

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 08/15/2024
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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one (Residents #1) of three residents reviewed for parenteral fluids. The facility failed to ensure Resident #1 received routine PICC line dressing changes per physician orders. This failure placed the residents at risk for infections. Findings included: Review of Resident #1's MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included hypertension, diabetes, encounter for other orthopedic aftercare, and infection reaction due to sepsis (a serious condition in which the body responds improperly to infection) to joint prosthetic. The MDS further reflected Resident #1's cognition was intact, and he was on IV medications. Review of Resident #1's care plan created on 07/21/24 reflected Resident #1 used a PICC line (a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart) for administration of IV antibiotic. Interventions included to change PICC line dressing every Wednesday 6:00 AM-2:00 PM and as needed. Review of Resident #1's August 2024 monthly physician orders reflected: Change PICC line dressing every Wednesday on the 6-2 (6:00 AM-2:00 PM) shift and PRN. Review of Resident #1's MAR/TAR for August 2024 reflected the PICC line dressing should have been changed on Wednesday 08/14/24 and it was blank, indicating the dressing change had not marked as done. Observation and interview on 08/15/24 at 8:54 AM revealed Resident #1 was in bed watching television, and he was connected to an IV pump with medication infusing. The resident's PICC line was on his left arm and the dressing was coming off and was soiled and it was dated 08/06/24. Resident #1 stated the dressing had been coming off for 2 to 3 days now and he had told the nurses, but did not give any names, but the dressing had not been changed. The PICC site was intact and there was no redness, swelling, or any other signs of infection. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/15/24 at 1:20 PM with RN A revealed she had changed Resident #1's PICC line dressing today, 08/15/24 , because she noted it was coming off, but she had not checked the order on when it needed to be changed. RN A further stated she had attempted to change the dressing the day prior, 08/14/24, but the resident had told her he was not ready. RN A also said risks of not changing the PICC line dressing as ordered increased the risk of infection. Interview on 08/15/24 at 2:01 PM with the ADON revealed PICC line dressings should be changed every 7 days, and that the facility they were set to be changed every Wednesday. The ADON further stated it was important to change PICC line dressing as ordered to ensure the site remained clean and to prevent infection. Interview on 08/15/24 at 2:14 PM with the DON revealed PICC line dressings were to be changed every 7 days and as needed and at the facility, most PICC line dressings were to be changed every Wednesday. The DON said Resident #1 would pick at his dressing at times stating it was itching, causing it to lift, so the resident's needed to be changed more frequently at times. The DON also stated risks of not changing the PICC line dressings as ordered to prevent bacteria from entering the site and getting infected. Review of the facility's undated policy titled Central Venous Catheter reflected the following: .Obtain physicians order for dressing change		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 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 1 (Resident #2) of 8 residents reviewed for infection control. The facility failed to investigate and report to the County Health Department when Resident #2 was diagnosed with shigella. This failure placed residents at risk for infections. Findings included: Review of Resident #2's MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility [DATE]. His diagnoses included cancer, cerebrovascular accident (stroke), and seizure disorder and Resident #1's cognition was moderately impaired. The MDS further reflected the resident used a wheelchair for mobility. Review of Resident #2's progress notes dated [DATE] reflected the following: Received order and sent resident out to Hospital via EMS for medical evaluation and treatment of altered mental status, diarrhea, nausea and abdominal pain. Review of Resident #2's hospital records dated [DATE] reflected the following: .Assessment/Plan: Sepsis (a serious condition in which the body responds improperly to an infection) Patient found to have ESBL bacteremia with shigella (intestinal infection caused by a family if bacteria and the main sign is diarrhea, which often is bloody. Shigella can also be passed infected food or by drinking or swimming in unsafe water) Further review of Resident #2's hospital records dated [DATE] documented by the infectious disease doctor reflected the following: .Impression ESBL bacteremia with shigella - atypical; gastroenteritis .Plan: (shigella - intestinal infection caused by a family if bacteria and the main sign is diarrhea, which often is bloody. Shigella can also be passed infected food or by drinking or swimming in unsafe water) 1. Continue meropenem (antibiotic) ordered 10 day total 2. Organism may need to be reported to the [County] (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on [DATE] at 8:44 AM with Resident #2 revealed he was in bed watching television. The resident said he had been to the hospital not long ago, but did not specify the date, because he was running a fever and had diarrhea. While he was at the hospital he was told he had an infection in his stomach from something he ate and the infection that then gone into his blood stream. Resident #2 further stated the hospital staff said the infection could have been caused by eating eggs that were not fully cooked. Resident #2 said he ate all of his meals at the facility and would eat scrambled eggs in the morning for breakfast. Interview on [DATE] at 9:51 AM with the [NAME] revealed all of the eggs they served were pasteurized. and the scrambled eggs were delivered frozen in a bag. The bag of eggs were then put in boiling water until they formed a hard scramble, and then they were served. The [NAME] also said they were not allowed to make over easy eggs and if a resident ordered a fried egg, they had to ensure the yolk was fully cooked. The [NAME] further stated they had not had any concerns or reports of residents becoming sick after eating the meals. Observation on [DATE] at 11:20 AM of the facility's kitchen revealed all refrigerated dairy products were dated, and there were no expired items stored. Observation of the scrambled eggs revealed they were in single large bags, and there were no concerns regarding expiration dates. Interview on [DATE] at 11:27 AM with the Dietary Manager revealed all the eggs they served to the residents were pasteurized and if residents ordered a fried egg, they were not allowed to serve them over easy and made sure the yolk was fully cooked. She said the scrambled eggs came in a bag and they were precooked and had a fridge life of two years as long as they remained frozen. The Dietary Manager further stated they did not have any concerns or incidents of resident becoming sick after eating breakfast or any of the meals. Review of the facility's infection control log for July and [DATE] reflected there were no concerns of an gastrointestinal infection outbreak. Interview on [DATE] at 12:46 PM with the Physician revealed he had not been made aware Resident #2 had been diagnosed with shigella and had he known he would have placed the resident on contact isolation precautions. The Physician said he would have expected the facility staff to look into the origin of the infection and follow-up with other residents to see if they were also affected. Interview on [DATE] at 2:01 PM with the ADON revealed she had been told Resident #2 had been treated for Ecoli in the urine when he returned from the hospital so he had been put in isolation. The ADON said the DON was responsible for reading hospital records prior to residents admitting from the hospital or the hospital usually called in and gave report to the charge nurses. The ADON further stated she was not aware Resident #2 had been diagnosed with shigella but since the resident had been put in isolation, they would not have done anything different. Interview on [DATE] at 2:14 PM with the DON revealed there was a facility liaison group, but she did not know who they were, that reviewed resident hospital records before they were admitted to the facility. The DON said she then would get an email letting her know the resident had been approved to admit and Resident #2 had been approved and knew he required isolation. The DON further stated she was not aware Resident #2 had been diagnosed with shigella and was told he had ecoli and believed it was in the urine. She said if they would have been aware the resident had shigella, they would have continued the same precautions and kept the resident on contact isolation. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:35 PM with the Administrator revealed when Resident #2 returned from the hospital, the resident said he wanted to warn her that the health department had been notified he had gotten an infection for eating eggs that had not been cooked all they way. The Administrator said at that time she spoke to the dietary staff and she was told all of their eggs were pasteurized and served fully cooked. She also said there were no other resident who were experiencing the same symptoms so there was no outbreak. The Administrator further stated she was not aware Resident #2 had been diagnosed with shigella and said they would not have done anything different because the resident had already been placed on isolation precautions when he returned. Interview on [DATE] at 2:53 PM with RN B revealed she had readmitted Resident #2 from hospital and she did not recall who told her the resident has been diagnosed with ESBL in his bowels; therefore, he was immediately put in isolation. RN B further stated she did not read the resident's admitting paperwork; therefore, she was not aware Resident #2 had been diagnosed with shigella. Interview on [DATE] at 2:53 PM with the County Epidemiologist revealed shigella was a disease that should be reported to the County Health Department by the nursing facilities because it was easily spread from person-to-person. The County Epidemiologist said an infected resident would require contract isolation precautions during the remainder of the antibiotic regimen. Review of the facility's policy titled Infection Prevention and Control Program revised [DATE] reflected the following: Purpose The ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease an infection in accordance with Federal and State requirements. Policy .1. Identifies, investigates, controls, and prevents infections in the Facility		