

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1111 Rockingham Dr Richardson, TX 75080	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32581</p> <p>Based on observation, interview, and record review the facility failed to treat residents with respect and dignity for one (Resident #1) of seven residents reviewed for resident rights.</p> <p>The facility failed to ensure LVN A did not stand over Resident #1 while assisting the resident with her meal in the dining room on 01/15/25.</p> <p>This failure could affect residents who require assistance with activities of daily living and place them at risk of feeling rushed to eat or not interested in eating, which could result in weight loss and decreased psycho-social well-being of anguish or frustration.</p> <p>The findings include:</p> <p>Review of Resident #1's Admission MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a staff assessment BIMS score of 03 (Severely impaired). She had partial to moderate assist with eating and active diagnosis of other neurological conditions. She was diagnosed with anemia, hypertension, renal insufficiency, diabetes mellitus, thyroid disorder, malnutrition, and anxiety. And she had a mechanically altered and therapeutic diet and no issues with swallowing food and drinks.</p> <p>Review of Resident #1's Care Plan dated 10/18/24 and revised 10/18/24 revealed, The resident has an ADL self-care performance deficit Activity Intolerance, fatigue, impaired balance, limited mobility: Goals - The resident will maintain current level of ADL function Target Date: 03/26/2025 and interventions: Eating - The resident requires set up assist of (1) staff for eating. Care plan dated 10/30/24 revealed Resident #1 is dependent on staff for meeting emotional, intellectual, physical, and social needs, cognitive deficits, disease process (Specify), physical limitations. Goals: Resident #1 will show signs of enjoyment in activities thru next review Date Initiated: 10/30/2024 Revision on: 11/03/2024 Target Date: 03/26/2025. Interventions: The resident needs assistance with ADLs as required during the activity.</p> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 01/15/25 at 5:15 pm in the dining room, LVN A was standing at the dining room table next to Resident #1 who was sitting at the table in her wheelchair. There was 90% of Resident #1's macaroni noodle and meat meal on her plate and LVN A had a fork in her hand with food on it. LVN A lifted up the food and was telling Resident #1 she needed to eat her food and Resident #1 said she did not want to eat. LVN A said, You need to eat your food and Resident #1 said no. At 5:17 pm, LVN A put the fork down and walked behind Resident #1's wheelchair, grabbed the handles and took Resident #1 out of the dining room and to her room.</p> <p>Interview on 01/15/25 at 5:21 om, LVN A stated they were supposed to sit down to feed the residents. She said she initially sat down to feed Resident #1 and was only standing up next to Resident #1 because she was about to take her to her room. She stated she was not sure why she had the fork with food in her hand while she was standing next to Resident #1.</p> <p>Interview on 01/16/25 at 2:38 pm, RN B stated the CNA's and nurses were supposed to sit down when feeding the residents for the dignity of the residents. She stated they should not hover over the residents because she would not want someone standing over her like that. She stated standing over the residents could make the residents feel they were being forced or rushed to eat. She stated sitting while feeding the residents created more of a companionship with the residents and to also see better to ensure they were not swallowing the wrong way.</p> <p>Interview on 01/16/25 at 3:51 pm, the DON stated the staff should be feeding the residents sitting down at eye level with the residents. She stated sitting down while feeding the residents was good for the staff to see how the resident swallowed. She stated feeding the residents standing up was a dignity issue. She stated she was not aware of any staff standing up feeding the residents and added they just had an annual training on it last month to ensure they did the dining room processes properly. She stated that was way out of line that LVN A stood up while feeding Resident #1. She stated she would talk to LVN A about not doing that again. She stated LVN A should be encouraging Resident #1 to eat and that was not very inviting for the resident to want to eat if staff stood up to feed them.</p> <p>Interview on 01/16/25 at 4:14 pm, ADON C stated staff should feed the residents for comfortability. He stated looking down to the residents while feeding them could make the residents feel the staff really did not feel like feeding them but had to do it.</p> <p>Interview on 01/16/25 at 5:35 pm, the DON stated LVN A said she was getting ready to leave with Resident #1 and when the HHSC Surveyor was passing by, she was giving Resident #1 a few more bites. She stated she told LVN A she should always feed the residents sitting down and once completed feeding them, then stand up. She stated the ADON's, evening shift supervisor and weekend supervisor were responsible for ensuring the staff sat down to feed the residents. She stated overall she was responsible for ensuring the staff followed their feeding assistance policy. She stated her expectations was for the staff to be sitting down at eye level of the residents, to feed them.</p> <p>Record review of the facility's 1:1 Assistance with meals training with LVN A dated 01/16/25 revealed highlight of: 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting, them with meals.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Assistance with meals training with the nursing facility staff dated 01/16/25 revealed highlight of: 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting, them with meals.</p> <p>Record Review of the Facility's Assistance with meals policy dated 2001 and revised March 2022 revealed, Assistance with Meals: Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation Dining Room Residents: 1. All residents will be encouraged to eat in the dining room. 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting, them with meals.</p>		