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	12/12/2024

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 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** 50444 Based on observation, interview, 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 2 of 12 residents (Resident #49 and Resident #77) reviewed for Respiratory Care. 1. The facility failed to ensure Resident #49 had an order for oxygen administration. 2. The facility failed to ensure Resident #77's BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs) mask was properly stored. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings include: 1. Review of Resident #49's Face Sheet, dated 12/10/2024, reflected a [AGE] year-old female who initially admitted on [DATE] and the most recent admitted was 08/06/2023. Resident #49 admitted with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Review of Resident #49's Quarterly MDS Assessment (tool used to measure health status), dated 10/17/2024, reflected intact cognition with a BIMS (screening tool to test cognition) score of 15, and resident was treated for chronic obstructive pulmonary disease. Review of Resident #49's Comprehensive Care Plan, dated 10/17/2024, reflected Resident is at risk for shortness of breath, respiratory distress, increased anxiety due to DX of COPD. One intervention was to Provide O2 as ordered and indicated. Date Initiated: 01/17/2023. Review of Resident #49's Physician's Order, dated 02/06/2023, reflected Oxygen tubing change weekly Label each component with date and initials. every night shift every Sun (Sunday) Label each component with date and initials. There was no order for Resident #49 to receive oxygen therapy. (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

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 12/12/2024

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Observation and interview on 12/10/24 at 10:50 AM revealed Resident #49 lying in bed watching television. There was an oxygen concentrator on the floor next to the resident's bed. The concentrator was set at 2 liters per minute (amount of oxygen flow delivered into the nostrils over a period of one minute). Oxygen tubing was connected to the concentrator and stored in a plastic bag. The tubing was dated. Resident #49 stated she used the oxygen every night and had been receiving oxygen for quite a while.

During an interview on 12/10/24 at 04:28 PM LPN G stated she works the evening shift and Resident #49 puts on oxygen each night at bedtime. She stated if the resident has been out walking in the facility and was out of breath, Resident #49 will put on oxygen when returning to her room. LPN G stated the oxygen concentrator was supposed to be set at 2 liters. LPN G opened Resident #49's electronic medical record and after viewing the orders stated Resident #49 did not have an order for oxygen. LPN G stated Resident #49 should have an order for oxygen in her chart. LPN G stated there was an order to change the oxygen tubing weekly that was initiated in March of 2024. LPN G stated it was necessary to have an order for oxygen. She stated staff cannot provide any treatment without a physician order. LPN G stated if you give too much oxygen that's not good for the resident. LPN G stated respiratory therapy and the physician determine what the resident's needs are and a nurse puts the prescribed order in the chart. LPN G stated, we have to make sure there is an order for every treatment we provide.

During an interview on 12/10/24 at 04:40 PM, the DON stated that if a resident needs oxygen, the nurse contacts the physician for an order. She stated oxygen was a medication and we need an order to administer it. She stated she would make sure the nurses know an order for changing oxygen tubing did not supplement an order for oxygen administration. The DON stated she would make sure it was corrected and in-service staff regarding this.

2. Record review of Resident #77's Face Sheet, dated 12/11/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #77 had a diagnosis which included Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep).

Record review of Resident #77's Quarterly MDS Assessment, dated 10/23/2024, reflected she was cognitively intact with a BIMS score of 15. The resident was on non-invasive mechanical ventilator.

Record review of Resident #77's Comprehensive Care Plan, dated 09/06/2024, reflected the resident used BiPAP and one of the interventions was apply BiPAP ST Mode @ 18/8, rate 16, with full mask during hours of sleep. Remove BiPaP Q am.

Record review of Resident #77's Physician Orders, dated 03/08/2024, reflected Apply BiPAP ST Mode @ 18/8, rate 16, with full mask during hours of sleep for dx of sleep apnea two times a day for sleep apnea.

Record review of Resident #77's Physician Orders, dated 03/08/2024, reflected Remove Bi-Pap Q am in the morning for BiPaP care.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Rockingham Dr Richardson, TX 75080	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #77 on 12/11/2024 at 7:49 AM revealed Resident #77 was on her electric wheelchair inside the room. It was observed that there was a BiPAP mask on the resident's side table. The BiPAP mask was not bagged. The resident said she used her BiPAP the night before. She said sometimes she would take it off but nobody told her to put it in a plastic bag and she was not given a bag for the BiPAP. She asked, Am I supposed to put it in a plastic bag? The resident propelled her wheelchair out of her room. Observation and interview with RN B on 12/11/2024 at 8:10 AM revealed RN B was about to check Resident #77's blood sugar. She prepared the things needed for blood sugar check, entered the room, and placed the things needed on the resident's overbed table. The overbed table was adjacent to the side table where the resident's BiPAP was. She did not notice that the BiPAP mask was not bagged. After the provision of care, RN B went out of the room and still did not notice that the BiPAP mask was not bagged. When asked if the resident was using BiPAP, RN B said Resident #77 would sometimes use the BiPAP and sometimes she would refuse to wear it. When asked where should the BiPAP mask be placed, RN B went inside the room and saw the BiPAP mask was not bagged. She said she would get a plastic bag, clean the BiPAP mask , and put it in the bag. She said it should be bagged to prevent cross contamination. She said she did not notice the unbagged mask when she did her round. She said even though the resident was the one taking it off, the staff should check if it was in a bag and if not put it in a bag. In an interview with ADON A on 12/11/2024 at 7:43 AM, ADON A stated the BiPAP mask should be bagged when the resident was not using it to prevent cross contamination and infection. She said the staff who take off the mask should put it in a bag. She said if the resident was the one taking it off, there should be a bag ready for them to put the mask in. She also said that the resident should be educated why the mask should be bagged. She said the expectation was for the staff to bag the BiPAP mask and double check if the BiPAP mask was bagged. She said she would do an in-service about respiratory care. In an interview with the DON on 12/11/2024 at 8:37 AM, the DON stated BiPAP mask should had been bagged and was not placed on top of the table. She said the mask should be bagged when not in use to prevent contact with dirty surfaces. She added the BiPAP mask should be cleaned before putting it inside the plastic bag. She said the expectation was for the staff to bag the BiPAP mask when not in use. She said if the resident was the one taking it off sometimes, the staff should check it and put it in a bag. She said they would do an in-service about respiratory care and would personally monitor if the staff were bagging the BiPAP mask when not in use. In an interview with RN F on 12/12/2024 at 6:29 AM, RN F stated she was the nurse for 10 PM to 6 AM for hall 300. She said most of the time, the resident would wake up early. She said the resident had an order for BiPAP but sometimes she refused to wear it. She said the BiPAP mask should be in a plastic bag to keep it clean. She said if the resident would wake up early and would take it off sometimes, she should monitor if the BiPAP mask was bagged. In an interview with VP of Clinical Operations on 12/12/2024 at 8:25 AM, the VP of Clinical Operations stated the BiPAP masks should be stored properly to prevent respiratory issues or exacerbation of whatever respiratory issues the residents already had. The Administrator said the expectation was for the staff to be mindful during their rounds and make sure the BiPAP masks were bagged. she said the DON already initiated an in-service about respiratory care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Oxygen Administration, Revised October 2010, reflected Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Record review of the facility's policy, Noninvasive Ventilation The Compliance Store, no revision date, reflected Policy: It is the policy of this facility to provide noninvasive ventilation as per physician's order . Compliance Guidelines . 7. Store mask when not in use via bagging.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview, and record review, the facility failed to ensure that one of two (Resident #86) residents were provided medications and/or biologicals and pharmaceutical services to meet their needs. The facility failed to ensure LPN C flushed the g-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) before and after each medication on 12/10/2024. This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings include: Record review of Resident #86's Face Sheet, dated 12/11/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #86 was diagnosed with gastrostomy (medical procedure where a tube is inserted into the stomach) status. Record review of Resident #86's Quarterly MDS Assessment, dated 11/22/2024, reflected the resident was unable to complete the interview to determine the BIMS score. The resident was on tube feeding (delivery of nutrition through a tube inserted in the stomach) while a resident of the facility. Record review of Resident #86's Quarterly Care Plan, dated 11/22/2024, reflected the resident required tube feeding (delivery of nutrition through a tube inserted in the stomach) for 100% nutrition and the interventions were to monitor signs and symptoms of tube dysfunction, distension, and dehydration. Record review of Resident #86's Physician Order, dated 12/06/2024, reflected every 4 hours Jevity 1.5 at bolus, give 1 cartoon (237cc) 6 times per day. Record review of Resident #86's Physician Order, dated 11/04/2024, reflected Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug*. Give 1 tablet via G-Tube three times a day for pain related to PAIN, UNSPECIFIED. Record review of Resident #86's Physician Order, dated 11/04/2024, reflected clonazepam Oral Tablet 0.5 MG (Clonazepam) Controlled Drug. Give 1 tablet via G-Tube three times a day for anxiety related to ANXIETY DISORDER, UNSPECIFIED. Record review of Resident #86's Physician Order, dated 11/04/2024, reflected Risperdal Oral Tablet 2 MG (Risperidone). Give 1 tablet via G-Tube three times a day for SCHIZOPHRENIA related to SCHIZOPHRENIA, UNSPECIFIED. Record review of Resident #86's Physician Order, dated 11/04/2024, reflected Clonidine HCl Oral Tablet 0.1 MG (Clonidine HCl). Give 0.1 mg via G-Tube three times a day for antihypertensive Hold for Systolic bp less than 100 or Diastolic bp less than 64 or pulse less than 55. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #86's Physician Order, dated 11/20/2024, reflected every shift Flush tube with 150 cc q shift, 30 cc water before & after each med pass & bolus feeding (administering a large dose of formula through a feeding tube several times a day). Record review of Resident #86's Physician Order, dated 12/11/2024, reflected every shift Flush GT with 30ml water pre/post medication administration and 5-10 ml water between each medication. Mix medications with 5-10 ml of water before administering via GT. Observation on 12/10/2024 at 12:01 PM revealed LPN C performed hand hygiene, put on a gown and a pair of gloves, and checked the resident's blood pressure. After checking the resident's blood pressure, LPN C removed hid gown and gloves and started to prepare the medications by putting each medication in a small plastic cup. He prepared Clonidine 0.1 mg, Risperdal 2 mg, Norco 5-325 mg, and Clonazepam 0.5 mg. After preparing the medications, he crushed the medications one by one, and put the medications back on their respective cups again. He went inside the room, put the cups on the resident's overbed table, and pulled the privacy curtain. He washed his hands, put on a gown and gloves, and sanitized the ball of the stethoscope. He raised the bed of the resident and told the resident that he would be administering his medications. LPN C put 15 ml of water on each cup of medications and dissolved them. He connected an extension tube with a feeding port to the resident's g-button and checked for Resident #86's g-tube placement. LPN C checked for Resident #86's G-tube placement by connecting a 60 ml piston syringe with plunger (inside the syringe) to the feeding port and introduced air into the abdomen by pushing the plunger of the syringe. After checking for the placement, LPN C then pulled the plunger to check for any residual. The was no residual noted. He detached the syringe, pulled the plunger of the syringe, and attached it again to the feeding port of the g-tube. LPN C started to administer the medications by pouring the dissolve medications one after another. He did not flush the g-tube before administering the medications and in between each medications. After administering the medications, he flushed the g-tube with 30 ml of water and then poured 237 ml of Jevity 1. 5 calories. After giving the formula, LPN C flushed it with 30 cc of water. He detached the syringe along with the plunger and the extension tube from Resident #86's G-tube and put them in a plastic measuring cup. He went to the restroom, washed them, dried them, and placed them in a plastic bag. He removed his gown and gloves and then washed his hands. In an interview with LPN C on 12/10/2024 at 12:39 PM, LPN C stated flushing was done during medication administration to make sure the g-tube was patent before medication administration. He said he was supposed to flush in between medications to prevent clogging and make sure the medications were absorbed. He said he added water to the medications but there should also flushing in between the medications. He said the water he used to dissolve the medications were not considered flushing. In an interview with ADON A on 12/11/2024 at 7:43 AM, ADON A stated the g-tube should be flushed before administering medications and in between medications to make sure there was no blockage, and the medications were delivered appropriately. If the g-tube were not flushed, the tubing could be blocked, and the absorption of the medications could be compromised. She said the expectation was for the staff to flush the g-tube in between medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on 12/11/2024 at 8:37 AM, the DON said the g-tube should be flushed prior to administering the medications. She said the water used to dissolve the medications were not considered flushing. She said the procedure should be flush the g-tube, give one medication, flush, medication, flush, medication, flush and so on and so forth until the last medication was administered. She said the g-tube needed flushing to prevent adverse reactions from mixed medications and to prevent clogging. She said the expectation was for the staff to do the right procedure to prevent any issues with g-tube. She said she would do an in-service and would monitor the medication administration personally. In an interview with VP of Clinical Operations on 12/12/2024 at 8:25 AM, the VP of Clinical Operations stated the g-tube should be flushed before and after medication administration. She said flushing was to be done to prevent clogging and mixture of the medications. She said the expectation was for the staff to follow the procedure in administering medications through g-tube. She said the DON already initiated the in-service and check-off about the issue. Record review of the facility's policy Administering Medications through an Enteral Tube 2001 MED-PASS. Inc., revised November 2018 revealed Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Steps in the Procedure . 12. Administer medication by gravity flow . a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion . c. Begin flush before the tubing drains completely . 13. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47743 Based 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 two of eight residents (Resident #77 and Resident #199) reviewed for Infection Control. 1. The facility failed to ensure CNA E changed her gloves and performed hand hygiene while providing incontinent care to Resident #77 on 12/10/2024. 2. The facility failed to ensure CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #199 on 12/10/2024. 3. The facility failed to ensure that RN B would not bring the whole container of test strips used for checking blood sugar inside Resident #77's room on 12/11/2024. These failures could place residents at risk of cross-contamination and development of infections. Findings include: 1.Observation on 12/10/2024 at 10:01 AM revealed CNA E was about to do incontinent care for Resident #77. She prepared the things needed for incontinent care on an overbed table. She washed her hands and put on a pair of gloves. She unfastened the brief and pushed it between the resident's thighs. She removed her gloves, sanitized her hands, and put on a new pair of gloves. She pulled some wipes, cleaned the resident's belly, and threw the wipes on the trash bag. She pulled some more wipes and cleaned the resident perineal area (area between the thighs) using the front to back technique. She did it three times. When she was done cleaning the perineal area, she assisted the resident to roll towards the wall and cleaned the resident's bottom. After cleaning the resident's bottom, CNA E took the new brief from the overbed table, put it under the resident, and fixed it. She did not change her gloves after cleaning the bottom of the resident and before touching the new brief. After fixing the brief, CNA E assisted the resident to roll back and fastened the brief on both sides. CNA E took off her gloves, threw them in the trash bag, and washed her hands. In an interview with CNA E on 12/10/2024 at 10:34 AM, CNA E stated she washed her hands before incontinent care and sanitized her hands when she changed her gloves. She said but after cleaning the bottom of the Resident #77, she was not able to change her gloves before touching the new brief. She said she was supposed to change her gloves from dirty to clean. She said her gloves were already considered soiled because she used them to clean the bottom of the resident. She said she would be mindful in doing incontinent care next time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Observation on 12/10/2024 at 1:49 PM revealed CNA D was about to do incontinent care for Resident #199. Resident #199 ambulated towards the comfort room followed by CNA D. Resident #199 pulled down her pants and sat down on the toilet seat. CNA D put on a pair of gloves, took a brief, placed it on top of the toilet tank, and waited for Resident #199 to finish. CNA D did not wash her hands before putting on the pair of gloves. When the resident was done urinating, she stood up, and cleaned the resident's perineal area using the front to back technique. CNA D cleaned the bottom after cleaning the resident's perineal area. After cleaning the resident's bottom, she took the brief from the toilet tank cover and put it on the resident. She did not change her gloves and do hand hygiene before getting the brief. she fixed the brief and pulled the resident's pants up. In an interview with CNA B on 12/10/2024 at 2:02 PM, CNA B stated she was supposed to wash her hands before doing incontinent care. She said she was also supposed to change her gloves after cleaning the resident's bottom because her gloves were already soiled with whatever was from the resident's bottom. She said because she did not change her gloves the brief that the resident wore was also deemed soiled. She said she did have an in-service about hand washing but was not able to apply it. 3.Observation on 12/11/2024 at 8:10 AM revealed RN B was about to check Resident #77's blood sugar. She washed hands and prepared the things needed to check the resident's blood sugar. RN B sanitized the glucometer, prepared two alcohol wipes, a push button safety lancet and the container of test strips. RN B went inside Resident #77's room and told the resident she would be checking her blood sugar. RN B brought with her the wipes, the push button safety lancet, the glucometer, and the whole container of the test strips inside Resident #77's room and placed them on the resident's overbed table. RN B put on a pair of gloves, took a strip from the container and inserted it on the glucometer. She wiped the resident's right index finger, waited for it dry up, and then pricked the right index finger with the push button safety lancet. RN B scooped a drop of blood from the resident's index finger with the tip of the test strip that was inserted in the glucometer. After scooping the blood, the glucometer displayed 141. She went back to her cart and put the container of strips on top of her cart. She turned on her computer and checked the resident's order for insulin. Interview with RN B on 12/11/2024 at 8:19 AM, RN B stated she brought with her the container of the test strips. She said she brought it inside in case she needed another test strip. She said she should have left the container of test strips on top of the cart because the strip was for all the residents that needed their blood sugar checked. She said if the if the container of test strip was for Resident #77 only, she could bring it inside. She said bringing an item inside the resident's room, putting it on the resident's table, and then using it to another resident could result to cross contamination. She said what she should have done was put two or three strips in a plastic cup and then discard those that were not used. RN B threw the container of strips and said she would get a new one and would make sure she would not bring it inside the room of the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON A on 12/11/2024 at 7:43 AM, ADON A stated hand hygiene was included in all the procedures of any care. She said the staff should do hand hygiene before and after care and in between changing of gloves. She said gloves should be changed after cleaning the residents' bottom, before getting a new brief. She said not changing the gloves after touching soiled items, or after touching soiled body parts could result in cross contamination and probable infections. She the container of the strips used to check the blood sugar should stay in the cart. She said the staff should only bring the strip she would be using for blood sugar check and some extras just in case the first try would fail. She said the container could be a medium of She said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, and when transitioning from a dirty site to a clean site. She said another expectation was for the staff not to bring the container of strips used for blood sugar checks inside the room of any resident. She said the staff should be mindful that they should provide the highest care possible to prevent any kind of infection. ADON A said she would do in-services about infection control, hand hygiene, and not bring any item inside a particular room if the item is for multiple use. In an interview with DON on 12/11/2024 at 8:37 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said hands should be washed before and after any care. She said gloves should be changed after touching the soiled brief to prevent transfer of microorganisms to any clean items. She said any item used for several items should stay in the cart and should not be brought inside the residents' room unless that item was specific to the resident. She said the expectation was for the staff to wash their hands before and after any care, change their gloves when going from dirty to clean, and leave the container of strips in the cart. She said the staff could bring two or three strips inside and then discard what were not used. She said she would do an in-service about hand hygiene, infection control, not bringing the container of strips inside any resident's room. In an interview with VP of Clinical Operations on 12/12/2024 at 8:25 AM, VP of Clinical Operations stated not washing the hands before any care, not changing the gloves from soiled to clean, and bringing the container of strips inside the resident's room could contribute to cross contamination and infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said she would collaborate with the DON on how to handle the issue about infection control and hand hygiene. Record review of facility policy, Handwashing/Hand Hygiene 2001 MED-PASS, Inc. revised August 2019 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids k. After handling used dressings, contaminated equipment, etc. Applying and Removing Gloves . 1. Perform hand hygiene before applying non-sterile gloves. Record review of facility policy, Perineal Care 2001 MED-PASS, Inc. revised February 2018 revealed Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . Steps in the Procedure . 2. Wash and dry your hands thoroughly . 7. Put on gloves . 12. Remove gloves . Wash and dry your hands. (continued on next page)

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 12/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, Infection Prevention and Control Program The Compliance Store revised 09/01/2022 revealed Policy: This facility has established and maintains 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 . 9. Equipment Protocol . Single-use devices must be discarded after use and are never used for more than one resident.

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 12/12/2024
NAME OF PROVIDER OR SUPPLIER Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Rockingham Dr Richardson, TX 75080	

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 50444 Based on observation and interviews, the facility failed to maintain all patient care equipment in the laundry room in safe operating condition. The facility failed to ensure one (the washer located near the back wall) of two washing machines in the laundry room was maintained. These failures could place residents at risk of contamination and improper laundering of items. Findings Included: An observation and interview 12/11/24 at 08:22 AM revealed sudsy water running from the door of a front-loading washer in the laundry room onto the floor below. The drain was directly in front of the washer. A trash bag was twisted and looped through the handle of the washer door and tied to a handle on the washer panel, just above the door. There was lime buildup along the front of the washer below the door and on the side of the washer. The laundry employee stated they had used the trash bag for 2 days to secure the washer door. Review of the maintenance log on 12/11/24 revealed there was no pending work order for the washer. During observation and interview 12/12/24 at 09:20, the Housekeeping Manager stated a bolt had to be tightened on the door latch of the washer. He stated they received new dispensers for the chemicals used in the washers. He stated the technician who installed the dispensers jammed the washer door and they were unable to open it. He stated the Maintenance Director had to force it open and this caused the bolt to come loose. He stated yesterday (12/11/24) he noticed the bolt was loose and tightened it. Further observation on 12/12/24 revealed there was no water on the floor in front of the washer. A trash bag was not being used to secure the front door of the washer and the floor was dry. In an interview 12/12/24 at 03:55 PM, the Maintenance Director stated a washer seal was replaced 12/12/24. He stated there was not a recommended time change for these. He stated the seal lasts a few years and were changed as needed. Review of facility's policy Physician Environment: Space and Equipment, Revised February 2023, reflected Inspection of resident care equipment will be completed routinely and as needed to maintain and ensure safe operating conditions according to manufacturer's recommendations.