STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675109	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arapaho Rehabilitation and Care Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 one (Resident #3) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #3's room was in a position that was accessible to the resident on 06/17/2025. 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: Record review of Resident #3's Face Sheet, dated 06/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with paraplegia (paralysis of the legs and lower part of the body) and weakness. Record review of Resident #3's Quarterly MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 05/14/2025, reflected the resident had a severe impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 03 (requires significant assistance and support in daily life). The Quarterly MDS Assessment indicated the resident was dependent on staff for personal hygiene, transfer, and bed mobility. Record review of Resident #3's Comprehensive Care Plan, dated 04/29/2025, 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. Observation on 06/17/2025 at 9:46 AM revealed Resident #3 was in her bed with her eyes closed. It was observed that the cord of the resident's call light was hanging on the mounting bracket of a lamp attached on the wall by the head of the resident. The call light was not within the reach of the resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/17/2025 at 9:53 AM, LVN A stated the call light should be with the resident at all times in cases like the resident needing assistance or needing something from the nurse. She went inside the room and saw the Resident #3's call light was hanging on the wall. She took the call light from the wall and placed it where the resident could reach it. She said she did not notice the call light was not with the resident when she did her rounds. She said the CNA on the hall changed her and maybe forgot to place back the call light after she was done. In an interview on 06/17/2025 at 11:38 AM, the ADON stated the call lights were important and should always be with the residents in case they needed assistance or help. She said whenever a staff was done with their treatment or care, they needed to make sure the call lights were with the residents before leaving the room. She said the call lights were for all residents, independent or dependent, and all the staff were responsible in making sure the call lights were with the residents. She said she would coordinate with the DON to do an in-service about call light placement. In an interview on 06/17/2026 at 12:21 PM, the DON stated call lights were used by the residents to call the staff. Some residents were bed bound and could not get up to call the staff. She said, even for the residents that could get up, the call lights should still be with them because they might be having medical issues and nobody would know. The DON said all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said she would initiate an in-service regarding call light placement. In an interview on 06/17/2025 at 12:58 PM, CNA C stated she call lights should be with the residents at all times so they could call the staff if they needed to. She said she did not notice that Resident #3's call light was not with her during her initial rounds or when she was done changing her. She said call lights should be with the residents so they could call the staff if they needed something. She said staff should make sure the call lights were within reach of the residents before they leave the room so that the needs of the residents could be addressed and also to prevent falls. In an interview on 06/17/2025 at 1:20 PM, the Administrator stated the call lights were used by the residents to call the staff if they needed something or assistance. She said staff should make sure the call lights were with the residents before leaving the room. She said if they needed to hang the call light when they were changing the residents or making the bed, they needed to make sure they would place the call lights where the residents could reach them before leaving the room. She said she would coordinate with the DON about the issue regarding call lights. Record review of the facility's policy Call Lights: Accessibility and Timely Response Policy revised 05/16/2025 revealed Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside . to allow residents to call for assistance . 5. Staff will ensure the call light is within reach of resident and secured.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for one (Residents #4) of one resident reviewed for privacy and confidentiality. The facility failed to ensure LVN A closed, locked, or minimized her laptop's monitor when she left her cart on 06/17/2025 and Resident #4's medical information was visible. This failure could place the residents at risk of exposure of their personal and medical information to unauthorized individuals. Findings included: Record review of Resident #4's Face Sheet, dated 06/17/2025, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #4's Comprehensive MDS Assessment, dated 03/14/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00 (requires significant assistance and support in daily life). 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 #4'd Comprehensive Care Plan, dated 03/14/2025, reflected the resident had a suprapubic catheter (device inserted into the stomach to the bladder to drain urine) and one of the interventions was to change the catheter as ordered. Record review of Resident #4's Physician's Order, dated 12/10/2024, reflected Change Suprapubic Cath 18 Fr (unit of measurement for catheter sizes), 10 cc bulb DX: Neurogenic Bladder (the normal bladder function is disrupted due to nerve damage) 10th of every month. Record review of Resident #4's Progress Notes, dated 06/16/2025, reflected Resdt returned from hospital @ about 0130 hrs with a new s/pubic cath in place, no new orders. NP . for Dr . facility DON and ADON notified, resdt is his own responsible party. Presently, resdt is in bed resting peacefully, stable, denies pain, completed ADL, HOB up 35 degrees, S/pubic cath patent and draining urine, call light in place, will cont monitor. Observation and interview on 06/17/2025 at 10:06 AM revealed LVN A said she would get an Oxygen in Use for one of the residents. She left her cart and went to get the sign. She left her computer open and the monitor of the computer displayed Resident #4's name, his recent re-admission to the facility, that the resident had a suprapubic catheter, was stable, and was denying pain. She returned to her cart and saw some information about the resident was visible. She said she locked her screen before leaving but failed to notice that documentation from the previous shift was still not closed. She said she should have closed her computer before leaving her computer and made sure no information about any resident was visible. She said it was a HIPAA violation because other individuals that were not part of her care might see the information that were supposed to be confidential. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 11:38 AM, the ADON stated the staff should close the computer or minimize the monitor before leaving the cart unattended. She said the resident's information was confidential and should not be seen by unauthorized individuals. She said some residents might be embarrassed that others would know they had such sickness or was taking a certain type of medication. She said she would collaborate with the DON about the issue on privacy and confidentiality. In an interview on 06/17/2026 at 12:21 PM, the DON stated medical information about a resident should only be seen by authorized individuals caring for the resident like the residents themselves, their responsible party, medical doctor, and nurses. She said the health information of the residents 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 with access to the residents' profile were expected to provide full privacy and confidentiality of the residents' information. The DON stated the failure to not protect the resident's information could cause poor self-esteem and embarrassment for the resident. The DON stated she would start an in-service about privacy and confidentiality of the residents' information. In an interview on 06/17/2025 at 1:20 PM, the Administrator stated the staff must be careful that everytime they leave their carts, their computer was minimized or locked and make sure the residents' information were not exposed because they were confidential and it was a HIPAA violation when unauthorized individuals could read them or have access to them. She said the expectation was for all the staff to make sure the resident's information were protected. She said she would collaborate with the DON to do an in-service about privacy and confidentiality. Record review of facility's policy, Resident Rights undated revealed Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation .1. Federal and state laws guarantee certain basic rights to all residents of this facility . t. privacy and confidentiality . 3. The unauthorized release, access, or disclosure of resident information is prohibited.

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	675109	A. Building B. Wing	06/17/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **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 (Resident #3) of one resident reviewed for feeding tube (a way of providing nutrition directly to the stomach). The facility failed to ensure that Resident #3's, who had a g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach), head of the bed was raised on 06/17/2025. This failure could place residents with g-tubes at risk for reflux and aspiration. Findings included: Record review of Resident #3's Face Sheet dated 06/17/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #3's Comprehensive MDS Assessment, dated 05/14/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #3's Comprehensive Care Plan, dated 04/26/2025, reflected the resident required tube feeding and one of the interventions was the resident needed the head of the bed elevated at 45 degrees. The Comprehensive Care Plan did not indicate that the resident refused to elevate the head of the bed. Record review of Resident #3's Physician's Order, dated 04/03/2025, reflected Enteral Feed: Elevate head of bed 30-45 degrees during feeding & for 30-45 minutes after every shift related to GASTROSTOMY STATUS (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). Observation on 06/17/2025 at 9:46 AM revealed Resident #3 was in her bed with her eyes closed. It was observed that the resident had a bottle of formula for feeding tube at the bedside table. It was also observed that the resident was lying flat. Observation and interview on 06/17/2025 at 9:53 AM, LVN A stated Resident #3 had a g-tube and she should not be lying flat. She raised the resident's head of the bed and said the purpose of raising the head of the bed was to prevent the possibility of aspiration. It was observed that when LVN A raised the head of the bed, the resident did not complain of any pain or discomfort. She said the CNA on the hall changed her and maybe forgot to raise the head of the bed after she was done. She also said she did not know when was the last time the resident was given here bolus feeding. (continued on next page)

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	675109	A. Building B. Wing	06/17/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 11:38 AM, the ADON stated the head of the bed should be elevated for residents with g-tube because of the risk of aspiration. She said raising the head of the should be implemented specially during feeding and medication administration and several minutes thereafter. She said the best practice was to always raise the head of the bed when the residents were in their bed to be sure there were no harm inflicted to the resident. She said she would coordinate with the DON to do an in-service about care of residents with g-tube. In an interview on 06/17/2025 at 12:21 PM, the DON stated the head of the bed of residents with a g-tube should always be elevated to prevent aspiration. She said the expectation was for the staff to make sure the head of the bed was raised after feeding, medication administration, and incontinent care. She said she would initiate an in-service regarding raising the head of the bed of a resident with g-tube. In an interview on 06/17/2025 at 12:58 PM, CNA C stated she did change Resident #3 but did not make sure the head of the bed was raised when she was done. She said the nurses would remind them to raise the head of the bed of residents with a g-tube. She said for Resident #3, the resident did not want her head of the bed raised and would complain that her back hurts. Observation and interview on 06/17/2025 at 1:12 PM, revealed Resident #3 was in her bed, awake. She said she was doing alright and was not in any sort of pain. It was observed that the resident's head of the bed was raised approximately 30 degrees and there were no non-verbal indications that the resident was in pain due to the raised head of the bed. In an interview on 06/17/2025 at 1:20 PM, the Administrator stated she was a nurse and knew that the head of the bed should be raised for residents with g-tube to prevent aspiration that could lead to aspiration pneumonia. She said staff should make sure the head of the bed of residents with g-tube were elevated. She said she would coordinate with the DON to do an in-service about g-tube care. Record review of the facility's policy Gastrostomy Site Care Policy revised 05/02/2025 revealed Policy: It is the policy of this facility to perform gastrostomy site care as ordered and per current standards of practice . Policy Explanation and Compliance Guidelines . 22. Reposition the resident to appropriate position.

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	675109	A. Building B. Wing	06/17/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for six (Residents #1 and #2) of six residents reviewed for respiratory care. 1. The facility failed to ensure Resident #1's breathing mask (used to receive medications by breathing in mist through nose and mouth) was properly stored when not in use on 06/17/2025. 2. The facility failed to ensure an Oxygen in Use sign was placed outside of Resident #2's room when she was admitted to the facility on [DATE]. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #1's Face Sheet, dated 06/17/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure (condition where there is no enough oxygen in the body or too much carbon dioxide in the body) and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Comprehensive MDS Assessment, dated 03/25/2025, reflected the resident was cognitively intact with a BIMS score of 15 (capable of normal cognition and needs little support). The Comprehensive MDS Assessment indicated the resident respiratory failure and chronic obstructive pulmonary disease. Record review of Resident #1's Comprehensive Care Plan, dated 05/07/2025, reflected the resident had altered respiratory status and one of the interventions was to administer medications/puffers as ordered. Record review of Resident #1's Physician's Order, dated 03/19/2025, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours for SOB while awake. (continued on next page)

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	675109	A. Building B. Wing	06/17/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/17/2025 at 9:35 AM revealed Resident #1 was in bed, awake. It was observed that the resident had a nebulizer on top of his side table. A breathing mask was attached to the nebulizer and the breathing mask was not bagged. The resident said, when his breathing treatment was done, the nurse would take it off. He said he did not know where the nurse would put his mask after it was taken off. In an interview and observation on 06/17/2025 at 9:43 AM, LVN A stated Resident #1 was on breathing treatment due to his shortness of breath. She said she did not notice that his breathing mask was not bagged when she made her morning rounds. She said the breathing mask should be bagged to prevent respiratory infections and inhaling small particles that could lodge to the lungs. She said she would get a new breathing mask for the resident and would ensure it was bagged always. She disconnected the breathing mask and threw it in the trash can. 2. Record review of Resident #2's Face Sheet, dated 06/17/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with respiratory failure (condition where there is not enough oxygen in the body or too much carbon dioxide in the body). Record review of Resident #2's Baseline Care Plan, dated 06/17/2025, reflected the resident was at risk for impaired gas exchange related to respiratory failure and one of the interventions was to administer supplemental oxygen. Record review of Resident #193's Physician's Order, dated 06/17/2025, reflected On continuous oxygen 3 liters per minute for respiratory failure every shift. Record review of Resident #193's Progress Notes, dated 06/17/2025, reflected RESDT ON F/U NEW ADMT . O2 @ 3L/MIN VIA TRACH (is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) IN PROGRESS. Observation on 06/17/2025 at 10:01 AM revealed Resident #2 was in her bed with her eyes closed. It was observed that the resident was on oxygen therapy via tracheostomy. It was also observed that there was no Oxygen in Use sign outside the resident's room. Observation and interview on 06/17/2025 at 10:06 AM, LVN A stated Resident #2 was admitted on [DATE]. She said she started with the resident's admission process and was continued by the incoming nurse. She said the resident was on oxygen when she came to the facility but she did not put a sign outside the room. She said she would get a sign and would put it outside the resident's door. She said the purpose of the sign was to make everybody aware that oxygen was being used in the facility. (continued on next page)

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	675109	A. Building B. Wing	06/17/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 11:38 AM, the ADON stated the breathing masks used for breathing treatments should be stored properly inside a plastic bag if the residents were not using them. She said the staff were responsible for ensuring all the breathing masks were clean every time the residents used them. She said the expectation was for the staff to be mindful and bag all of them to prevent respiratory issues. She said another expectation was for the staff to check if there was an Oxygen in Use sign outside the door of residents that were using oxygen. She said the sign for oxygen use was to remind the staff and visitors to be careful not to cause any ignition that could cause explosion. She said she would coordinate with the DON to do an in-service regarding bagging the breathing mask and putting a sign outside the door of residents using oxygen. In an interview on 06/17/2026 at 12:21 PM, the DON stated the breathing masks should be in a plastic bag to prevent cross contamination and respiratory infection. She also said that if a resident was using oxygen, there should be an Oxygen in Use sign outside the resident's door so the staff and the visitors were aware that oxygen was being used in the facility. She said she would start an in-service pertaining to bagging the breathing mask and putting an Oxygen in Use outside the door. In an interview on 06/17/2025 at 1:20 PM, the Administrator stated everything used for the resident should be kept clean to prevent cross contamination and respiratory infection. She said there should be a sign outside the door if a resident was using oxygen so everyone would be aware that there was oxygen being used in the facility. she said she would coordinate with the DON to educate the staff about bagging the breathing mask as well as placing a sign outside the residents' room if the resident was using oxygen. Record review of the facility policy Oxygen Administration 2001 MED-PASS revised October 2010 revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . Steps in the Procedure . 2. Place an Oxygen in Use sign on the outside of the room entrance door. The facility's policy for bagging the breathing mask requested on 06/17/2025 at 1:07 PM but was not provided prior to exit.

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	675109	A. Building B. Wing	06/17/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored properly in locked compartments for one medication (wound cleanser solution) of one medication reviewed for storage of drugs and biologicals. The facility failed to ensure that the wound cleanser solution was not left inside Resident #3's bedside. This failure could place the residents at risk of accidental consumption or misuse of medications. Findings included: Observation on 06/17/2025 at 9:46 AM revealed Resident #3 was in her bed with her eyes closed. It was observed that there was a bottle of wound cleanser solution on the resident's bedside table. Observation and interview on 06/17/2025 at 9:53 AM, LVN A said the wound cleanser was not supposed to be inside any resident's room. She said she did not notice the wound cleanser inside Resident #3's room when she did her morning rounds. She said she did not know who left the wound cleanser and if it was used for the resident because as far as she knew the resident did not have any wounds that needed cleansing. She said it should not be on the resident's bedside table because the resident might accidentally drink it or confused resident saw it, took it from the bedside table, and drink it. She took the wound cleanser solution and said she would put it inside the treatment cart. In an interview on 06/17/2025 at 10:15 AM, the Wound Care Nurse stated she did not leave the wound cleanser on Resident #3's bedside table. She said the resident did not have any wound that was why she was wondering what the wound cleanser was doing inside the resident's room. She said the wound cleanser was a form of medication and should be inside the treatment cart after using it because residents might unintentionally drink it. In an interview on 06/17/2025 at 11:38 AM, the ADON stated there should be no medications inside the residents' rooms and the wound cleanser solution is a form of medications. She said it contained chemicals that could cause adverse reactions such as allergic reactions, skin irritation, and swelling. She said it was left on the table and was accessible to the Resident #3. She said it could be accidently ingested, drank, or applied to the skin. She said she would coordinate with the DON to do an in-service about medication storage. In an interview on 06/17/2026 at 12:21 PM, the DON stated the wound cleanser was a form of medication because it was used for medical treatments. She said the wound cleanser promoted healing and contained specialized solution designed for different types of wounds. She said it should be in the treatment cart when not in use and not inside the resident's room and at the beside for that matter. She said there could be adverse reactions especially if the solution had chemicals in it. she said she would find out who left the solution at Resident #3's bedside table. She said the expectation was no medications would be inside the residents' rooms. She said she would do an in-service about medication storage. (continued on next page)

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	675109	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arapaho Rehabilitation and Care Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/2025 at 1:20 PM, the Administrator stated all medications used for wound treatment should be in the cart and not inside the residents' room. She said leaving the wound cleanser solution inside the resident's room could result to accidental consumption. She said the expectation was for the staff to make sure no medications were inside the room or were easily accessible to other residents and visitors. She said she would coordinate with the DON so the issue would not happen again. Record review of facility policy, Storage of Medications 2001 Med-Pass, Inc. revised April 2021 revealed: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 6. Antiseptics, disinfectants, and germicides used in any aspect of resident care . shall be stored separately from regular medications.