

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 06/25/2024
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices for one of three residents (Resident #1) reviewed for wound records. The facility failed to accurately document Residents #1's wound care. This failure could place residents at risk of missed wound care and infection. Findings included: Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident#1 was a [AGE] year-old male who was admitted to the facility on [DATE] and a re-admission on 10/17/23. Resident #1 had diagnoses which included paraplegia (paralysis of the legs and lower body). He had a BIMS score of 15, which indicated he was cognitively intact. In the section Skin Conditions reflected he was at risk of developing pressure ulcer injuries. Record review of Resident #1's, undated, care plan reflected multiple Non-Pressure and Pressure/ Injuries r/t Immobility, he is often not compliant with treatment. Does not want staff to provide treatment. Interventions: Administer Treatments as Ordered and Monitor for Effectiveness. Resident refuses treatment at times, doesn't like the ordered treatment -nurse will work with him to reach an acceptable treatment, she will educate him on the risks and hazards of non-compliance with treatment. Record review of Resident #1's physician orders reflected an order written on 06/11/24 for Cleansing Site with normal saline. Mix Nystatin Powder with zinc Oxide Ointment 2) apply to affected areas 2X's daily, as needed after each incontinent episode one time a day for (Promotion of Wound Healing) related to paraplegia. Record review of the Resident#1's June 2024 MAR reflected the nurses were documenting wound care was being provided. There were no days omitted. Observation of LVN A on 06/25/24 at 10:00 AM performing a skin assessment on Resident #1 revealed he had wounds on his right and left ischium. The wound was clean with no signs of infection noted. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 675034
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/25/24 at 11:00 AM, Resident #1 stated he was supposed to get wound care every day, but he did not. He stated he was aware the nurses were supposed to apply cream on his ischium, and they documented it was done when it was not. He stated he learned there was documentation in his record showing he had gotten wound care, and he knew there were days he would not get wound care. Interview on 06/25/24 at 1:42 PM with LVN B revealed she worked Monday through Friday morning shift. She said she had been providing wound care to Resident #1 but not every day. She stated some days the Wound Care Nurse would perform the resident's wound care, and she documented that the wound care was provided to Resident #1 even when she had not witnessed the wound care being done. She stated she would document that it was done even on the days she had not done the wound care, so her records would not show red reporting care was late or not done. LVN B stated she was aware she was not supposed to falsify records. She stated failure to follow the doctor's orders could lead to the resident developing an infection. She stated she had completed an in-service regarding documentation and wound care. Interview on 06/25/24 at 2:31 PM with RN C revealed she worked the Monday evening shift. She stated she knew Resident #1 had orders for wound care in the evening, but Resident #1 would not allow her to apply the cream when he got to bed. She stated she would assume the Wound Care Nurse performed wound care and instead of documenting the resident refused she was documenting that the wound care had been done. She stated she had no reason for doing that. She stated she knew she was supposed to notify management of his refusal, but she did not. She stated failure to follow physician orders could lead to wound infection and affect wound healing. RN C stated she was aware failure to administer, treat and document as administered was falsifying the records. She stated she had not done training on documentation. Interview on 06/25/24 at 3:24 PM with LVN A, who was the Wound Care Nurse, revealed she was responsible for all wounds in the facility. She stated she was in school now, so she went to the facility early to perform some wound care. She stated she would let the nurses know, which residents she had not provided wound care. She stated wound care for Resident #1 was on the nurses' MAR because of his timing. She stated Resident #1 sometimes refused care in the morning. She said she was not aware the nurses were documenting they provided care on the MAR when they had not. She revealed she was also not documenting on the nurses' MAR when she provided care. She revealed she did not have any reason why she was not documenting on the nurses' MAR or notifying them when she provided care. She stated failure to follow orders could lead to infection and affect wound healing. Interview on 06/25/24 at 5:05 PM with the DON revealed her expectation was for the nurse to document on the MAR only the care given. If Resident #1 refused care, they were supposed to document the refusal in the progress notes. The DON stated they care planned Resident #1's refusal of care and not being compliant with treatment. She stated she interviewed her nurses and LVN B told her she did not like seeing red on her computer that was why she signed off. The DON stated LVN C was written up due to not following the physician orders in another incident on 05/07/24. The DON stated the risk of documenting care as given when it was not could lead to infection and not following the physician orders the nurses were falsifying the administration records. Record review of the facility training records reflected they had done in-services on the documentation of medication administration on 05/09/24. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's current, undated Medication Administration policy reflected the following: .XVI. The Licensed Nurse will chart the drug; time administered and initial his/her name with each medication administration. Record review of the facility's Documentation - Nursing policy, revised June 2020, reflected the following: To provide documentation of resident status and care given by nursing staff. Nursing documentation will be concise, clear, pertinent, accurate and evidence based . Nursing staff will not falsify or improperly correct nursing documentation. .H. Medication administration records and treatment administration records are completed with each medication or treatment completed. J. Treatments completed and documented as per physician's order.		