish stains on it. The room floor near the bed had dark stains in the corner of the floor. During an observation on 04/07/26 at 10:58 a.m., of room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 04/07/26 at 11:02 a.m., of room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The middle of the room floor had grayish stains. During an observation on 04/07/26 at 11:06 a.m., of room [ROOM NUMBER] reflected the room floor had grayish stains in the corners of the door frame and corners of the floor. The floor near the closet had dark stains. The middle of the room floor had dak grayish stains. The bathroom floor had brownish stains behind the toilet. During an observation on 04/07/26 at 11:12 a.m., of room [ROOM NUMBER] reflected the room floor had a brownish substance on the floor near a wall. The walls near the door and behind the resident's bed had brownish stains streaking down the wall. The bathroom floor had brownish stains along the edges of the floor and behind the toilet. During an observation on 04/07/26 at 11:15 a.m., of room [ROOM NUMBER] reflected the privacy curtain had reddish and black stains all over it. The room floor had grayish stains all over the floor. During an observation on 04/07/26 at 11:19 a.m., of room [ROOM NUMBER] reflected the room floor had grayish stains all over the floor. The bathroom floor had dark stains in the corners of the floor, and behind the toilet. During an interview on 04/09/26 at 10:24 a.m., Housekeeping L was informed by the Surveyor of concerns observed in the Shower room in the Sunflower section. She stated housekeeping was to clean the entire shower area, which included the tub in it. She stated it was hard to get it cleaned and she was not assigned to the Sunflower section but will be assigned to cleaning this section moving forward. She stated not cleaning the areas thoroughly could cause residents to get an infection.During an interview on 04/09/26 at 10:24 a.m., Housekeeping M was informed by the Surveyor of concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, and #7. She stated housekeeping was responsible for cleaning the entire rooms and the areas shown in the photos. She stated she was responsible for cleaning the rooms mentioned in the Sunflower area. She stated she did not know the risk to<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents if rooms were not thoroughly cleaned.During an interview on 04/09/26 at 10:24 a.m., the Housekeeping Supervisor, stated she had been the supervisor for the past 4 months. She stated housekeeping was to clean the entire resident room, including the bathrooms. She stated housekeeping were to clean the entire shower room. She was shown by the Surveyor photos of Resident rooms #1, #2, #3, #4, #5, #6, and #7 and the shower room on the Sunflower hall. She stated housekeeping were to clean the areas mentioned. She stated if the rooms and shower rooms were not thoroughly clean it could impact the resident's health.During an interview on 04/08/26 at 12:10 p.m., the Administrator was informed by the Surveyor of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, and #7 and the shower room on the Sunflower hall. She stated the rooms needed to be thoroughly cleaned because it should be a homelike environment for the residents.Review of the facility's policy on Safe and Homelike Environment (05/02/25) revealed In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 3 of 6 residents (Residents #1, #7, and #34 ) reviewed for care plan. The facility failed to ensure Resident #1 was care planned for catheter (flexible tube inserted into the bladder to remove the urine) care when he was re-admitted to the facility on [DATE].The facility failed to ensure Resident #7's care plan reflected an intervention which included bed being in the lowest position and fall mat alongside bed. The facility failed to ensure Resident #34's care plan reflected a care plan for smoking.These failures could place residents at risk of their needs not being met. Findings include:Record review of Resident #1's Face Sheet, dated 04/07/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness).Record review of Resident #1's Comprehensive MDS Assessment, dated 03/09/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag).Record review of Resident #1's Physician Order, dated 03/09/2026, reflected Foley (device used to help drain urine from bladder)/Suprapubic (device inserted into the stomach to the bladder to drain urine) Catheter Care every shift and as needed.Record review on 04/07/2026 of Resident #1's Comprehensive Care Plan reflected no care plan for catheter. Record review of Resident #1's Progress Notes, dated 03/09/2026, reflected Resident . Foley catheter 16 Fr (French: unit of measurement for catheter sizes) in place draining clear yellow urine.During an observation on 04/07/2026 at 9:17 a.m. revealed Resident #1 was in his bed with eyes closed. It was observed that the resident had a catheter bag hanging on the resident's bed frame.During an interview on 04/07/2026 at 2:31 p.m., CNA C said Resident #1 had the catheter for almost a month. She said the resident went to the hospital and came back to the facility with a catheter. She said she would empty his catheter when it was already half full during her shift.During an interview on 04/08/2026 at 1:17 p.m., RN F said Resident #1 was re-admitted last March 07, 2026 after he was sent out to the hospital. She said the resident had a catheter when he was re-admitted to the facility. She said the MDS Nurse was the one doing the care plan.During an observation and interview on 04/09/2026 at 7:48 a.m., the MDS Coordinator said the nursing department was responsible in doing the acute care plan when a resident was re-admitted to the facility. She said if the resident was re-admitted with a catheter, then a care plan for catheter care should been completed so that the staff would be aware of the specific care needed by the resident and so that the staff taking care of the resident would be in the same page in terms of the resident's care. She logged on to her computer and saw that the Resident #1 did not have a care plan for his catheter. She said the care plan should reflect the current status of the resident. She said she would do the comprehensive care plan. She said if the residents did not have a care plan, there could be confusion on their care or care would be not provided at all. She said she already started auditing the care plans of the residents. During an observation and interview on 04/09/2026 at 8:04 a.m., the ADON saidcare plans were important so the staff would be in the same with regards to the care of the residents. She said she thought she did a care plan for Resident #1's catheter when he was re-admitted to the facility. She logged on to her computer and saw that the resident did not have a care plan for the resident. She said it was an oversight on her part because she was responsible in making the care plan of the residents re-admitted to the facility or if there was a change in condition.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | She said she would coordinate with the DON and the MDS Nurse to make sure the residents had appropriate care plans. During an observation and interview on 04/09/2026 at 8:34 a.m., the DON said care plans were important so the staff would be in sync with the care of the residents. She said without the care plan, needed interventions might not be provided. She said Resident #1's catheter should be care planned because he was re-admitted with it. She logged on to her computer and saw that the resident did not have a care plan for his catheter. She said she did not know why the resident did not have a care plan since they talked about it during their morning meetings. She said it was an oversight on het part because she did not check on it. She said she would coordinate with the MDS Coordinator to audit the care plans of the residents. She said the expectation was all the issues of the residents were care planned. During an interview on 04/09/2026 at 8:59 a.m., the Administrator said that all the residents should have a care plan in line to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said the expectation was for all the residents were care planned appropriately. She said she would coordinate with the DON to make sure all the residents were care planned.Record review of Resident #7's Face Sheet, dated 04/07/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had a diagnosis of muscle wasting.Record review of Resident #7's Initial MDS Assessment, dated 03/19/26, reflected the Resident had a BIMS score of 6 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of inflammation and infection of his bones.Record review of Resident #7's Comprehensive Care Plan, dated 03/20/26, reflected the resident being a fall risk; however, there were no interventions for bed being in the lowest position and fall mat alongside bed. During an observation on 03/24/26 at 11:36 a.m., Resident #7 was observed lying in bed. His bed was in the lowest position, and a fall mat was placed alongside his bed.During an interview on 04/08/26 at 9:13 a.m., the ADON stated Resident #7 was a fall risk and his bed should be in a low position, fall mat in place, and call light within reach. She was informed by the Surveyor the care plan had no interventions for the bed being in a low position and fall mat alongside his bed. She stated the care plan needed to be updated to reflect the resident's plan of care. She stated the ADON updated the baseline care plan, the MDS Nurse updated the Comprehensive care plan, and the DON updated the care plan for interventions when there was a change of condition. During an interview on 04/08/26 at 9:34 a.m., the MDS Nurse stated she was responsible for updating Resident #7's Comprehensive care plan. She stated the resident was a fall risk and she added the intervention of the resident needing a fall mat alongside his bed today. She was informed by the Surveyor of the resident's bed being in a low position and the resident having a fall mat. She stated updating the resident's care plan may have been an oversight. She stated the ADON and DON should have also added interventions during their IDT meetings. She stated if the interventions were not included in the care plan, staff may not be aware of care needed and the interventions may not be in place.During an interview and observation on 04/08/26 at 10:51 a.m., the DON stated Resident #7 was a fall risk and his bed was to be placed be in a low position, fall mat in place, and call light within reach. She was informed by the Surveyor the care plan of no interventions for the bed being in a low position and fall mat alongside his bed. She stated the interventions should have been included to ensure staff was aware of the plan of care. She stated it was the ADON, DON, and MDS nurse responsibility to update the resident's care plan.Record review of Resident #34's Face Sheet, dated 04/08/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #34 had a diagnosis of mental and behavior disorders.Record review of Resident #34's Initial MDS Assessment, dated 03/11/26, reflected the Resident had a BIMS score of 4 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of dementia (cognitive decline).Record review of Resident #34's Comprehensive Care Plan, dated 01/04/26, did not reflect the resident was a smoker.Record review of Resident #34's Smoking Assessment, dated 12/12/25, reflected the resident used tobacco products.During an interview on 04/08/26 at 12:10 p.m., the DON and MDS Nurse were informed of Resident #34 not being care planned for smoking. The (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | DON stated she thought Resident #34 had quit smoking. The DON stated if the resident was still a smoker, she needed to be care planned because it was an area that required monitoring.During an interview on 04/09/26 at 11:10 a.m., the ADON stated she had completed Resident #34's smoking assessment on 04/08/26 and she had confirmed Resident #34 was still a smoker and had observed her smoking outside on 04/08/26.Record review of facility's policy, Comprehensive Care Plans, 4/8/2026, reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for six of eighteen residents (Residents #7, #34, #41, #54, #66) reviewed for accident hazards. The facility failed to ensure Residents #7 and #66 had physician orders for a scoop mattress (a scoop mattress features raised sides and a concave center). The facility failed to ensure Residents #34 and #41 had Quarterly Smoking Assessments completed.The facility failed to ensure Resident #41 did not have tobacco products in his room. The facility failed to ensure there was no container of odor neutralizer left inside Resident #54's room on 04/07/2026. These failures could prevent the residents from having an environment that was free from accidents, potential injury, and exposure to toxic chemicals.Findings included: Record review of Resident #7's Face Sheet, dated 04/07/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had a diagnosis of muscle wasting.Record review of Resident #7's Initial MDS Assessment, dated 03/19/26, reflected the Resident had a BIMS score of 6 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of inflammation and infection of his bones.Record review of Resident #7's Comprehensive Care Plan, dated 03/20/26, reflected the resident being a fall risk; and an intervention included a scoop mattress. Record review of Resident #7's Physician Order, dated 04/08/26, reflected no Physician orders for a scoop mattress. During an observation on 04/07/2026 at 11:42 a.m., Resident #7 was observed lying in bed on a scoop mattress. During an interview on 04/08/26 at 9:05 a.m., LVN A, stated Resident #7 was a fall risk and his bed should be in a low position and a fall mat alongside his bed. He stated the scoop mattress was to provide support on his side because he always wanted to get out of bed without help. He stated the resident needed physician orders for the scoop mattress so it would not be considered a restraint. Record review of Resident #66's Face Sheet, dated 04/07/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #66 had a diagnosis of muscle weakness and lack of coordination.Record review of Resident #66's Quarterly MDS Assessment, dated 03/21/26, reflected the Resident had a BIMS score of 99 (unable to complete the interview). The MDS assessment reflected the resident had an active diagnosis of lack of coordination.Record review of Resident #66's Comprehensive Care Plan, dated 02/03/26, reflected the resident being a fall risk; and an intervention included a scoop mattress. Record review of Resident #66's Physician Order, dated 04/08/26, reflected no Physician orders for a scoop mattress.During an observation on 04/07/2026 at 11:14 a.m., Resident #66 was observed lying in bed on a scoop mattress. During an interview on 04/08/26 at 9:13 a.m., the ADON stated Residents #7 and #66 were fall risk and an intervention included the use of a scoop mattress. The ADON was informed by the Surveyor of Residents #7 and #66 not having physician orders for the scoop mattress. She stated she was not aware the residents required physician orders for the mattress. She stated physician orders were needed so the physician was aware of the care being provided to the resident. She stated all nurses were responsible for obtaining physician orders. During an interview on 04/08/26 at 10:51 a.m., the DON stated Residents #7 and #66 were fall risk and an intervention included the use of a scoop mattress. The DON was informed by the Surveyor of Resident #7 and not having physician orders for the scoop mattress. She stated she was not aware the resident needed physician orders for the mattress. She stated physician orders were needed so the physician approved of the care being provided to the resident. She stated all nurses were responsible for obtaining physician orders. Record review of Resident #34's Face Sheet, dated 04/08/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #34 had a diagnosis of mental and behavior disorders.Record review of Resident #34's Initial MDS Assessment, dated 03/11/26, reflected the Resident had a BIMS score of 4 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dementia (cognitive decline).Record review of Resident #34's Comprehensive Care Plan, dated 01/04/26, did not reflect the resident was a smoker.Record review of Resident #34's Smoking Assessment, dated 12/12/25, reflected the resident used tobacco products. Record review of Resident #41's Face Sheet, dated 04/08/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #41 had a diagnosis of chronic obstructive pulmonary disease (difficulty breathing). Record review of Resident #41's Initial MDS Assessment, dated 03/09/26, reflected the Resident had a BIMS score of 7 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of chronic obstructive pulmonary disease.Record review of Resident #41's Comprehensive Care Plan, dated 01/06/26, reflected the resident dipped snuff (smokeless tobacco) and required no supervision.Record review of Resident #41's Smoking Assessment, dated 08/22/25, reflected the resident did not use any tobacco products. During an observation and interview on 04/07/26 at 2:00 p.m., Resident #41 was observed sitting in a wheelchair in his room. He was observed with a can of chewing tobacco on his nightstand. He stated he chewed tobacco and he stated he currently had chewing tobacco in his mouth. During an interview and observation on 04/08/26 at 10:37 a.m., the ADON was informed by the Surveyor of Resident #41 having cans of smokeless tobacco in his room. She stated she was unaware the resident used smokeless tobacco. She stated if she did not know, then her staff may not have known also. She stated the risk of the resident using smokeless tobacco in his room could result in him choking. She stated the resident should have had a smoking assessment completed quarterly. She was informed the resident had a smoking assessment last completed on 08/23/25. She stated it was the nursing staff's responsibility to complete the assessment quarterly. She stated not completing the quarterly assessments could result in the resident choking. During an interview on 04/08/26 at 10:51 a.m., the DON was informed by the Surveyor of Resident #41 having cans of smokeless tobacco in his room. She stated she did not know what smokeless tobacco was and only knew of the tobacco that was smoked. She stated she was unaware the resident used smokeless tobacco. She stated the risk of the resident using smokeless tobacco was a safety concern. She stated the resident should have had a smoking assessment completed quarterly. She was informed the resident had a smoking assessment last completed on 08/23/25. She stated it was the nursing staff's responsibility to complete the evaluation quarterly. She stated not completing the quarterly assessment was a safety concern.During an interview on 04/08/26 at 12:10 p.m., the DON and MDS Nurse were informed of Residents #34 and #41 not having an updated quarterly smoking assessment nor did she have a care plan for smoking. The DON stated she thought Resident #34 had quit smoking. The ADON stated she had completed Resident #34's smoking assessment on 04/08/26 and she had confirmed Resident #34 was still a smoker and had observed her smoking outside on 04/08/26. The DON and ADON stated the resident being a smoker needed to be care planned because it was an area that required monitoring and her.During an interview on 04/08/26 at 12:20 p.m., the Administrator and the Regional Director of Operations were informed by the Surveyor of Residents #34 and #41 not having accurate and updated smoking assessments. They stated the nursing staff was not familiar with smokeless tobacco and they did not know what to look for when they observed Resident #41's room. They stated Resident #41 should not have had the items in his room and they were removed and secured with the other smoking products. The RDO stated she had educated them about smokeless tobacco. They stated the assessments needed to be done quarterly to ensure the residents were safe smokers. Record review of Resident #54's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows) and peptic ulcer (open sores in the lining of the stomach). Record review of Resident #54's Comprehensive MDS Assessment, dated 03/09/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had bipolar disorder and peptic ulcer.Record review of Resident #54's Comprehensive Care Plan, dated 01/30/2026, reflected the (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident had a diagnosis of bipolar disorder, characterized by alternating episodes of mania (abnormally elevated mood) and depression (persistent feeling of sadness or loss of interest), placing the resident at risk for mood instability, impaired judgment, safety concerns and had a history of peptic ulcer. The interventions for both was to administer medications as ordered.During an observation on 04/07/2026 at 9:15 a.m. revealed a container of odor neutralizer on top of Resident #54's mini refrigerator. At the back of container was written, Warning: May cause sensitivity or irritation to skin, eyes, and/or lungs and Keep out of the reach of children. The container was accessible and was on plain view.During an interview on 04/07/2026 at 9:16 a.m., Resident #54 said it was left by a housekeeper the day before but she did not know the name of the housekeeper.During an observation and interview on 04/07/2026 at 9:45 a.m., revealed LVN B went inside Resident #54's room and saw the odor deodorizer on top of the resident's mini refrigerator. She took the container of odor deodorizer and read the warning at the back of the container. She said it should have not been left inside the room of the resident because the deodorizer had chemicals that might be hazardous to the resident. She said confused residents might spray the deodorizer on their face. She said housekeeping was the ones using the deodorizer and they usually store it inside their carts. She said she did not notice the deodorizer when she did her morning round and she had no idea how long the deodorizer was inside the resident's room. She took the deodorizer and said she would give it to housekeeping.During an observation and interview on 04/07/2026 at 9:49 a.m., HK E said she was not the one who left the container of deodorizer inside Resident #54's room. She opened her cart and took the deodorizer that she was using. She said it would be dangerous if a resident would drink the deodorizer because it had chemicals in it.During an interview on 04/08/2026 at 9:02 a.m., the HK Supervisor said she was told about the deodorizer left inside Resident #54's room. She said she asked HK E but said she was not the one who left the deodorizer inside the room. She said she also asked the other HK but all of them said they did not. She said deodorizers had chemicals in them and would be dangerous if the resident would drink them of put them in their eyes. She said HK used gloves when they use it because it could cause irritation to the skin.During an interview on 04/09/2026 at 8:04 a.m., the ADON said the container of odor neutralizer should not have been left inside the resident's room because they were hazardous and might cause irritations. She said the content of the container was harmful if the resident accidentally sprayed it on her face and skin. She said the odor neutralizer should be stored inside the carts of housekeeping. She said they would coordinate with housekeeping to do an in-service about not leaving the container of odor neutralizer inside the rooms of the residents.During an interview on 04/09/2026 at 8:34 a.m., the DON said the containers of odor neutralizer should be locked in the housekeeping carts and not left inside the rooms of the residents because its content was unsafe if it had contact with the eyes and skin. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She said she would coordinate with the housekeeping department to re-educate the housekeepers to not leave anything hazardous inside the room of the residents.During an interview on 04/09/2026 at 8:59 a.m., the Administrator said anything harmful should not be left inside the rooms of the residents and should be locked inside the carts of the housekeepers because hazardous to the residents if consumed or used to clean the skin. She said she would collaborate with housekeeping so that the incident of the unattended container of odor deodorizer would not happen again.Record review of facility's policy, Resident Smoking, 03/20/26, reflected It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and nonsmoking residents. Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted. Residents must complete a Resident Safe Smoking Assessment and be determined safe to smoke independently without supervision. The assessment will evaluate cognitive status, physical ability, judgment, coordination, vision, respiratory status, oxygen use, and prior smoking-related<br>(continued on next page) |

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| | 455872 | A. Building<br>B. Wing | 04/09/2026 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | safety concerns. Determinations will be documented in the medical record and reflected in the resident's plan of care. Smoking materials must be stored in the lock box when not in use. Materials may not be stored in resident rooms outside of the lock box, common areas, or near oxygen, heat sources, or flammable materials. Storage location will be identified in the care plan and comply with life safety requirements. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process.Record review of facility's policy, Resident Smoking, undated, reflected The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.Record review of the facility's policy Medication Storage The Compliance Store revised November 02, 2025 reflected Policy Explanation and Compliance Guidelines . External Products: Disinfectants . are stored separately.Record review of the facility's policy, Resident Rights The Compliance Store, undated, reflected 8. Safe environment. The resident has a right to a safe . environment. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for four of eighteen residents (Resident #20, #22, #39, and #67) reviewed for medication storage.1. The facility failed to ensure Resident #22 did not have a roll-on medication inside her room on 04/07/2026.2. The facility failed to ensure Resident #20's zinc oxide was not left on top of the resident's overbed table beside the resident's food tray on 04/07/2026.3. The facility failed to ensure Resident #39's zinc oxide was not left on top of the resident's drawer on 04/7/2026.4. The facility failed to ensure Resident #67's opened sachet of barrier cream was not left on top of the resident's side table on 04/07/2026.These failures could place residents at risk of wrong medication administration, not getting the full benefit of the medication, accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #22's Face Sheet, dated 04/07/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows), and pain to the right leg. Record review of Resident #22's Comprehensive MDS Assessment, dated 03/09/2026, reflected the resident has a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident received PRN pain medication, had Alzheimer's disease, and bipolar disorder.Record review of Resident #22's Comprehensive Care Plan, dated 02/15/2026, reflected that the resident had a diagnosis of bipolar disorder and borderline personality disorder, characterized by alternating episodes of mania and depression, placing them at risk for mood instability, impaired judgment, safety concerns and one of the interventions was to administer medications as ordered. The plan indicated that the resident was at risk for pain and had an impaired cognitive function and the intervention for both was to administer medications as ordered.Record review on 04/07/2026 of Resident #22's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications.Record review on 04/07/2026 of Resident #22's Physician Order reflected the resident did not have an order for a topical roll-on analgesic.During an observation on 04/07/2026 at 9:15 a.m. revealed that Resident #22 was in her bed with eyes closed. It was observed that a roll-on pain relieving gel was observed on the resident's overbed table at bedside that was in plain view and accessible.During an observation and interview on 04/07/2026 at 9:45 a.m., revealed LVN B stated the topical pain relieving medication should not be inside the resident's room unless they have an assessment that it was safe for them to administer the medication themselves. She said even though the resident was independent and doing things by themselves, there should be assessment. She said confused residents sometimes go inside other resident's rooms and might get hold of the medication and use it inappropriately. She went inside Resident #22's room and saw the medication. She took the roll-on pain-relieving gel and said she would talk to the resident when she woke up. She said she would also check if the resident had an order for the topical analgesic.2. Record review of Resident #20's Face Sheet, dated 04/07/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and depression (persistent feeling of sadness or loss of interest). Record review of Resident #20's Comprehensive MDS Assessment, dated 03/04/2026, reflected the resident has a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident was incontinent (unable to control) for bowel<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and bladder.Record review of Resident #20's Comprehensive Care Plan, dated 01/01/2026, reflected the resident experienced urinary loss of urine and one of the interventions was barrier cream would be applied as needed. Record review on 04/07/2026 of Resident #20's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications.During an observation and interview on 04/07/2026 at 9:25 a.m. revealed Resident #20 was in his bed, awake. It was observed that a tube of zinc oxide (a form of barrier cream used to treat skin irritations, diaper rash, and other skin conditions) was on top of the resident's overbed table, beside a tray of food. When asked about who left the zinc oxide, the resident shrugged his shoulder. 3. Record review of Resident #39's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #39's Comprehensive MDS Assessment, dated 03/11/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel.Record review of Resident #39's Comprehensive Care Plan, dated 03/10/2026, reflected the resident experienced urinary loss of urine and one of the interventions was barrier cream would be applied as needed.Record review on 04/07/2026 of Resident #39's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications.During an observation on 04/07/2026 at 9:27 a.m. revealed Resident #39 was not inside his room. A tube of zinc oxide was observed on top of the resident's drawer. The zinc oxide was accessible and was visible from the hallway.During an observation and interview on 04/07/2026 at 9:30 a.m., LVN A said barrier cream with zinc oxide should not be within reach of the resident to prevent misuse of the medication. He said zinc oxide was a form of topical medication used to prevent skin issues. He said confused residents might consume the cream or put it in their eyes resulting in irritation. He took the tubes of zinc oxide from Resident #20 and Resident #39's room and said he would put them in a zip lock and put them in his cart. He said the CNAs might have forgotten them when they changed the residents. He said he would remind them not to leave the zinc oxide where the residents could reach them.4. Record review of Resident #67's Face Sheet, dated 04/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cognitive impairment (difficulty in thinking, remembering, and making decisions) and kidney disease. Record review of Resident #67's Quarterly MDS Assessment, dated 02/23/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was incontinent for bowel and bladder.Record review of Resident #67's Comprehensive Care Plan, dated 01/26/2026, reflected the resident had bowel and bladder incontinence and one of the interventions was to monitor for signs and symptoms of urinary tract infection. The plan indicated that the resident had the potential for pressure ulcer due to incontinence and one of the interventions was to apply barrier cream.Record review on 04/07/2026 of Resident #67's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications.During an observation on 04/07/2026 at 10:35 a.m. revealed Resident #67 was not inside his room. It was observed that two sachets of barrier cream were on top of the resident's side table. One of the sachets was open. During an observation and interview on 04/07/2026 at 10:42 a.m., CNA C said she was not the one who left the sachets of barrier cream inside Resident #67's room. She said the barrier cream should not be left inside the rooms because the resident might eat it. She went inside the resident's room and took the sachets from the side table and threw them in the trash can. During an interview on 04/09/2026 at 8:04 a.m., the ADON said medicated creams should not be left accessible to the residents because a confused resident might get a hold of them and use them inappropriately. She said residents with poor eyesight might mistakenly think that zinc oxide was a condiment and put it on their food. She said there should not be a topical analgesic inside the room unless the resident could self-administer medications safely. She said they would sweep the rooms and check if there were any medications inside the rooms of the residents. She said they would re-educate the staff not to leave the tubes of zinc oxides inside<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the rooms of the residents.During an interview on 04/09/2026 at 8:34 a.m., the DON said medications should not be inside the rooms of the residents because it could cause probable harm such as irritation and allergic reactions. She said the residents should have an assessment for self-medication to determine if they were able and if it was safe for the residents to administer their own medications. She said the same rationale applied to the zinc oxides. She said confused residents might use the creams inappropriately such as consume them or use them in their eyes. She said she would start an in-service about medication storage.During an interview on 04/09/2026 at 8:59 a.m., the Administrator said the expectation was if the resident did not have an assessment for self-medication, then there should not be any medication inside the room of the resident. She said the staff should be the one administering the medication. She said the zinc oxides should not be accessible to the residents to prevent them from using them inappropriately. She said she would let the DON take the lead about the issue of medication storage. Record review of the facility's policy Medication Storage The Compliance Store revised November 02, 2025 reflected Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms . and sufficient to ensure proper . security . Policy Explanation and Compliance Guidelines . 1. General Guidelines . a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . b. Only authorized personnel will have access to the keys to locked compartments. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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 the facility's only kitchen, reviewed for food and nutrition services. The Dietary Manager failed to wear a head cover and she failed to ensure a vendor was wearing a beard cover in the kitchen while food was being prepared.The facility failed to properly label and date stored food received from vendors.The facility failed to ensure the ice machine in the kitchen was thoroughly cleaned.The facility failed to ensure the deep fryer was properly cleaned.These failures placed residents at risk of exposure to food contamination and illness. Findings included:Observations on 04/07/26 from 9:08 a.m. to 9:20 a.m. in the facility's only kitchen revealed: The Dietary Manager was in the kitchen near a pot of food being cooked and she was not wearing a head cover. A vendor was in the kitchen making repairs near a pot of food being cooked and he was not wearing a beard cover. The vendor's beard was at least half inch in length. An ice machine, located in the kitchen had reddish stains along the inside panel wall of the ice machine. Two large bags of sausages, located in the freezer, were not dated with the month, day, and year they were stored upon receipt from the vendor. One large bag of taquitos, located in the freezer, was not dated with the month, day, and year it was stored upon receipt from the vendor. One large bag of cookie dough, located in the freezer, was not dated with the month, day, and year it was stored upon receipt from the vendor. The deep fryer, in the kitchen area, had light brownish substances floating all over the top of the cooking oil in the fryer. During an interview on 04/08/26 at 1:15 p.m., the Dietary Manager was informed by the Surveyor of the concerns observed in the kitchen area on 04/07/26. She stated she had a hairnet but had taken it off when she briefly left the kitchen. She stated she was busy preparing food for lunch and forgot to put a hairnet back on. She stated she had the vendor place a hairnet on his head but forgot to have him place a beard covering on. She stated she cleaned the ice machine weekly, which included the inside of the unit. She stated the kitchen staff stored food first in and first out, so she did not think the year had to be included on the food when stored. She stated the deep fryer had not been used for a long period of time, so she did not think it needed cleaning since it was inoperable. She stated the concerns observed in the kitchen could result in food contamination. During an interview on 04/08/26 at 12:10 p.m., the Administrator was informed by the Surveyor of the concerns observed in the kitchen area on 04/07/26. She stated she expected the kitchen to comply with policy and the concerns observed could result in food contamination.Record Review of the Facility's policy titled Food Storage and Supplies, dated 2012, revealed, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. Best practice is that scoops should not be left in food containers or bins, but if so, handles should be upright and not contacting the food item. Containers are cleaned regularly. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires, and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD Texas Chapter 228 Retail Food adopts the U.S FDA Food Code. 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. 3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepare. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of eighteen residents (Resident #19, #23 and #86) reviewed for infection control. 1. The facility failed to ensure CNA C performed hand hygiene and changed her gloves during Resident #19's incontinent care on 04/07/2026. 2. The facility failed to ensure CNA D performed hand hygiene, changed her gloves, did not put gloves inside her pockets, and wore a gown during Resident #23's incontinent care on 04/08/2026. 3. The facility failed to ensure LVN A performed hand hygiene before checking Resident #86's blood sugar on 04/08/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #19's Face Sheet, dated 04/08/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting and atrophy.Record review of Resident #19's Comprehensive MDS Assessment, dated 01/11/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 0. The Comprehensive MDS Assessment indicated the resident had bowel and bladder incontinence.Record review of Resident #19's Care Plan, dared 01/30/2026, reflected the resident experienced involuntary loss of stool and urine and one of the interventions was to clean her perineal (area between the legs) area after each episode.During an observation on 04/07/2026 at 2:02 p.m. revealed CNA C was about to do Resident #19's incontinent care. She washed her hands, put on a pair of gloves, and proceeded with incontinent care. After fixing the brief under the resident, she noticed that the resident's left inner upper leg was still soiled. She took some wipes and cleaned the inner leg. She then proceeded to fix the brief without changing her gloves.During an interview on 04/07/2026 at 2:31 p.m., CNA C said she should have changed her gloves when she wiped the resident's legs to prevent urinary tract infection.2. Record review of Resident #23's Face Sheet, dated 04/08/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #23's Comprehensive MDS Assessment, dated 03/10/2026, reflected that the resident was not able to complete the interview to determine the BIMS score. The Staff Assessment for Mental Status reflected that the resident had memory problems and was severely impaired for daily decision making. The assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #23's Comprehensive Care Plan, dated 01/30/2026, reflected that the resident was incontinent for bowel and bladder and one of the interventions was to clean, and dry the perineum. The plan indicated that the resident had a pressure injury due to limited mobility and one of the interventions was to use pressure- relieving devices.Record review of Resident #23's Physician Order, dated 03/18/2026, reflected Wound Location: SACRUM (bone at the lower back) Cleanse wound with NS/wound cleanser Peri (around) wound: House Barrier Cream Primary Dressing: CALCIUM ALGINATE with SILVER Secondary Dressing: Secure with: Dry gauze dressing every 8 hours as needed WHEN SOILED OR DISLODGE.Record review of Resident #23's Physician Order, dated 03/27/2026, reflected ENHANCED BARRIER PRECAUTIONS: Resident requires enhanced barrier precautions. Wear PPE per facility protocol. Required for high contact resident care activities. Indications: wound. During an observation on 04/08/2026 at 9:23 a.m. revealed CNA D was about to do incontinent care for Resident #23, who had an open wound to her sacrum. She went inside the room and put on a pair of gloves. She did not wash her hands before putting on her gloves. She also did not wear a gown before doing incontinent care. It was observed that there were no gloves and sanitizer on the resident's table. She took a brief from the resident's overbed table, opened it, and placed it on the resident's side. She cleaned the resident's perineal area using the front to back technique. She took off her gloves, pulled a pair of gloves from her pocket, and put them on. She did not sanitize her<br>(continued on next page) |

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| | 455872 | A. Building<br>B. Wing | 04/09/2026 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | hands when she changed her gloves. She then rolled the resident and cleaned the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief and threw it to the trash can. She took the opened brief from the side of the resident, placed it under the resident, and fixed it. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She took off her gloves when she was done with incontinent care. There was a sign outside the resident's room that stated the resident was on EBP and a gown was required when changing the brief. The sign also indicated to clean the hands before entering and when leaving the room.During an interview on 04/08/2026 at 9:40 a.m., CNA D said the EBP sign outside the room was for Resident #23 because she had a wound on her bottom. She said the sign outside indicated to wear gloves and a gown during care for residents with open wound. She said she forgot to wear a gown. She said the gown served as an added protection to prevent cross contamination. She said hands should be washed before and after incontinent care to make sure her hands were clean before touching the resident. She said she was supposed to change her gloves after cleaning the resident's bottom and before touching the new brief to prevent using dirty gloves that could result in cross contamination. She said gloves should not be placed in the pockets because the pockets were not always clean. She said her actions could contribute to cross contamination and infection. 3. Record review of Resident #86's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #86's Comprehensive MDS Assessment, dated 03/18/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin. Record review of Resident #86's Comprehensive Care Plan, dated 03/21/2026, reflected that the resident had diabetes mellitus and one of the interventions was to administer insulin.Record review of Resident #86's Physician Order, dated 03/28/2026, reflected Insulin Lispro Injection Solution (Insulin Lispro) Inject 3 units subcutaneouslythree times a day for DM TYPE 2 HOLD IF BS LESS THAN 110.During an observation on 04/08/2026 at 11:21 a.m. revealed LVN A was about to check Resident #86's blood sugar. He parked his cart in front of the resident's room, prepared his glucometer, alcohol wipes, and test strips. He then put on a pair of gloves and proceeded to check the resident's blood sugar. He did not sanitize his hands before checking the resident's blood sugar.During an interview on 04/08/2026 at 11:28 a.m., LVN A said he should have sanitized his hands before checking Resident #86's blood sugar to make sure his hands were clean before touching the gloves that he would be using to check the blood sugar. He said he would be mindful the next time he would do treatment to do hand hygiene before and after treatment.During an interview on 04/09/2026 at 8:04 a.m., the ADON said gloves should not be placed inside the pockets because the pockets were dirty, rendering the gloves dirty when used during incontinent care. She said hands should be washed before any care and treatment. She said the staff should change their gloves after cleaning the resident's bottom to make sure the staff were not using soiled gloves when they touched the new brief. She said staff should also sanitize their hands when they were changing their gloves. She said if the resident was on EBP, then the staff should wear a gown in addition to the gloves. She said hand hygiene, changing of gloves, sanitizing in between changing of gloves, not putting gloves in the pocket, and wearing PPE were ways to prevent cross contamination and spread of infections. She said they would re-educate the staff on the importance of hand hygiene and infection control.During an interview on 04/09/2026 at 8:34 a.m., the DON said if a resident was on EBP, then the staff doing care should wear a gown every time they had contact with the resident to prevent cross contamination and spread of infection. She said hand hygiene was the most effective way to prevent cross contamination and spread of infection and staff should do hand hygiene before, during, and after any care. She said gloves should have been changed after cleaning the resident's bottom and before touching the new brief. She said there might be no policy that would say not to put the gloves in the pockets, but the best practice was not to put gloves inside the pockets to make sure the gloves being used were clean. She said it was also an infection control issue if the staff did not sanitize their<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | hands when changing their gloves. She said the expectation was for the staff to be mindful not to spread any infection and that the staff would adhere to the policy of hand hygiene, EBP, and infection control. She said she would start an in-service about hand hygiene, EBP, and infection control.During an interview on 04/09/2026 at 8:59 a.m., the Administrator said that the expectation was for the staff to wear gowns in addition to the gloves if the residents were on EBP, not to put gloves in their pockets, to perform hand hygiene before and after care and treatment, and to change their gloves if required. She said the concerns discussed would all contribute to the development and spread of infection. She said she was not a clinician and would let the DON take the lead on the issue of infection control.Record review of the facility's policy Enhanced Barrier Precautions The Compliance Store revised April 04, 2026 reflected Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . 3. Implementation of Enhanced Barrier Precautions . b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include . h. Wound care: any skin opening requiring a dressing.Record review of the facility's policy Hand Hygiene The Compliance Store revised April 09, 2026 reflected Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . 1. Staff will perform hand hygiene when indicated . 3. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations . Hands are visibly soiled with blood or other body fluids . After handling contaminated objects . Before applying and after removing personal protective equipment (PPE), including gloves . Before preparing or handling medications . Before performing resident care procedures . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #34 and Resident #60) of twenty residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #34 and Resident #60's rooms was in a position that was accessible to the resident on 04/07/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #34 Record review of Resident #34's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with abnormalities of gait and physical debility (weakness).Record review of Resident #34's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 03/11/2026, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 04. The Quarterly MDS Assessment indicated the resident needed assistance for hygiene, shower, dressing, and transfer.Record review of Resident #34's Comprehensive Care Plan, dated 04/04/2026, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach.During an observation and interview on 04/07/2026 at 9:09 a.m., revealed Resident #34 was in her bed, awake. It was observed that the resident's call light was on the floor and tucked behind the resident's side table. When asked where her call light was, the resident looked for call light. She said the staff forgot to clip her call light again. She said she had been looking for it since morning but her call light was nowhere to be found. Resident #60 Record review of Resident #60's Face Sheet, dated 04/07/2026, reflected a [AGE] year-old male admitted on [DATE]. The resident was diagnosed with muscle weakness, visual (pertaining to the eyes) loss, chronic pain.Record review of Resident #60's Quarterly MDS Assessment, dated 02/20/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident needed assistance for hygiene, shower, dressing, and transfer.Record review of Resident #60's Comprehensive Care Plan, dated 01/30/2026, reflected the resident was at risk for fall due to poor safety awareness and one of the interventions was for the call light to be in reach.During an observation and interview on 04/07/2026 at 9:04 a.m. revealed Resident #60 was in his bed, awake. It was observed that the resident's call light was on the floor and was under the roommate's bed. When asked where his call light was, the resident said he was looking for his call light since the day before. He said he looked for his call light at the side of his bed but could not find it.During an observation and interview on 04/07/2026 at 9:38 a.m., LVN B said call lights were used by the residents to call the attention of the staff when they needed something or needed assistance. She said the call lights were supposed to be accessible to all the residents always to ensure prompt actions from the staff to meet their needs. She said the residents would call if they needed to be changed, for a refill of their pitcher, or if they were having pain and discomfort. She went inside Resident #60's room, looked for the call light, and found it under the roommate's bed. She said it must have fallen when the staff fixed Resident #60's bed. She picked up the call light and clipped it at the side of Resident #60's bed. She then went to Resident #34's room and looked for the call light and found it behind the resident's side table. She pulled the call light and clipped it where the resident could access it. She said she did not notice the call light was on the floor when she checked on the residents. She said staff should have made sure the call light was with Resident #34 and Resident #60 before leaving the room, because even though the resident could stand up and walk. She said the resident might be having distress and could not get up to pick-up or pull the call light. During an interview on 04/07/2026 at 11:06 a.m., CNA C said call lights were important for the residents<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | because the residents used them to call the staff when they needed something or needed assistance. She said the residents might fall trying to get the call light or trying to do some activities that needed assistance. She said she would check the call lights of the residents assigned to her. She said she did her morning round but did not notice that Resident #34 and Resident #60's call lights were not with them.During an interview on 04/09/2026 at 8:04 a.m., the ADON said call lights should always be with the residents or within reach of the residents to prevent falls. She said the staff should make sure that the call lights were with the residents before they leave the room. She said the call lights had clips on them and the staff could use them to prevent the call lights from falling. She said the call lights were for all residents, regardless of whether they were dependent or independent. She said independent residents might be in distress and could not call the staff because their call lights were not with them. She said everybody was responsible in making sure the call lights were with the residents. She said housekeeping could call the nurses or the CNAs if they see the call lights were on the floor or not within reach. She said the expectation was for the staff to make sure that all the call lights were within reach of the residents. She said they would re-educate the staff regarding call lights. During an interview on 04/09/2026 at 8:34 a.m., the DON said call lights were used by the residents to communicate with the staff if they needed something. She said residents would call the staff if they needed any medication, they needed to be changed, or if they wanted to get up. She said if the call lights were not within reach, their needs would not be met. She said the call lights were for all residents and all the staff were responsible for the call lights. She said the expectation was for the staff to inspect the residents' room when they did their rounds and make sure the call lights were within reach of the residents before they leave the room. She said she just bought some clips to replace the clips of the call lights that were already worn out. She said she would start an in-service about call light placement and would continually educate the staff about the importance of call lights for the residents. During an interview on 04/09/2026 at 8:59 a.m., the Administrator said call lights should be within the reach of the residents at all times, whether the resident was mobile or not. She said some residents use the call light in cases of emergencies, if they needed any medication, or even a glass of water. She said without the call lights, their needs would not be met and the residents might be upset. She said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. She said she would collaborate with the DON about the issue regarding call lights.Record review of facility's policy Call Lights: Accessibility and Timely Response The Compliance Store revised April 08, 2026 reflected Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside . 5. Staff will ensure the call light is within reach of resident and secured . 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during personal care and confidentiality of personal and medical records for two of twenty residents (Resident #7 and Resident #19) reviewed for privacy and confidentiality.1. The facility failed to ensure LVN A closed, locked, or minimized his laptop monitor before leaving his cart, thus exposing Resident #7's medical information, on 04/08/2026. 2. The facility failed to ensure CNA C closed the blinds of Resident #19's window, which was overlooking to the parking lot, during incontinent care on 04/07/2026. These failures could place the residents at risk of not having their personal privacy maintained while care was provided, which could result in the residents feeling uncomfortable during care and having their personal and medical record exposed to unauthorized individuals.Findings included: 1. Record review of Resident #7's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypotension (low blood pressure) and hypertension (High blood pressure).Record review of Resident #7's Comprehensive MDS Assessment, dated 03/19/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had hypotension and hypertension.Record review of Resident #7's Care Plan, dated 03/01/2026, reflected the resident had a history of hypertension and hypotension and one of the interventions was to administer antihypertensive/antihypotensive medications as ordered.Record review of Resident #7's Physician Order, dated 03/12/2026, reflected Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet via PEG-Tube (a flexible feeding tube inserted directly to the stomach) every 8 hours for low blood pressure HOLD IF SBP > 140 OR DBP > 90.During an observation on 04/08/2026 at 11:22 a.m. revealed LVN A was looking at his computer in the hallway. He then left his cart to go to the other hall. He left his computer open with Resident #7's medical information exposed. He then went back to his computer and looked at his computer again. He then left his computer again with the resident's medical information still exposed. The computer was on top of his cart and was facing the hallway. The screen of the laptop displayed Resident #7's name, date of birth , name of his physician, location, code status, allergies, special instructions, his latest vital signs, his latest weight, his latest pain level, and his medication for low blood pressure.During an interview on 04/08/2026 at 11:42 a.m., LVN A said he went to get something, that was why he left his cart. He said it was a HIPAA (law protecting health information aimed to ensure confidentiality) violation because the personal and medical information of Resident #7 was exposed. He said information should be secure and confidential. He said he should have minimized or locked the screen of his laptop before leaving his cart.2. Record review of Resident #19's Face Sheet, dated 04/08/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting (loss of muscle leading to its shrinking and weakening) and atrophy (decrease in size of a body part).Record review of Resident #19's Comprehensive MDS Assessment, dated 01/11/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had bowel and bladder incontinence.Record review of Resident #19's Care Plan, dated 01/30/2026, reflected the resident experienced involuntary loss of stool and urine and one of the interventions was to maintain privacy and dignity during incontinence care to support emotional well-being.During an observation on 04/07/2026 at 2:02 p.m. revealed CNA C was about to do Resident #19's incontinent care. It was observed that the resident's bed was parallel to the window, which was overlooking the parking lot. CNA C pulled the privacy curtain but did not close the window blinds before doing incontinent care. She did not tell the resident that she would close her blinds nor did the resident tell CNA C that she did not want her blinds closed. During incontinent care, CNA C went to the room's sink to wash her hands leaving the resident without any brief and with the perineal area exposed. After incontinent care was done, CNA C took off (continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the resident's hospital gown exposing her breasts. At this point, the blinds were still open and it was observed that the window did not have a curtain.During an observation and interview on 04/07/2026 at 2:31 p.m., CNA C said she thought the window blinds were not working and that was why she did not close them. She went to check on the blinds and the blinds worked. She said she should have closed them during Resident #19's incontinent care to provide privacy from the outside of the facility. During an interview on 04/07/2026 at 2:36 p.m. Resident #19 did not reply when asked if it was okay that her blinds were open during incontinent care.During an interview on 04/09/2026 at 8:04 a.m., the ADON said leaving the computer open with residents' personal and medical information exposed was a HIPAA violation because that information should be confidential. She said the staff should minimize or lock the screen of the laptop before leaving it unattended. She said the blinds should have been closed when incontinent care was being done to provide privacy and open it again when it was done. She said staff closed the doors and pull privacy curtains to provide privacy from the inside of the facility and the staff should be mindful to provide privacy from the outside of the facility. She said it did not matter if the residents mind or not, but the expectation was for the staff to be sensible enough that if they were in the residents' position, they might want the blinds closed so that those individuals walking in the parking lot would not see their private areas. She said they would re-educate the staff regarding privacy during care and confidentiality of residents' information.During an interview on 04/09/2026 at 8:34 a.m., the DON said the staff should have closed the blinds during incontinent care so that the resident would not be exposed from the parking lot. She said she did not know that there was no curtain on Resident #19's window because if the resident did not want her blinds closed, at least the curtain could be used to provide privacy. She said, the issue was not if the residents minded or not, but that the staff did not provide privacy. She said leaving the computer open with a resident's medical information exposed was a HIPAA violation. She said the medical information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said all the staff were expected to provide full privacy during care and confidentiality of information for all residents. The DON stated she would start an inservice about privacy and confidentiality and would personally monitor if the staff were in compliance to the policy.During an interview on 04/09/2026 at 8:59 a.m., the Administrator said the staff should have closed the lid of the computer before leaving the cart to ensure no medical information about the residents was exposed. She said medical information should be secured because it was confidential. She said privacy should be provided during care. She said she would collaborate with the DON about the issue regarding privacy and confidentiality.Record review of the facility's policy, Confidentiality of Personal and Medical Records The Compliance Store, undated, reflected Policy: This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record.Record review of the facility's policy, Resident Rights The Compliance Store, undated, reflected Policy: The facility will inform the resident both orally and in writing . of his or her rights . 7. Privacy and confidentiality . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . a. Personal privacy includes . personal care . b. The resident has a right to secure and confidential personal and medical records. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance for 1 of 3 residents (Residents #7) reviewed for assisted nutrition and hydration.The facility failed to notify the Dietician of Resident #7's weight loss of over 12% within a week.This failure could prevent the Dietician from reviewing the resident's plan of care and addressing the excessive weight loss.Findings include:Record review of Resident #7's Face Sheet, dated 04/07/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had a diagnosis of malnutrition.Record review of Resident #7's Initial MDS Assessment, dated 03/19/26, reflected the Resident had a BIMS score of 6 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of malnutrition.Record review of Resident #7's Comprehensive Care Plan, dated 03/20/26, reflected Monitor/record report to MD PRN signs of malnutrition, muscle wasting, significant weight loss: 3 lbs. in 1 week; >5% in 1 month; >7.5% in 3 months; >10% in 6 months. Record review of Resident #7's weight was recorded on 03/12/26 at 140 lbs. and the resident's weight on 03/19/26 was reported at 122 lbs., which was over a 12% decrease of weight in a week. During an observation on 03/24/26 at 11:36 a.m., Resident #7 was observed lying in bed. The resident appeared thin.During an interview on 04/08/26 at 11:15 a.m., the DON and ADON were informed by the Surveyor of Resident #7 having a care plan for possible nutritional problems, and an intervention included reporting significant weight loss of 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, and >10% in 6 months. They were informed of the system of record only reflecting the resident's initial weight of 140 lbs. on 03/12/26 and no other weight recorded. The DON stated they had captured the resident's weekly weight and charted it on a paper. The paper chart provided reflected Resident #7 was weighed on 03/19/26 and his weight was reported at 124 lbs. The DON stated she did not think the resident's original weight was recorded correctly and she did not think he weighed 140 lbs., upon admission. The DON stated she doubted the resident had sustained an 18-pound weight loss within a week because she and the ADON did not observed the resident to be thinner compared to the prior week. The DON stated she had not reported the weight loss to the Dietician at the time this was observed and she was waiting to notify the Dietician when she had visited the facility on 04/08/26. The DON stated not notifying the Dietician of the suspected weight loss, would prevent the Dietician from implementing an intervention to address the weight loss.During an interview on 04/08/26 at 11:39 a.m., the Consulting Dietitian stated Resident #7 could be at risk of weight loss. She stated she did not update care plans. She stated she pulled reports twice a month to alert her of any residents with significant weight loss, or staff reached out to her and notified her. She stated the resident's records only reflected his initial weight on 03/12/26 of 140 lbs., and no other records were inputted in the facility's system of record. She was informed by the Surveyor of the resident having an initial weight of 140 lbs. on 03/12/26, and on 03/19/26 the resident weighed 124 lbs. She stated the facility should have notified her so she could make modifications to the resident tube feeding if needed. She stated she was not made aware of this reduction in weight. She stated she would review the resident's weight and address the potential weight loss.Record review of the facility's policy Weight Monitoring, dated 4/9/26, reflected Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss. e. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455872 | A. Building<br>B. Wing | 04/09/2026 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of three residents (Resident #7) reviewed for feeding tube management.The facility failed to ensure LVN A checked Resident #7's g-tube placement and flushed the g-tube before and after medication administration as ordered on 04/08/2026.This failure could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and dehydration.Findings included:Record review of Resident #7's Face Sheet, dated 04/08/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing).Record review of Resident #7's Comprehensive MDS Assessment, dated 03/19/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach).Record review of Resident #7's Quarterly Care Plan, dated 03/12/2026, reflected the resident required tube feeding (delivery of nutrition through a tube inserted in the stomach) and one of the interventions was to monitor for nausea, vomiting, bloating, and discomfort during or after feeding.Record review of Resident #7's Physician Order, dated 03/12/2026, reflected Check enteral tube (flexible tube used to deliver nutrition directly to the stomach) placement prior to giving meds or bolus (large dose of medication or food given at once) feed by air auscultation (listening to the sounds inside the body using a stethoscope) & aspirate (to draw by suction) contents, then return contents to stomach, if > 100 ml stop feeding and notify physician. every shift AND as needed.Record review of Resident #7's Physician Order, dated 03/12/2026, reflected Flush enteral tube with 60 ml H2O before and after meds or bolus feedings.During an observation on 04/08/2026 at 1:19 p.m., revealed LVN A was about to give Resident #7's medication via g-tube. He sanitized his hands, put the medication in a small plastic cup, crushed it, returned the crushed medication to the small plastic cup, and dissolved it. He put the cup of crushed medication in a tray along with a cup of half-filled water. He then went inside the resident's room and placed the tray on top of the resident's overbed table. He took a 60 ml piston syringe from the IV pole at bedside. He put on a gown and a pair of gloves, raised the bed, elevated the head of the bed, turned off the g-tube pump, and disconnected the g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) from the formula. After disconnecting the g-tube, he attached the syringe to the g-tube, and checked the residual (food, liquid, and secretions remaining in the stomach). He disconnected the syringe, pulled the plunger of the syringe, and connected the barrel of the syringe. He flushed the g-tube with 20 cc of water, poured the dissolved medication, and flushed the g-tube with 10 cc of water. He did not check for placement of the resident's g-tube before flushing and administering the medication. After he was done administering the medications, she detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe. It was observed that a stethoscope was hanging on the computer brace of his cart.During an observation and interview on 04/08/2026 at 1:47 p.m., LVN A said he forgot to check Resident #7's g-tube placement before flushing the g-tube. He said the placement should be checked to make sure that the g-tube was not dislodged. He said the dislodged g-tube could cause aspiration. He logged on to his computer and saw that the order specified to check for placement through auscultation. He said he did flush the g-tube before and after medication administration. He checked the order for flushing and saw the order specified to flush 60 cc before and after medication administration. He said he only flushed the g-tube with 10 cc of water before and 20 cc after medication. He said the g-tube should be flushed to make sure that the medication went through the tube to the stomach. He said a specific amount of water was ordered to help with the resident's hydration as well.During an interview on 04/09/2026 at 8:04 a.m., the ADON said g-tube<br>(continued on next page) |

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| | 455872 | A. Building<br>B. Wing | 04/09/2026 |

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| Arlington Residence and Rehabilitation Center | 405 Duncan Perry Rd<br>Arlington, TX 76011 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | placement should be checked before giving the medications to ensure the g-tube was in the right place and would not cause aspiration. She said even though the residents were on continuous feeding, the placement should still be checked. She said if the order said through auscultation, then a stethoscope should have been used. She said the g-tube should be flushed to make sure the tube was patent (unobstructed), functioning well, and was not clogged. She said if the order said to flush 60 cc before and after medication then the staff should have flushed it with 60 cc before and after medication administration. She said a specific amount of water was ordered to ensure hydration and that the medication was delivered safely. She said she would coordinate with the DON about the issue during medication administration via g-tube.During an interview on 04/09/2026 at 8:34 a.m., the DON said the placement of the g-tube was done through the use of a stethoscope. She said it was important to check for placement before flushing it and before medication administration to ensure the medications and the fluid would enter the stomach and not the lungs. She said if the order specified 60 cc then the staff should have given 60 cc before and after medication administration. She said the staff should have followed the order because water intake for residents with g-tube was calculated based on the individual needs, to prevent dehydration and fluid overload. She said the expectation was for the staff to follow the orders in medication administration via g-tube. She said she would start an in-service about g-tube medication administration.During an interview on 04/09/2026 at 8:59 a.m., the Administrator said the expectation was for the staff to check the g-tube placement and flush as per order. She said she was not a clinician and would let the DON take a lead on the issue about g-tube. Record review of the facility's policy Care and Treatment of Feeding Tubes The Compliance Store revised April 09, 2026 reflected Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . Policy Explanation and Compliance Guidelines . 1. Feeding tubes will be utilized according to physician orders . 4. The facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs . 6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location . a. Tube placement will be verified before beginning a feeding and before administering medications. |