

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024
NAME OF PROVIDER OR SUPPLIER Arbor Lake Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Pennsylvania Ave Fort Worth, TX 76104	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on interview, and record review, the facility failed to provide and document sufficient preparation to ensure safe and orderly discharge from the facility for one resident (Resident #1) of five residents reviewed for discharge. The facility failed to ensure Resident #1's home health and wound care services were confirmed and in place prior to discharge. These failures could place residents at risk of being discharged without preparation, causing a disruption in their care and place the residents at risk for their needs not being met. Findings included: Review of Resident #1's Face Sheet, dated 06/03/2024, revealed a [AGE] year-old male originally admitted on [DATE], readmitted on [DATE], and discharged on [DATE] with diagnoses that included: osteomyelitis of vertebra (the most common form of vertebral infection), sacral and sacrococcygeal region, Brown-Sequard syndrome (is a rare neurological condition characterized by a lesion in the spinal cord which results in weakness or paralysis on one side of the body and a loss of sensation on the opposite side), sepsis (a serious condition in which the body responds improperly to an infection), muscle weakness, lack of coordination, unsteadiness on feet, type two diabetes mellitus without complications, neuromuscular dysfunction of the bladder. Review of Resident #1's Care Plan, dated 05/31/2024, revealed Resident #1 has Sacral Stage 4 with slough and/or eschar present on admission, Resident #1 has a suprapubic catheter placed, Resident #1 has bowel incontinence immobility and paralysis Review of Resident #1's discharge MDS assessment, dated 05/30/2024, revealed resident #1's BIMS was noted as 15, which indicates the resident's cognition was intact. Resident #1 functional status documented on discharge MDS is not completed. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/2024 at 10:50 a.m. with SW revealed Resident #1's discharge was resident initiated and planned. Resident #1 was to the home on 05/30/2024 and would transfer from home to another rehabilitation facility on 06/01/2024. SW stated once residents decide to discharge will ask resident and/or family if they require home health services and what equipment is at home, if residents require additional items for home will place referral. In this case resident refused home health, so no order or referral was provided for Resident #1 due to family member refusal of home health services. Social worker could not provide documentation of refusal. During an interview on 06/02/2024 at 1:08 p.m. with Resident #1's family member revealed that Resident #1 was discharged home on 5/30/2024. Resident #1's family member expressed concern on providing care for resident due to not able to be present all day. Resident #1's family member stated that the facility did not provide proper education was not shown how to perform wound care. Additionally, resident's #1 family member stated the facility did not provide and instructions on wound care. She stated that the facility did provide wound care supplies. During an interview on 06/02/2024 at 1:37 p.m. with LVN B revealed that Resident #1 had a stage four pressure wound on sacrum and was incontinent of the bowels. This required Resident #1 to be changed prior to treating the wound to prevent infection. Due to incontinence issues Resident #1 required frequent wound care during each shift. LVN B felt it was not safe to transfer home without home health care as Resident #1 required constant care and assistance times two to transfer from bed to chair. Wound care training was provided once to family when they came to visit at that time resident had wound vac (an alternative method of wound management, which uses the negative pressure to prepare the wound for spontaneous healing or by lesser reconstructive options) on. No other training was provided to family of Resident #1. During an interview on 06/02/2024 at 1:57 p.m. with the Wound Physician via phone revealed that Resident #1 wanted to return home but told Resident #1 if he transferred home someone would need to be at home 24 hours to assist with his wound care dressing changes. The Wound Physician suggested to Resident #1 home health would be best option for Resident #1 to discharge home. During an interview on 06/02/2024 at 3:48 p.m. with ADON revealed Resident #1 was ready to go home, but needed more care so agreed to go to another rehabilitation facility. Resident #1 and family were encouraged to remain at the facility, but family refused to pay the private pay for days that would not be covered. Resident #1 was educated, instructions for care were provided and wound care supplies provided prior to discharge. Additionally, the facility provided the resident his remaining medications. ADON was unable to provide discharge instructions or medications resident was sent home with. During an interview on 06/03/2024 at 2:00 p.m. with LVN E revealed Resident #1 had a stage four wound, muscle weakness in legs and was unsteady so would need transfer assistance from bed to chair. LVN E stated she felt it would be safe for resident to transfer home if he had home health as resident was incontinent of the stools, so whoever was caring for his wound would need to first clean him prior to any dressing changes. LVN E said if this did not occur it could lead to infection. (continued on next page)		

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/2024 at 3:00 p.m. with Regional Nurse revealed Resident #1 was alert and oriented to person, place, time and situations , he was a Medicare patient with days were running out and decided to discharge with family support. Family did not want to pay the private pay days. Resident #1's family member was trained by treatment nurse and given supplies to care for resident until his transfer to another rehabilitation facility.		