

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 Gibbins Rd Arlington, TX 76011	

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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>45053</p> <p>Based on observation, interview and record review the facility failed to ensure that survey results were posted and, in a place, readily accessible to residents and visitors at the facility.</p> <p>The facility failed to ensure that survey results were posted and accessible for review on 07/15/24.</p> <p>This failure could impact the residents and visitors' ability to freely review the facility's outcome of regulatory compliance surveys without asking staff for survey results.</p> <p>Findings Included:</p> <p>Observation on 07/15/24 at 12:05 PM during rounds revealed no survey results binder or sign indicating location of results was posted anywhere in the facility.</p> <p>Observation on 07/15/24 at 1:34 PM during rounds revealed no survey results binder or sign indicating location of results was posted anywhere in the facility.</p> <p>An interview with the Administrator on 07/15/24 at 3:37 PM revealed that she was responsible for ensuring that the survey results sign and binder was posted in a clear and accessible spot within the facility per facility policy. The Administrator said that she had the survey results and sign posted at the front of the facility in the past, but they have since disappeared. The administrator stated that the survey results should be posted at the front of the facility and residents, staff and family members should have the ability to access the results. The administrator did not give any risks associated with not having the most recent survey results posted.</p> <p>A review of the facility policy titled, Survey Results, revised on April 2007, reflected:</p> <p>Copies of survey results, are maintained in the administrative offices. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up visits reports, etc along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or activity room.</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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on interview, and record review, the facility failed to coordinate the assessment with the pre-admission screening and resident review (PASRR) program for one (Resident #10) of five resident assessments reviewed for PASRR evaluations.</p> <p>The facility did not correctly identify Resident #10 as having a mental illness diagnosis, failed to correct his PASARR Level One screen accurately to reflect the information, and failed to appropriately complete Form 1012, Mental Illness/Dementia Resident Review, in a timely manner to be signed by the attending physician for Resident #10.</p> <p>This failure could place residents with psychiatric diagnoses with Dementia as their primary diagnosis at risk for missed assessments, interventions and services.</p> <p>The findings were:</p> <p>Review of Resident #10's Annual MDS assessment dated [DATE] reflected he was a [AGE] year-old male, readmitted to the facility on [DATE]. He had a BIMS score of 15/15 indicating no cognitive impairment. The MDS revealed that Resident #10 had an active diagnoses of bipolar disorder (mental illness characterized by mood swings)</p> <p>Review of Resident #10's care plan, no date indicated, did not reflect residents current or active diagnoses of bipolar disorder.</p> <p>Review of Resident #10's current physician orders reflected an order for Seroquel Oral Tablet 100mg (Quetiapine Fumarate). Directions for the medication indicate that the medication was to be given one tablet by mouth at bedtime related to bipolar disorder.</p> <p>Surveyor requested from the facility Resident #10's most recent PASRR Level One submission as related to his most recent re-admitted [DATE]. Surveyor was provided a PASRR Level One, dated 09/20/22 for Resident #10. Review of PASRR Level One, dated for 09/20/22, reflected Resident #10 did not have a mental illness.</p> <p>Review of resident's form titled Mental Illness/Dementia Resident Review Form 1012 of Texas Health and Human Services. Form 1012 revealed that this form was to be completed only for nursing facility residents with a current Negative PASRR Level 1 (PL1) Screening for Mental Illness to determine whether to submit a new Positive PL1 screening form on the long-term care portal before further evaluation is needed.</p> <p>Section A. Resident Nursing and Facility Identifying Information revealed to be for Resident #11</p> <p>Section B. Dementia Review states that if the individual has a primary diagnosis of dementia as defined above. The physician signs and dates the form attesting to the dementia diagnosis, form is circled yes, the individual has a primary diagnosis of dementia as defined above, but it is not signed by the physician attesting to the dementia diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Section B.1 Physical Attestation of Form 1012 revealed to be blank and not signed by the physician.</p> <p>Section C Mental Illness (MI) Indication revealed to be blank</p> <p>Record review of Form 1012 revealed to be signed by facility MDS nurse, dated for 7/17/24.</p> <p>An interview with the DON on 07/17/24 at 12:50 PM revealed that the MDS Nurse was responsible for ensuring that all PASRR Level 1 Screenings and related forms were accurate and reflected the residents current and active diagnoses.</p> <p>An interview with the MDS nurse on 07/17/24 at 2:19 PM revealed that she was responsible for ensuring that residents PL1's was coded appropriately and uploaded for review along with all necessary forms. The MDS nurses revealed that she was the only one in the facility responsible for PASRR submissions on new admissions or updated diagnoses as well as completion of Form 1012 timely and ensuring they were signed by the physician. MDS nurse revealed that she was in the process of auditing all PL1's and completing Form 1012 as indicated and was working on Resident #10's Form 1012. When asked about risks associated for not ensuring that residents have an appropriate PL1 coded or Form 1012 signed by the physician or submitted in a timely manner, MDS nurse stated it could place residents at risks for not receiving the services they need.</p> <p>An interview with the Administrator on 07/18/24 at 3:55 PM revealed that it was the MDS Nurse's responsibility for ensuring that the PASRR's were accurate and reflected the resident's current diagnosis and needs as well as completing all necessary forms. Interview with the administrator revealed that this process should be completed on admission.</p> <p>Review of the facility policy titled, PASRR (Pre-Admission Screening and Resident Review), revised February 2018, revealed that it is the purpose of this procedure to ensure that any resident with a PASRR need is identified. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admissions Screening and Resident Review (PASRR) process. If the Level 1 screen indicates that the individual may meet the criteria for MD, ID, or RD he or she is referred to the state PASRR representative for the Level II (evaluation and determination) screening process. The admitting nurse or designee notified the social services department, when a resident is identified as having a possible (or evident) MD, ID or RD.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on interview, and record review the facility failed to ensure that baseline care plans were completed within 48 hours of the resident's admission for 3 out of 5 residents (Resident #6, Resident #7, Resident #8) whose care was reviewed for baseline care plans.</p> <p>The facility failed to ensure that baseline care plans were completed within 48 hours for Resident #6, Resident #7, and Resident #8.</p> <p>This failure could place the resident at risk for not having continuity of care among nursing home staff to safeguard against adverse events that are most likely to occur right after admission.</p> <p>The findings included:</p> <p>Record Review of Resident #6's Admission MDS assessment dated [DATE] reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. She had a BIMS scoring of 14/15 indicating no cognitive impairment. Her diagnoses included: Muscle weakness, chronic respiratory failure with hypoxia (Condition where your body is not getting enough oxygen to your blood) and cognitive communication deficit (condition that refers to difficulties with communications that are affected by disruptions in cognition).</p> <p>Record Review of Resident #6's Care Plans on 07/15/24 reflected no baseline care plan was completed.</p> <p>Record Review of Resident #7's Admission MDS assessment dated [DATE] reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. He had a BIMS scoring of 14/15 indicating no cognitive impairment. His diagnosis included: Malignant neoplasm of bladder (abnormal growth or cancerous tissue found in the bladder), muscle weakness and urinary tract infections.</p> <p>Record Review of Resident #7's Care Plans on 07/15/24 reflected no baseline care plan completed.</p> <p>Record Review of Resident #8's Admission MDS assessment dated [DATE] reflected a [AGE] year-old female, readmitted to the facility on [DATE]. He had a BIMS scoring of 9/15 indicating moderately impaired cognition. Her diagnoses included: Cerebral infarction (condition where the blood flow to the brain is disrupted) , Edema (condition that causes excess fluid accumulation in the body tissues) and Cognitive Communication Deficit (condition that refers to difficulties with communications that are affected by disruptions in cognition).</p> <p>Record Review of Resident #8's Care Plans on 07/15/24 reflected no baseline care plan completed.</p> <p>An interview on 07/16/24 with the DON at 9:35 AM revealed that he was unsure of what the baseline care plan was. The DON said the MDS Nurse was responsible for completing the baseline care plan on admission. The DON revealed that risks to the residents without baseline care plans could include missing care for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 07/16/24 at 9:50 AM with the MDS nurse revealed that the admitting nurses were responsible for completing the baseline care plans. The MDS Nurse revealed that the nursing management including the ADON, DON and MDS Nurse audited the residents clinical record daily to ensure compliance of baseline care plans. The MDS Nurse revealed that risks to the residents without base care plans could include missing items in the resident's comprehensive plan of care.</p> <p>An interview on 0 7/17/24 at 3:46 PM with LVN B revealed that it would be the admitting nurse's responsibility to complete the baseline care plan. LVN B revealed that the baseline care plan should be completed within 24 hours admission.</p> <p>Interview on 07/18/24 at 4:08 PM with the Administrator revealed that the admitting nursing staff was responsible for ensuring all admitting assessments and documentation was completed. The administrator stated that the resident could face service delays if baseline care plans were not completed.</p> <p>A review of the facility policy titled, Care plans Preliminary, revised on August 2006, reflected that a preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission. Per the facility policy, the preliminary care plan will be used until the staff can conduct the comprehensive assessment and develop the interdisciplinary plan of care.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames that met the residents clinical and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #10) out of 6 residents reviewed for care plans.</p> <p>The facility failed to ensure that Resident #10's comprehensive care plan included his diagnosis of bipolar disorder.</p> <p>This failure could place residents at risk of having received inadequate interventions not individualized to their care needs.</p> <p>Findings Included:</p> <p>Record Review of Resident #10's demographic sheet, dated 07/18/24, reflected he was a [AGE] year-old male, admitted to the facility originally on 5/4/07 and then readmitted to the facility recently on 8/9/23. Resident #32's diagnoses included: Bipolar disorder (a serious mental illness characterized by extreme mood swings), Alzheimer's disease (brain disorder that causes problems with memory, thinking and behavior), and Major Depressive Disorder, severe with psychotic symptoms (mental health disorder which includes having episodes of psychological depression with psychotic symptoms)</p> <p>Record Review of Resident #10's MDS, dated [DATE] reflected a BIMS score of 15/15 indicating no cognitive impairment. Section I- Active diagnoses revealed that the resident has an active diagnosis of bipolar disorder.</p> <p>Record Review of Resident #10's care plan reviewed on 7/18/24 did not include his current diagnoses of bipolar disorder.</p> <p>Record Review of a document titled, [Name of Psychiatry Provider] Psychiatry Document for 7/1/2024 titled Psychiatric Subsequent Assessment.</p> <p>Record Review revealed the following:</p> <p>Primary Treating DX: Bipolar Disorder, current episode, moderate.</p> <p>An interview with the ADON on 07/18/24 at 11:10 AM revealed that it was the responsibility of the MDS nurse to ensure that the comprehensive care plans were personalized to each residents' current orders and needs. The ADON revealed that a residents current and active diagnoses should be included in the resident's comprehensive plan of care. The ADON could not name any risks for not care planning active diagnoses.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on 07/18/24 at 11:19 AM revealed that it was the responsibility of the MDS nurse to ensure that the comprehensive care plans were personalized to each resident. The DON revealed that a residents current and specific antipsychotic usage should be in the residents comprehensive care plan along with their diagnoses. When asked about risks associated for not having active diagnoses in the comprehensive care plan the DON stated a risk would be lack of information to resident's direct care staff.</p> <p>An interview with the MDS nurse on 07/18/24 at 11:31 AM revealed that she was responsible for ensuring that the residents comprehensive care plan was personalized to each residents' orders, diagnoses, preferences and needs. Interview with the MDS nurse revealed she was not sure why Resident #12's care plan did not include his current diagnosis of bipolar disorder. MDS nurse revealed that she was currently auditing all comprehensive care plans to ensure all active psychiatric diagnoses and antipsychotic usage was in all resident's comprehensive care plans. The MDS nurse revealed that she will update Resident #10's care plan to reflect his current diagnosis of bipolar disorder. The MDS nurse revealed that direct care staff could miss items related to the resident's care.</p> <p>An interview with the Administrator on 07/18/24 at 4:05 PM revealed that it was the MDS's nurses' responsibility for ensuring that the comprehensive care plans were accurate and reflected the resident's needs, preferences, and services.</p> <p>Record Review of the facility's MDS Coordinator job responsibilities titled, MDS Coordinator, no date listed, revealed that the purpose of the position, MDS Coordinator is to provide and coordinate the delivery of premier resident centered care to optimize profitability through the coordination and implementation of clinical, regulatory and reimbursement systems so the facilities financial and clinical objectives are met or exceeded. The desired results of the MDS Coordinator position was timely and accurate completion of residents MDS care plans.</p> <p>Record Review of the facility's policy titled, Care Plans Comprehensive, dated for December 2010, revealed that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The residents comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on observation, interview and record review the facility failed to provide both facility-sponsored group activities individual activities that are designed to meet the residents' interests, and support the physical, mental, and psychosocial well-being of 4 out of 6 residents (Resident #2, Resident #3, Resident #4, and Resident #5) whose care was reviewed in the facility's secured unit.</p> <p>1. The facility failed to post a designated activity calendar outlining the monthly activities for residents in the facility's secured unit and in each of the residents' designated rooms within the facility's secured unit.</p> <p>2. The facility failed to ensure that a designated activity program was created and implemented in the facility's secured unit. The facility failed to ensure that the residents in the secured unit had direct access to engaging activity items such as books, newspapers, music items, arts/craft items or any items designated in the residents MDS assessment or comprehensive plan of care related to activities.</p> <p>These failures place the residents at risk for an increase in depression and isolation.</p> <p>Findings Included:</p> <p>Record Review of Resident #2's Quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female and admitted to the facility on [DATE]. She had a BIMS score of 5/15 or severe cognitive impairment. Her diagnoses included cerebral infarction (condition that results in the death of brain tissue due to lack of blood and oxygen supply), schizophrenia (mental disorder characterized by reoccurring episodes of psychosis), bipolar disorder with psychotic features (disorder characterized by extreme shifts in mood and energy levels), and panic disorder (anxiety disorder characterized by sudden and repeated panic attacks). It was very important for the resident to do her favorite activities, be around animals such as pets, listen to music she likes and somewhat important for her to have books, newspapers, and magazines to read.</p> <p>Review of Resident #2's clinical record revealed a note dated for 03/19/24 titled, Activities Quarterly note reflected staff will, continue to provide daily activities for Resident #2, she continues to enjoy musical events, socializing with her peers and staff, exercise, and balloon ball toss.</p> <p>Review of Resident #2's clinical record reflected a note dated 06/18/24 titled, Activities Quarterly Note reflected that Staff will, continue to encourage Resident #2 to attend daily activities, especially music events.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #3's Annual MDS assessment dated [DATE] reflected she was an [AGE] year-old female and admitted to the facility on [DATE]. She had a BIMS score of 2/15 indicating a severe cognitive impairment. Her diagnoses included: dementia (a group of symptoms that affects memory, thinking and interferes with daily life), psychotic disorders with delusions (mental disorders characterized by disconnection from reality with results in disturbances in thought, perception and sensory), and major depressive disorder (mental health disorder which includes having episodes of psychological depression). It was very important to do her favorite activities, to be around animals such as pets, very important to keep up with the news, and somewhat important to listen to music she liked.</p> <p>Record Review of Resident #3's clinical record revealed a note dated for 02/16/24, that staff will provide Resident #3 with various activities, Resident #3 is very active, she enjoys socializing with her peers and helping to encourage them. Staff will continue to provide her activities.</p> <p>Record Review of Resident #4's Annual MDS assessment dated [DATE] revealed he was an [AGE] year-old male and admitted to the facility on [DATE]. He had a BIMS score of 2/15 indicating a severe cognitive impairment. His diagnoses included: Unspecified dementia without behavioral disturbance (condition of confusion or mild cognitive impairment which cannot be clearly diagnosed as a specific type of dementia), altered mental status (broad term used to indicate an abnormal state of alertness or awareness), major depressive disorder (mental health disorder which includes having episodes of psychological depression). Record Review of Resident #4's Annual MDS assessment dated for 05/22/24 revealed that, It was very important for Resident #4 to be around animals such as pets, important to keep up with the news, do his favorite activities and somewhat important to go outside to get fresh air when the weather was good.</p> <p>Record Review of Resident #4's clinical record revealed a note dated for 2/27/24 that staff will continue to provide resident with daily visits, musical events, balloon volleyball toss and various games to engage him.</p> <p>Record Review of Resident #5's Quarterly MDS assessment dated for 05/13/24 revealed he was an [AGE] year-old male and admitted to the facility on [DATE]. He had a BIMS score of 0/0 indicating a severe cognitive impairment. His diagnoses included: Alzheimer's disease (type of brain disorder that causes problems with memory, thinking and behavior), unspecified dementia with agitation (condition of confusion or mild cognitive impairment which cannot be clearly diagnosed as a specific type of dementia with behavioral and psychological symptoms such as agitation) , psychotic disorders with delusions (mental disorders characterized by disconnection from reality with results in disturbances in thought, perception and sensory). A staff assessment of daily and activities preferences was completed. Staff assessment within the coded interview reflected that it was not significant for the resident to participate in his favorite activities, spending time outdoors, participate in religious activities or preferences and listening to music.</p> <p>Record Review of Resident #5's clinical record reflected a note dated for 5/13/24 titled activities quarterly note that staff will continue to provide Resident #5 with various activities and encourage him to attend.</p> <p>Record Review of Resident #5's clinical record reflected a note dated for 02/12/24 that Resident #5 was on the secure unit, he attended activities of choice, and enjoyed socializing with his peers. Staff would continue to provide him with various activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the secure unit on 07/15/24 at 9:48 AM revealed Resident #2 was sitting in her wheelchair with her eyes closed. Resident #3 and Resident #4 were sitting in wheelchairs. Resident #5 was observed pacing back and forth in the facility's secured unit dining area. CNA E was sitting near the group of residents (Residents #2, #3, #4), on his phone.</p> <p>Observation of the secure unit on 07/15/24 at 9:55 AM revealed that there were no activity calendars posted anywhere in the facility secured unit. There was no music stimulation or current activities in progress.</p> <p>Observation of the secure unit on 07/15/24 at 9:56 AM revealed that Residents #2, #3, #4, #5 had no activity calendar posted in their rooms.</p> <p>In an interview on 07/15/24 at 10:55 AM with CNA E revealed that he has been working in the facility's secure unit for the past 8 months. CNA E verbalized that there was no daily activity involvement within the facility's secure unit however he could not state why the facility did not have any activities planned or posted for 07/15/24. CNA E verbalized that there was not an activity calendar posted anywhere in the facility's secure unit.</p> <p>In an interview on 07/15/24 at 11:00 AM with the Activity Assistant revealed that she was the Activity Assistant for the secured unit and served as a CNA. The Activity Assistant revealed that the current Activity Director has not yet made the activity calendar for July available, even though the month was half over. She revealed that typically there was an activity calendar that indicated what activities within the facility's secure unit occur for that day. She revealed that typically she coordinated with the Activity Director on daily activities that were supposed to take place in the facility's secure unit each day, but it had not occurred yet. The Activity Assistant verbalized there was not an activity calendar posted anywhere in the facility's secure unit.</p> <p>In an interview on 07/15/24 at 2:00 PM with the Activity Director revealed that she started employment at the facility on 06/25/24. Interview revealed that she was responsible for creating the activity calendar for both the secured unit and regular unit. The Activity Director also revealed that she was also responsible for ensuring activities were personalized based on the residents' comprehensive assessments, care plans and interviews. The AD stated that she had not gotten around to the activity calendar for the month of July for the secure unit and said that she was working on the activity calendar for August. The Activity Director said that residents can have an increase in depression and isolation if they did not have activities to participate in.</p> <p>Review of the facility's Activity Director Job Responsibilities titled, Job Description Facility Activity Director, revealed that it was the responsibility of the activity director to plan, organize and implement an ongoing program of group and individual resident activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each Resident.</p> <p>In an interview on 07/15/24 at 3:30 PM with the Administrator revealed that the Activity Director was responsible to ensure that each resident had a personalized plan of care related to activities that promoted quality of life. The administrator reported that not having a personalized activity program in place for the residents in the secure unit could place the residents at risk for an increase in depression and isolation.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 07/17/24 at 11:58 AM with LVN B revealed that there had been no activity involvement or engagement with the residents in the Memory Care Unit. LVN B stated that there used to be engagement and involvement under the old activity director, but since the current Activity Director had taken over, there had not been. LVN B verbalized the secured unit did not have an activity calendar or personalized activity program for the residents on the secured unit.</p> <p>Review of the facility policy titled, Activities, no date listed, revealed that it was the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community.</p> <p>Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but it not limited to:</p> <ul style="list-style-type: none"> A. RAI (Resident Assessment Instrument) Process: MDS/CAA (Care Area Assessment)/Care Plan B. Activity Assessment to include resident's interest, preferences and needed adaptations. C. Social History D. Discharge Information, when applicable. <p>Activities will be designed with the intent to:</p> <ul style="list-style-type: none"> A. Enhance the resident's sense of well-being, belonging, and usefulness B. Create opportunities for each resident to have a meaningful life. C. Promote or enhance physical activity D. Promote or enhance cognition E. Promote or enhance emotional health F. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence G. Reflect residents' interest and age H. Reflect cultural and religious interests of the residents I. Resident choices of the residents. <p>Scheduled activities are posted in the Resident's room, where appropriate, and in a prominent place in the facility.</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Residents #15) of 4 residents reviewed for quality of care.</p> <p>1. Resident #15 did not receive care on the overnight shift (10PM-6AM) on 08/05/24. Resident #15's entire, right leg hung from the bed throughout the night and was observed swollen. Resident #15 was in distress, discomfort, pain, shed tears and had a flushed face (blood vessels below the skin dilate and fill with more blood, making the skin appear pink, red.) Resident #15 call light and bathroom call light did not work properly. Resident #15 yelled and cried out for help continuously for thirty minutes at 7:00 AM on 08/06/24.</p> <p>On 08/07/24 at 3:46 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/12/24, the facility remained out of compliance at a severity level of - no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>These failures could place all residents at risk for abuse that could lead to serious injury, harm, impairment, or death.</p> <p>Findings included:</p> <p>Record review of Resident #15's face sheet, dated 08/12/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: paraplegia (the loss of muscle function in the lower half of the body, including both legs), abnormalities of gait and mobility, intervertebral disc degeneration (a condition that occurs when the spinal discs break down and lose function), lumbar region (spinal disks wear down), post-traumatic stress disorder (a mental health condition that caused by extremely stressful or terrifying event), pain unspecified, and retention of urine.</p> <p>Record review of Resident #15's initial MDS assessment, dated 06/28/24, reflected her BIMS score was 13, which indicated she was cognitively intact.</p> <p>Record review of Resident #15's care plan, revised on 08/02/24, reflected Resident #15 required skilled nursing care related to paraplegia. Resident #15 will safely transition to long term care. Resident #15 will continue to improve. Resident #15 has limited physical mobility/ADL deficit related to paraplegia, Chronic Obstructive Pulmonary Disease, anxiety, and bipolar disorder. Resident #15 were on skilled services and decided she wanted long term care instead of short stay. Resident #15 had rails on bed for positioning and turning. Resident #15 required bed mobility with 1 staff, transfers with 2 staff with a sliding board and a Hoyer lift with showers, toileting with 1 staff, and dressing/grooming with 1 staff. Goals: free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, and fall related injury through the next review date. Interventions: Monitor/document/report to MD PRN s/sx of immobility: contractures forming or worsening, thrombus formation, skin break down, and fall related injury .Provide supportive care, assistance with mobility as needed. Document assistance as needed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #15's progress note, late entry dated 08/08/24 by the social worker, reflected the following: [Resident #15] asked if she had to move rooms. SS explained to the resident that once a resident transition to long-term, they get a roommate. The resident then stated a staff member said she could stay in a private room if her family could pay the difference. When asked who told her that, resident said she could not remember. SS told the resident that they would ask the administrator and see what he says. The [Resident #15] then said she plans on leaving the facility September 1st and will move in with her.</p> <p>Observation on 08/06/24 at 7:00 AM revealed Resident #15 yelled for help from her bedroom. Observed Resident #15 right entire leg hanging out of the bed and appeared to be red and swollen. Observed Resident #15 face was red, in distress and she was crying.</p> <p>Observation on 08/06/24 at 7:30 AM of the social worker went into the room and then walked out. Observed Resident #15 call out for help again.</p> <p>Observation on 08/06/24 at 7:40 AM revealed LVN H and CNA N lifted Resident #15's leg back in the bed and gave her pain medication. LVN H stated to Resident #15 that they will assist her after breakfast with getting dressed and changed.</p> <p>Observation on 08/06/24 at 7:45 AM revealed Resident #15's call light in the room and in the bathroom did not work.</p> <p>Observation on 08/06/24 at 4:30 PM revealed Resident #15's call light worked properly.</p> <p>Interview and observation on 08/06/24 at 7:21 AM with Resident #15 who stated she was not checked on by the overnight shift. Resident #15 stated she had been calling out for help for a while and no one had been by to help her. Resident #15 was distressed and crying. Resident #15 stated that she felt alone and abandoned. Resident #15 stated the last time she saw staff was when she moved into the room.</p> <p>In an interview on 08/06/24 at 7:45 AM Resident #15 stated she did not know why she was moved to hallway 500, she was moved yesterday and was the only resident on that hall. Resident #15 stated her call light in the room and bathroom did not work. Resident #15 stated she had told the DON and other staff that her call light did not work on 08/05/24 around dinner time at 4:30 PM.</p> <p>In an interview on 08/06/24 at 8:10 AM with the social worker revealed Resident #15 was moved to the 500 hall because she wanted to be transferred to long term care and have a single room.</p> <p>In an interview on 08/06/24 at 9:00 AM LVN H stated Resident #15 was transferred to the 500 hall on 08/05/24 between first and second shift. LVN H stated that she was responsible for 300 and 500 hall. LVN H stated the facility had problems in the past with the call lights not working. LVN H stated that if residents were not checked on every 2 hours and as needed, they were in danger of falls and skin break down.</p> <p>In an interview on 08/06/24 at 9:10 AM CNA F revealed she did not know there was a resident on hallway 500. CNA F revealed residents were to be checked on every 2 hours.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview over the phone on 08/06/24 at 9:15 AM CNA N (overnight shift) stated she did not know a resident was on 500 hall.</p> <p>In an interview on 08/06/24 at 3:00 PM the DON stated that staff knew Resident #15 was on 500 hall and she had a history of lying, drinking, and smoking in the room and that was part of the reason why she was put on the hall by herself. The DON revealed that Resident #15 was transferring to long term care and wanted to stay in a room by herself. The DON stated the call light system just started to act up on 08/05/24. The DON stated the call light company would be out to repair the system. The DON stated residents are checked on every 2 hours and the residents who call lights did not work then bells would be provided. The DON stated residents are in danger of skin break down or falls if they are not checked every 2 hours.</p> <p>In an interview on 08/06/24 at 3:08 PM with Resident #15 stated that her entire left leg hung out of the bed all night and she did not know until she started to feel pain. Resident #15 stated her pain level this morning was at a ten and now she was down to an 8. Resident #15 stated she expected staff to answer the call light and help her as soon as they could. Resident #15 stated she understood the staff were busy but when they tell her they will come back staff don't. Resident #15 stated the social worker told her she was moved because she wanted to move to long term care and stay in a single room. Resident #15 stated the DON asked her if she wanted to move back to hall 100 and she told him no because she had too much stuff too.</p> <p>In an interview on 08/07/24 at 5:15 AM with LVN R (Overnight shift) stated she was responsible for hall 300, 400, and 500. LVN R revealed she changed Resident #15 once overnight the night before. LVN R stated since Resident #15's call light was not working she was checked on every 2 hours.</p> <p>In an interview on 08/07/24 at 5:20 AM with CNA N (Overnight shift) revealed she worked halls 100, 300, and 500. CNA N revealed that Resident #15 was checked on once.</p> <p>In an interview on 08/07/24 at 7:00 AM with the Maintenance Director stated the facility was in the process of updating the call light system and the owner would know more information about that. The Maintenance Director stated when the call light system did not work resident rounds should be every 30 minutes. The Maintenance Director stated residents could be at risk of not getting care when needed. The Maintenance Director stated the facility had on and off issues with the call lights. The Maintenance Director stated the call light company would be out on 08/07/24 after 12:00 PM to work on the system.</p> <p>Record review of facility in-service dated 08/06/24 titled: call light and resident care reflected:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident should be up in a WC and back to bed as needed and requested. If a resident wants to get up, we need to do all we can to get him/her up. If they want to go back to bed, assist them back in bed as need. Let us work with our residents to meet their needs. We should always encourage residents to get out if bed; not discourage them. We should also empower residents by allowing them to participate in the decision-making process. For example, we can ask: What time would you like to get up; What time would you like to go back to bed? I know you want to get up at 5 PM. At that time, we are passing dinner on the floor. Is it possible for you to get up earlier or later than 5pm? Make residents feel in control of daily lives. We need to do round on residents all the time and provide incontinent care as needed without delays to all halls INCLUDING 500 HALL Do not delay care or wait for the end of the shift when we know that a resident is wet and needs assistance. We cannot let our residents lie in urine and feces: placing them at remarkably high risks of all types of infection. We should always treat our residents with dignity and respect. DO not display a behavior or attitude that may be misinterpreted or make residents uncomfortable. Do not make fun at residents. When they need something, please take time to explain and answer all their questions to the best of your ability.</p> <p>Call lights should be answered in a timely manner without delays by all departments. When answering the call light, please refer to the service resident is requesting. Make sure to return and update resident. Leave the call light on until residents' needs have been met.</p> <p>No staff signatures included with in services.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 08/07/24 at 3:46 PM. The Administrator and DON was notified. The Administrator was provided with the IJ template on 08/07/24 at 4:00 PM.</p> <p>The following Plan of Removal was submitted by the facility and was accepted on 08/09/24 at 3:11 PM and reflected:</p> <p>Immediate Corrective Action for residents affected by the alleged deficient practice:</p> <p>Identified Immediate Jeopardy (IJ) Issues: Policy and procedure have and will be reviewed and will be re-in-serviced if change is required.</p> <p>1. Noncompliance with S483.12 (F 600) Freedom from Abuse, Neglect, and Exploitation</p> <ul style="list-style-type: none"> o Resident #1 was not checked on the overnight shift. o Call lights and bathroom lights were not functional. <p>Corrective Actions and Steps for Removal of Immediate Jeopardy:</p> <p>1. Ensuring Resident Safety and Dignity</p> <p>Immediate Staff Training:</p> <ul style="list-style-type: none"> o Action: Conduct immediate in-service training for all staff on the importance of resident checks, especially during night shifts, and proper use of the call light system. Review of Policy and Procedure for call light and ADL's. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>o Responsible Party: Director of Nursing (DON)</p> <p>o Completion Date: 08/09/2024</p> <p>Immediate Resident Checks:</p> <p>o Action: Implement a system to ensure residents are checked every two hours, with documentation of each check. Review of Policy and Procedure ADL's.</p> <p>o Responsible Party: Nursing Staff</p> <p>o Completion Date: Ongoing with immediate effect</p> <p>2. Functionality of Call Lights and Electrical Systems</p> <p>Repair Call Lights and Electrical Issues:</p> <p>o Action: Ensure all call lights in resident rooms and bathrooms are fully functional. A certified electrician will repair any non-functional lights immediately. Review of Policy and Procedure for call light and ADL's.</p> <p>o Responsible Party: Maintenance Supervisor</p> <p>o Completion Date: 08/09/2024</p> <p>Routine Maintenance Checks:</p> <p>o Action: Conduct daily checks of call light systems for two weeks, followed by weekly checks to ensure ongoing functionality.</p> <p>o Responsible Party: Maintenance Supervisor</p> <p>o Completion Date: Start immediately and continue weekly</p> <p>4. Resident Assistance and ADL Care</p> <p>Enhance ADL Care:</p> <p>o Action: Review and revise hall assignments to ensure adequate staffing on all halls, including hall 500. Ensure staff are aware of and meet residents' ADL needs promptly.</p> <p>o Responsible Party: DON and Nursing Supervisor</p> <p>o Completion Date: 08/09/2024</p> <p>Frequent Monitoring and Assistance:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>o Action: Implement a policy requiring staff to respond to call lights within 5 minutes. Regularly audit compliance and address any delays promptly.</p> <p>o Responsible Party: Nursing Supervisor</p> <p>o Completion Date: Start immediately with ongoing monitoring</p> <p>5. Family and Resident Communication</p> <p>Communication with Residents and Families:</p> <p>o Action: Inform residents and their families about the steps being taken to address the identified issues and ensure their safety and well-being.</p> <p>o Responsible Party: Administrator and Social Worker</p> <p>o Completion Date: 08/09/2024</p> <p>Monitoring and Verification</p> <p>Regular Audits:</p> <p>o Action: Conduct weekly audits for compliance with the above actions for the next three months, then transition to monthly audits.</p> <p>o Responsible Party: Quality Assurance Team</p> <p>o Completion Date: Ongoing</p> <p>Immediate Reporting:</p> <p>o Action: Any noncompliance or issues identified during audits must be reported to the DON and Administrator immediately for corrective action.</p> <p>o Responsible Party: Audit Team</p> <p>o Completion Date: Ongoing</p> <p>Completion and Documentation</p> <p>Document All Actions:</p> <p>o Action: Maintain thorough documentation of all corrective actions, training sessions, maintenance checks, and communication with residents and families.</p> <p>o Responsible Party: Administrator</p> <p>o Completion Date: On going</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's implementation of the Plan of Removal was verified through the following:</p> <p>Record review of in-service record sheet dated 08/07/24 titled: Call light/check residents. Purpose: plan of correction. Ensure resident safety and dignity: Make sure to check all residents at least every two hours every shift and as needed, especially at night. Before leaving the room make sure call light is working in room and the bathroom and within patients reach.</p> <p>Enhance ADL Care: Check residents in hall 500 at least every two hours every shift and throughout the night. Hall 500 assignments will be added to the staffing book. Check staffing book assignment daily to know who is assigned to hall 500. DO not ignore call light. Call light needs to be answered promptly. Even if you are not assigned to a resident, you must answer call light and address residents needs as much as you could. Provide showers to residents as scheduled and as needed. If a patient missed shower for more some reasons, we should provide it to them when requested even if it's not their shower day. When a patient refuses shower, notify the nurse immediately who will then inform family and document under PCC notes.</p> <p>Frequent Monitoring and assistance: We need to respond to call light immediately; within 5 minutes or less. Any staff that delay care or call light response will face disciplinary action.</p> <p>Record review of NMAR reflected: [Resident #15] check on resident at least every two hours every shift initiated on 08/08/24.</p> <p>Record review for in-services were initiated on 08/12/24 at 11:11 AM in a message to the team. Message reflected: Good morning, Team! Please see in-service regarding call lights/resident rooms from DON. We need to answer call light immediately. When we go to room, check to make sure call lights works in the room and bathroom. If it does not report it to charge nurse, DON and/or Maintenance.</p> <p>There are patients on 500 hall that need to be monitored as well. Check on all patients including the ones on hall 500 at least every two hours. Hall 500 assignments will be in staffing book. Please check it at the beginning of each shift. Please respond to acknowledge the in-service.</p> <p>An interview on 08/09/24 at 5:15 AM with RN P revealed residents were checked on every 2 hours and as needed. RN P revealed that checks were documented on the EMAR.</p> <p>An interview on 08/09/24 at 5:20 AM with RN Q revealed she worked over night with Resident #15, and she was checked on every 2 hours and as needed. RN Q revealed that checks were documented on the EMAR.</p> <p>An interview on 08/09/24 at 5:25 AM with CNA F revealed residents were checked on every 2 hours and as needed. CNA F revealed that checks were documented on the EMAR.</p> <p>An interview on 08/09/24 at 5:30 AM with LVN A revealed residents were checked on every 2 hours and as needed. LVN A revealed that checks were documented on the EMAR.</p> <p>An interview on 08/09/24 at 6:10 AM with LVN B revealed residents were checked on every 2 hours and as needed. LVN B revealed that checks were documented on the EMAR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 08/09/24 at 6:20 AM with LVN D revealed she worked with Resident #15 overnight and she was checked on every 2 hours and as needed. LVN D revealed that checks were documented on the EMAR.</p> <p>An interview on 08/10/24 at 1:30 PM with CNA X who stated residents are checked on every 2 hours. CNA X stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/10.24 at 1:37 PM with RN Y who stated residents are checked on every 2 hours. RN Y stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 5:45 AM with Med Aide S who stated residents are checked on every 2 hours. Med Aide S stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 5:58 AM with LVN R who stated residents are checked on every 2 hours. LVN R stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 6:00 AM with CNA T who stated residents are checked on every 2 hours. CNA T stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 6:00 AM with CNA V who stated residents are checked on every 2 hours.</p> <p>An interview on 08/11/24 at 6:03 AM with CNA U who stated residents are checked on every 2 hours.</p> <p>An interview on 08/11/24 at 6:03 AM with RN W who stated residents are checked on every 2 hours. RN W stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 8:41 AM with the DON stated the MAR needed to be updated to reflect every 2-hour check for residents. DON stated he needed to do in-services for residents on hall 500 and assigned task. DON stated he would send updated information before the end of the day. DON stated residents are checked on every 2 hours. DON stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/12/24 at 5:30 AM CNA J who stated residents are checked on every 2 hours. CNA J stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/12/24 at 6:00 AM LVN B stated who stated residents are checked on every 2 hours. LVN B stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 Gibbins Rd Arlington, TX 76011	
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 08/12/24 at 6:04 AM LVN H who stated she worked the day shift and is responsible for Resident #15 and she is checked on every 2 hours. LVN H stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>The Administrator was notified the IJ was removed on 08/12/24 at 12:15 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolation due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on observation, interview and record review the facility failed to ensure that the facility residents received proper treatment and care to maintain mobility and good foot health for 2 (Resident #11 and Resident #12) of 5 residents reviewed for foot care services.</p> <p>1. The facility failed to provide podiatry services to Residents #11 and #12.</p> <p>This failure could lead to increased potential negative outcomes related to foot health.</p> <p>Findings Included:</p> <p>Record Review of Resident #11's demographic sheet, dated 07/18/24, revealed he was a [AGE] year-old male with an initial admitted to the facility of 11/1/2023. Resident #11's active diagnoses included: Type 2 diabetes mellitus with hyperglycemia (person with a condition of diabetes that has high blood sugar levels), muscle weakness (generalized), peripheral vascular disease, unspecified (condition where the arteries narrow, causing reduced blood flow to the arms or legs). He had a BIMS score of 14/15 revealing no cognitive impairment.</p> <p>Record Review of Resident #11's care plan, no date indicated, revealed the following:</p> <p>Focus- Resident #11 has Diabetes Mellitus, Date Initiated- 1/18/24.</p> <p>Goal- Resident #11 will have no complications related to diabetes through next review, Date Initiated- 1/8/24, Revision on 4/19/24.</p> <p>Focus- Resident #11 has an ADL self-care performance deficit, Date initiated- 1/18/24.</p> <p>Goal- Resident #11 will be clean, dry and neatly dressed daily through next 90 days, date initiated on 4/19/24.</p> <p>Record Review of Resident #11's clinical record, progress notes, social work notes does not indicate a referral made for podiatry services.</p> <p>An interview and observation with Resident #11 on 07/18/24 at 1:45 PM revealed the resident was lying in bed. Observation of resident's toenails revealed toenails to be discolored, broken and dry. Resident #11 stated he has been at the facility for some time and could not remember ever seeing a podiatrist. When asked if he could independently manage his own foot care, Resident #11 responded no. The resident revealed that he would like to see a podiatrist routinely but was unsure who to ask.</p> <p>Record Review of Resident #12's, demographic sheet revealed he was a [AGE] year-old male with an initial admitted to the facility of 11/22/2019. Resident #12's active diagnoses included: Quadriplegia (paralysis of both the arms and legs), unspecified, Type 2 diabetes mellitus with foot ulcer and muscle weakness (generalized)</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of Resident #12's MDS dated [DATE] revealed he had a BIMS score of 0/15 indicating a severe cognitive impairment.</p> <p>Record Review of Resident #12's care plan, no date indicated revealed the following:</p> <p>Focus- Resident #12 has Quadriplegia r/t LE of CVA with LE dysphagia and Aphasia. Date initiated- 5/3/23.</p> <p>Goal- Resident #12 will remain free of complications or discomfort related to paraplegia through review date. Date initiated- 5/3/2023.</p> <p>Focus- Resident #12 has an ADL self-care performance deficit r/t Quadriplegia.</p> <p>Goal- Resident #12 will maintain current levels of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene mobility through next review date. Date initiated- 5/3/2023, revision date on 11/25/2023.</p> <p>Focus- Resident #12 has Diabetes Mellitus- Date initiated on 5/3/2023, Revision on 11/25/2023.</p> <p>Goal- Resident #12 will have no complications related to diabetes through review date. Date initiated on 5/3/2023, revision on 11/25/2023.</p> <p>Interventions/Tasks- Elicit a verbal understanding from the resident/family/caregiver that nails should always be cut straight across, never cut corners, file rough edges with emery board. Date initiated on 5/3/2024, revision on 8/2/2023.</p> <p>Record Review of Resident #12s clinical record document titled, Care plan Conference revealed the following:</p> <p>Care Plan Meeting Date and Time: 6/11/24 at 1:44PM</p> <p>Invitations: Family/Responsible Party, Invited and Attended.</p> <p>Participants: Nurse, Social Worker, Occupational Therapist, Activities Director.</p> <p>Social Services Summary: No changes, resident in a comatose state. Residents' family member attended the meeting over the phone.</p> <p>Consults Needed (Podiatry, Dental, Opth, etc.): None requested.</p> <p>Record review of Resident #12's clinical record document titled, Care Plan Conference revealed that the document was signed and locked by MDS nurse on 7/18/24 at 1:09 PM, date of record review during survey.</p> <p>Record Review of the document, [Name of Podiatry] Podiatry Group revealed that resident #12 was last examined by Podiatry Group on 6/22/2022. Document was electronically signed by the Podiatrist on 6/22/22. Record Review of the document, [Name of Podiatry] Podiatry Group revealed that, recall to be as medically necessary, but no sooner than 60 days.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of document titled, [Name of Podiatry Group] Visit Summary revealed the visit date to be 7/3/24. Document revealed the following:</p> <p>Treated Patients: Did not reveal resident #11 or resident #12 to be treated during the 7/3/24.</p> <p>Non-treated patients: Did not reveal Resident #11 or Resident #12 to be under the non-treated patients' section.</p> <p>Record Review of a facility document titled, [Name of Podiatry Group] Podiatry Group Schedule revealed a visit date of 8/9/2024. Record Review of the document did not reveal Resident #11 or Resident #12 to be scheduled for the 8/9/24 visit.</p> <p>An observation of Resident #11 on 07/18/24 at 2:20 PM revealed he was in bed, woke to verbal stimuli, but was unable to verbalize or correspond with the surveyor. Physical observation revealed toenails to be broken, discolored and long.</p> <p>An interview with Resident's Responsible Party on 07/18/24 at 2:41pm revealed they were the responsible party for Resident #12. He revealed that he had never been asked if he would like Resident #12 to be on routine podiatry services and could not recall the last time Resident #12 was seen at the facility by a podiatrist. Interview with the Resident's Responsibility Party revealed that he was unsure of who to ask at the facility if he would like the resident to be seen by the podiatrist.</p> <p>An interview with RN Q on 07/18/24 at 3:28 PM revealed that she had been working on the 400 hall since November 2023 and has been the nurse for both Resident #11 and Resident #12 during that time and had not seen podiatrist services for those residents. RN Q said she would go to the attending physician for an order for podiatry services. When asked about the risk for residents not receiving podiatry services who have an increased risk to their foot health related to their diagnoses, RN Q revealed that a risk would be an increase in skin breakdown.</p> <p>An attempt was made to interview the Social Worker on 7/18/24 at 3:40 PM via phone, no return call. Request made to administrator to have Social Worker call surveyor.</p> <p>An interview with the MDS nurse on 07/18/24 at 3:45 PM revealed that the Social Worker was responsible for ancillary service coordination, including podiatry services. When asked about risks associated for not having residents seen, consulted or on routine podiatry services who have increased risk of negative foot health due to their diagnoses, the MDS nurse revealed risks to be further breakdown and missing care. The MDS nurse revealed that Resident #11 was referred to the podiatrist last week but could not locate the referral or consents.</p> <p>An interview with the Administrator on 07/18/24 at 4:10 PM revealed that it was the responsibility of the social worker to ensure residents were referred to ancillary services including podiatry services.</p> <p>(continued on next page)</p>

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<p>F 0687</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 Social Worker Job Responsibilities titled, Job Description Facility Social Worker, no date indicated, revealed that the social worker is responsible for enabling each resident to function at the highest possible level of social and emotional well-being. The Social Service director also assures that the resident's continuing needs are met through the highest degree of quality resident care in accordance with state and federal regulations and facility policies and procedures. Responsibilities of the social worker include, assist and prepare residents to resume life in the community or long-term residence in the facility as appropriate to the resident's status and capability. Connect with resources appropriate to their needs, regardless of payment.</p> <p>Record Review of the Foot care policy titled, Skin integrity- Foot Care, revised October 2022, revealed that it is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. Policy revealed that the facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical condition.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents receives adequate supervision and assistance devices to prevent accidents for two of three residents (Resident #1 and Resident#16) reviewed for supervision.</p> <p>1.The facility failed to ensure Resident #1, who was known for seeking alcohol and becoming intoxicated, was adequately supervised to prevent him from leaving the facility without signing out.</p> <p>2.The facility failed to ensure Resident#16, who was known for seeking alcohol and becoming intoxicated, was adequately supervised to prevent him from leaving the facility without signing out at the front representative desk on 08/09/24. Resident#16 left out the back gate where the residents took smoke breaks at 10:00 PM during staff shift change.</p> <p>An Immediate Jeopardy (IJ) was identified on 07/16/24 at 3:00 PM. While the IJ was removed on 08/12/24 at 12:15 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> <p>This failure placed the residents at risk accidents, injuries, and possible death.</p> <p>Findings included:</p> <p>1. Review of Resident #1's quarterly MDS assessment, dated 03/28/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included Parkinson's disease, Bipolar disease, and Schizophrenia. The MDS reflected Resident #1 had a BIMS (Brief Interview for Mental Status - is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 12 indicating moderate cognitive impairment, moderately impaired decision-making, and the resident requiring cues/supervision.</p> <p>Review of Resident #1's care plan initiated on 07/07/24 revealed Resident #1 was unsafely leaving the facility and was unaware of physical limitations and poor safety awareness. The facility goal was that the resident would not successfully elope from the facility and would be monitored of his whereabouts on an ongoing basis.</p> <p>Facility interventions included: Facilitate resident to call close family/friend for reassurance when exit-seeking behaviors are occurring. Monitor resident for tail gaiting when visitor and staff are exiting the facility. Place in secured locked unit for safety.</p> <p>Review of Resident #1's Wandering Risk Assessments, dated 07/07/24, reflected Resident #1 was disoriented x3, forgetful, independently ambulating, with a known history of purposeful wandering.</p> <p>Review of the Release of Responsibility for Leave of Absence for Resident #1 reflected:</p> <p>07/07/24 5:30 PM - Resident signed out of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>07/07/24 6:30 PM - Resident signed back into the facility.</p> <p>Review of Resident #1's progress notes dated:</p> <p>06/24/24 at 6:35 PM written by the DON reflected,</p> <p>Resident has been leaving facility without signing out. Education provided on needs to sign in and out when leaving facility. Safety risks education provided including risk of death or accident. Verbalized understanding and stated that I'm a grown man. I do what I want. Sister called and notified. Sister informed DON that she does not want him to drink or leave the facility because of history of serious mental issues. Sister does not mind if he smokes but does not want him to drink alcohol. DON educated sister that we cannot hold resident against his will and cannot physically restraint him. Will continue to educate resident and monitor him closely as needed.</p> <p>07/04/24 at 11:14 AM written by the DON reflected,</p> <p>Pharmacy recommended gradual dose reduction for Olanzapine (antipsychotic medication used to treat schizophrenia and bipolar disorder) 15 milligrams in the morning. Since reduction, resident is more and more agitated, goes to bathroom on the floor in his room, not in the bathroom as he was doing, wandering around and outside facility. Leaves facility by back door without signing in and out. Physician notified. Ordered Olanzapine to previous order of 15 milligrams daily due to failed gradual dose reduction. Family notified that resident is frequently leaving the facility without signing in and out. Will go out and return drunk; sometimes in the middle of the night or when he leaves, he returns too late. He is the one buying cigarettes and alcohol for other residents. In the dining room he was screaming and yelling at staff making other residents and families uncomfortable. DON approached to redirect resident and urged him to calm down. He appeared under the influence of alcohol and cigarettes. Started yelling and cursing at DON. Sister and physician notified. Will continue to redirect as needed; educate resident; and update care as needed.</p> <p>07/04/24 at 5:14 PM written by the DON reflected,</p> <p>Resident continues to be aggressive and displays apparent erratic behaviors as someone who is under the influence. Yells, screams, and insults staff and other residents. Refuses redirection and starts cursing each time staff approach him. Sister once again notified. Physician updated. Will continue to redirect and educate resident as needed.</p> <p>07/07/24 at 4:38 PM written by LVN A reflected,</p> <p>Received call from psychiatric hospital around 4:00 PM that the resident was sitting in the lobby stating that he was there to check in. Nurse went to get him to come back to the facility but was unsuccessful. This writer with another employee then drove to the psychiatric hospital. Resident was observed sitting in the lobby drinking coffee. Nurse was able to convince the resident to return to the facility.</p> <p>07/07/24 at 6:25 PM written by LVN A reflected,</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident observed exiting the building through a side exit door. Informed resident that door was not the correct door to exit the facility. Resident extremely upset. Began cursing and yelling that nobody would give him the code to leave. Resident proceeded to hop the gate and continued walking down the street. Resident's assigned nurse followed him.</p> <p>07/07/24 at 6:47 PM written by LVN A reflected,</p> <p>Resident brought back to facility with assigned nurse and was placed in the locked unit for safety.</p> <p>07/07/24 at 10:19 PM written by LVN A reflected,</p> <p>Resident stated he wanted to be out of here. He stated he wants to go to the nearby psychiatric hospital because he wanted 45 dollars for cigarettes. After that he walked to the front door as if he was going to log himself out but instead, he was observed climbing through the fence. This nurse went after him and brought him back. For safety, the management asked if he temporarily sleeps in the (secure) unit today until he sees the doctor tomorrow.</p> <p>07/10/24 at 2:56 PM written by LVN B reflected,</p> <p>Resident calmer this shift, spent majority of the day in his room, and left room for short periods to go smoke with staff accompanying.</p> <p>07/11/24 at 5:34 PM written by ADON reflected,</p> <p>Resident moved back to his room [ROOM NUMBER]-B due to him hitting the doors and disrupting other residents. Remains calm in his room and promised not to yell, disrupt or go out of the facility unnoticed. Family member notified. No observable distress noted at this time.</p> <p>Review of Resident #1's Behavioral Health Solution Discharge Summary, dated 07/10/24, and written by Licensed Clinical Social Worker reflected:</p> <p>At the time of Discharge: Patient is considered to be at risk of harm to self or others. Verbally aggressive, with aggressive physical behaviors .pt should be monitored and sent out to psychiatric facility.</p> <p>An observation and attempted interview on 07/16/24 at 2:25 PM with Resident #1 revealed he was alert and able to answer questions. The resident had some confusion and spoke about things that did not make sense. He had memory issues and was independently ambulatory. Resident #1 said he would leave the facility. He said he was not supposed to sign out after 6:00 PM, but he would leave at 1:00 AM since it was a new day. Resident #1 said sometimes he would leave without signing out and would leave through a side door and slip through the fence. Resident #1 said he would leave the facility whenever he wanted to and go to the different buildings around the facility. He said he was placed in the secure unit because he was joking about a whiskey song. He said the staff turned over the tables and chairs in the secure unit and he hurt his back putting them back. He said he had been out of the secure unit for about 3 days. He said he went to the psychiatric facility because the DON said he was going to be placed in a rubber room in a mental hospital. He said he went to the psychiatric facility and had a coke (soda drink) with him. He said the coke was made with cocaine in it and the psychiatric facility said they could not take him.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 07/15/24 at 1:35 PM with LVN D revealed Resident #1 was alert and oriented and could differentiate between right and wrong. She said the resident used to sign out and leave the facility but was not safe to leave anymore She said the facility had to place him in the secure unit for a few days. She said she checked on him every hour.</p> <p>An interview on 07/15/24 at 1:45 PM with CNA C revealed she had worked at the facility for two and a half years. CNA C said Resident #1 was safe to leave the facility by himself. She said the resident was placed in the secure unit on 07/07/24 because he tried to leave the facility by going over the fence. She said Resident #1 was not on enhanced supervision.</p> <p>An interview on 07/15/24 at 2:05 PM with the ADON revealed he had worked at the facility for 6 weeks. He said Resident #1 was alert and oriented with intermittent confusion. He said he was safe to leave the facility unsupervised and could sign himself out. The ADON said the resident was placed in the secure unit because he was having confusion. The ADON said the resident was leaving, yelling, and trying to attack other residents. The ADON said on 07/11/24, he found out Resident #1 was in the secure unit and the resident told him he was ready to leave the secure unit and return to his room. The ADON said the resident was on regular supervision, every 2 hours. He said the resident would leave the facility, drink liquor, return to the facility, and be aggressive. The ADON said he did not know the Licensed Clinical Social Worker said on 07/10/24 that the resident was a danger to his self and others and needed to be on monitoring.</p> <p>An interview on 07/15/24 at 2:45 PM with the DON revealed Resident #1 was supposed to sign out to leave, but sometimes he would just walk out. The DON said safety outside the facility was a concern that had been expressed with the resident and his family. He said the resident was alert and oriented, but sometimes would get confused. The DON said on 07/07/24, the facility received three calls from the psychiatric facility because the resident would not return to the facility. The DON said he was supposed to not leave after 6:00 PM but the resident was seen out between 3:00 - 4:00 AM. The DON said the resident would leave and drink alcohol. The DON said on 07/07/24, the resident was placed in the secure unit because he had a change of condition and seemed lost, and the resident was going to the psychiatric hospital. The DON said the decision was made to move the resident back to the regular unit because he was more alert, not confused, and wanted to go outside to smoke.</p> <p>An interview on 7/15/24 at 3:10 PM with the Administrator revealed Resident #1 was safe to leave the facility by himself. She said recently the resident went to the psychiatric hospital three times in one day. She said usually the resident would walk to a fast-food restaurant. She said staff were concerned about him getting lost, but labs were drawn, and he was back to his usual self.</p> <p>An interview on 7/16/24 at 11:05 AM with the Environmental Services Director revealed Resident #1 would leave the facility through the side gate.</p> <p>An interview on 07/16/24 at 11:25 AM with the SW revealed Resident #1 would sign out and leave the facility. She said he would go to the fast-food restaurant and the gas station. She said the resident was going out late at night and returning late at night. The SW said the facility had a care plan meeting and Resident #1 was told not to leave after 6:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A follow-up interview on 07/16/24 at 1:08 PM with the ADON revealed he did not know why there were no monitoring notes for Resident #1 after 07/11/24. He said Resident #1 would leave and the ADON did not know how long the resident stayed out or if there was a timeframe for him to return. He said there was nothing in place to ensure the resident was safe while he was out. He also said he did not know if the resident had special monitoring in place while in the facility.</p> <p>A follow-up interview on 07/16/24 at 2:20 PM with the DON revealed he did not know why there were no follow-up notes after Resident #1 was seen by the Licensed Clinical Social Worker. The DON said at that time, the resident's behavior was erratic. The DON said the resident was currently back to his regular self. The DON said that it was well documented that the resident would leave the facility without signing out. The DON said the resident would also sign out and go out the front door, then return to the facility by a different door and not sign back in. The DON said the resident would sneak out the back door by the smoking patio and then sneak back in. The DON said the resident was supposed to be back before 6:00 PM but he was non-compliant. The DON said once Resident #1 signed out, he was no longer the facility's responsibility.</p> <p>2. Review of Resident #16's initial MDS assessment, initiated on 08/08/24 and not completed, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #16's had no diagnoses and BIMS indicated.</p> <p>Review of Resident #16's care plan initiated on 08/08/24 revealed Resident #16 has been advised of smoking policy. The resident requires supervision with smoking. Resident#16 is non-compliant with smoking. He goes out to smoke when it is not time and without supervision.</p> <p>Facility interventions included: Follow facility guidelines for unsafe practice.</p> <p>Review of Resident #16's Wandering Risk Assessments not initiated.</p> <p>Review of the Release of Responsibility for Leave of Absence for Resident #16 reflected:</p> <p>08/09/24 3:35 PM - Resident signed out of the facility.</p> <p>- Resident did not sign into the facility.</p> <p>Review of Resident #16's progress notes dated:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>08/09/24 at 6:35 PM written by the DON reflected, Was reported by nurse last evening that resident signed himself out and has not returned. Staff driving from facility observed resident rolling around corner store. Asked resident to return to facility. He stated that he is going to the store to purchase cigarette. Staff rushed to facility to alert the nurse. By the time they went back, they couldn't see resident. Police was then called. They found resident down the street, smelling alcohol, and appeared intoxicated. Police determined that it was not safe for him to drive his power chair back. He was then assisted in staff vehicle and resident was brought and assisted back in bed safely. Skin assessment completed. No wound, no skin tear, and no apparent injury related to the incident. Resident encouraged not to go out since he still new to the area. Verbalized understanding and stated that I do what I want, and you can't stop me. I have the right to go wherever I want. If I want to go the store, I will go. I don't need your permission. Became upset and stated using derogatory words. De-escalation initiated. Physician notified. Labs ordered. Referred to Psych eval. Incident report completed and care plan updated. Will monitor resident every hour for 3 days. Resident is own RP. Will continue to monitor, encourage resident to stay in facility as much as we could, and update care as needed.</p> <p>Record review Resident#16 of EMR under NMAR revealed updated monitoring of residents Monitor resident every hour. Encourage him to stay in the facility as much as possible. Every hour for 3 days initiated on 08/10/24.</p> <p>An observation on revealed 08/06/24 at 6:15 AM revealed no alarm on the side door adjacent to the piano. Observed an open gate that leads outside of the facility area. Observed a sign on the door that stated, No smoking.</p> <p>An observation on revealed 08/06/24 at 6:23 AM no latch on the actual gate opening and closure section for the smoking area back gate.</p> <p>An observation and record review of leave of absence form reflected on 08/06/24 at 6:30 AM revealed the leave of absence form had not been amended.</p> <p>An observation and record review of leave of absence form reflected on 08/07/24 at 11:00 AM revealed the leave of absence form had not been amended.</p> <p>An interview on 08/06/24 at 9:04 AM with DON revealed not everything from leave of absence form, acknowledge form, door monitor, EMAR monitoring and latch on gate the plan of removal from 07/16/24 had been completed. DON stated he tried to get all the nursing responsibilities done and the Maintenance Director was supposed to complete other duties. The DON stated the facility has been very busy.</p> <p>An interview on 08/11/24 at 5:45 AM with Med aide S who stated Resident#16 went out the back door. Med aide S stated another nurse got in their car and searched for him. Med aide S stated staff called 911 and he was brought back to the facility. Med aide S stated he was not for sure how long Resident#16 was gone for. Med aide S stated residents are to let staff know when they leave and come back. Med aide S stated residents are supposed to sign in and out on the leave of absence form at the front door. Med aide S stated if Residents do not come back after an hour of the listed time, then staff would start search for resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/11/24 at 5:58 AM with LVN R who stated Resident#16 went out the back door where residents smoke. LVN R stated she called 911 and reported that Resident#16 left the building. LVN R stated that someone saw him driving his electric wheelchair outside around 10:30 PM. LVN R stated she thinks that Resident#16 was gone for 20 minutes. LVN R stated residents are supposed to sign in and out on the leave of absence form at the front door. LVN R stated if Residents do not come back after an hour of the listed time, then staff would start search for resident.</p> <p>An interview on 08/11/24 at 7:00 AM with Resident#16 stated he went to the store around 10:00 PM to get cigarettes and a beer. Resident #16 stated he was okay and did not have any concerns.</p> <p>An interview on 08/11/24 at 8:41 AM with DON who stated Resident#16 signed out and went out the front door to go to the store. DON stated he stated the in-services on exit doors on 08/07/24. DON stated he still needed to overnight staff and PRN. DON stated the MAR needed to be updated to reflect every 2-hour check for residents. DON stated he needed to do in-services for residents on hall 500 and assigned task. DON stated he would send updated information before the end of the day.</p> <p>Policy Statement</p> <p>Staff shall investigate and report all cases of missing residents.</p> <p>Review of the facility policy, Accidents and Hazards, dated 2022, reflected:</p> <p>Policy:</p> <p>The resident environment will remain as free of accident/hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:</p> <ol style="list-style-type: none"> 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary . 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: <ol style="list-style-type: none"> a. Defined by type and frequency b. Based on the individual resident's assessed needs and identified hazards in the resident environment. <p>An Immediate Jeopardy (IJ) was identified on 07/16/24 at 3:00 PM. The IJ template was provided to the facility on [DATE] at 3:15 PM and signed by the Administrator. A plan of removal was requested at that time.</p> <p>The facility's plan of removal was accepted on 07/17/24 at 2:35 PM and reflected:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Immediate Corrective Action for residents affected by the alleged deficient practice:</p> <p>The residents who sign in and out of the facility had the potential to be affected by this deficient practice. Residents who leave the facility on pass were assessed and noted to be oriented to person and place as of 07/16/24. A review of the resident pass policy conducted by the administrator determined that while there is no specific guidance requiring a resident to state where they are going or how long they will be out, we will amend our leave of absence form to include these as optional fields. The nursing staff will monitor the resident's whereabouts from the hours of 10:00 PM-6:00 AM, this will be done every hour and will populate in our EMR software as an action item to be completed. The administrator and DON will educate the residents on the proper procedure for going out on pass including entering and exiting only through the front door, signing in and out, and letting staff know when they return. Additionally alarms for the doors were purchased by maintenance and will be placed in doors that lead out of other locations.</p> <p>The gate at the back smoking area has been secured and can no longer be pulled open, unless at the actual gate opening and closure which are used in the event of an emergency.</p> <p>Actions taken to prevent a serious adverse outcome from recurring:</p> <p>This deficient practice had the potential to affect all residents who sign in and out of the facility on pass.</p> <p>The administrator and director of nursing were educated on proper out on pass procedure including supervision, by the regional nurse manager on 07/16/24. In turn training of facility staff on resident pass procedures and keeping residents free of accidents and hazards was initiated by the Administrator and DON on 07/16/24.</p> <p>The Administrator has created an education for the residents regarding leaving the facility that includes a signed acknowledgement form. The administrator, DON, or designee will ensure the new sign out sheet is correctly adhered to daily for two weeks, weekly for two weeks and monthly for two months. Any negative findings will be taken to the administrator for immediate correction. Administrator or DON will continue to audit the passbook daily in the morning standup meeting as an ongoing process. The results of the new audit process will be reported to the QAPI team.</p> <p>The Medical Director was notified of the deficiency on 07/16/24. All findings will be reported to the QAPI team monthly for quality assurance.</p> <p>When Actions will be complete:</p> <p>Facility will have completed education by 07/17/24, if any staff member working in the facility is unable to be educated, they will be removed from the schedule until training has been provided.</p> <p>The facility's implementation of the Plan of Removal was verified through the following:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 07/18/24 at 11:15 AM with Resident #1 revealed he had been in-serviced and could only leave the facility during daylight hours. He said he understood he was not supposed to sign out at night and could only exit through the front door. He said he was following the process and signing in and out at the front desk. He said he understood he was not supposed to leave or return to the facility through the side or back door.</p> <p>Record review of the Release of Responsibility for Leave of Absence (sign-in and sign-out book) reflected Resident #1 was signing in and out to leave the facility correctly on 07/17/24 - 07/18/24.</p> <p>Interviews with 13 staff who worked all shifts on 07/17/24 at 3:40 PM through 07/18/24 at 4:00 PM revealed:</p> <p>Staff were able to voice that they were in-serviced regarding the plan of removal and elopements. Staff were able to verbalize the process for a resident to sign out to leave the facility. The facility kept a sign-in and sign-out book at the front desk. Residents had to notify the nurse if they were signing out. Staff said residents were to be checked on every 2 hours throughout their shifts to ensure residents were in the facility. Staff said residents could only leave through the front door of the facility and had to return through the front door of the facility to sign back in. Staff said if residents were gone longer than what they signed out for, staff were to notify the nurse and start the process to search for the resident.</p> <p>Staff interviewed included LVN H, RA I, CNA J, CNA K, CNA L, CNA M, CNA N, the receptionist, CNA O, RN P, RN Q, LVN R, and LVN B.</p> <p>An interview with the ADON on 07/18/24 at 3:25 pm revealed he was responsible for ensuring residents signed out when they left and signed back in. The ADON said if a resident left the facility without notifying staff and signing out, it was considered an elopement. He said if the receptionist was out, then the nurse at the front desk would handle the sign-in and sign-out process. He said the residents were notifying the nursing staff prior to signing out and leaving the facility. He said the residents could only sign-out through the front door. The ADON said the nursing staff were to monitor all residents every 2 hours to ensure they were in the building. He said if a resident was missing and not signed out, then it was considered an elopement.</p> <p>An interview on 07/18/24 at 12:45 PM with the DON revealed his role in the plan of removal was to supervise and ensure documentation was taken care of. He said if a resident left the facility without notifying staff, they were left at risk of being exposed to problems outside of the facility. The DON said the residents had been in-serviced and had to sign out at the front desk and notify the nurse before leaving the facility. The DON said if a resident was gone for an excessive time, the facility staff were to check the sign-out book and start the process to look for the resident.</p> <p>An interview on 07/18/24 at 4:00 PM with the Administrator revealed she was responsible for putting the plan of removal actions in place. She said residents who left the facility without signing out were at risk of coming to harm outside the facility. The Administrator said the residents could sign out at the front door and had to leave and return through the same door. She said residents who were not in the building and were gone longer than expected, staff were to notify the Administrator and start the process of looking for them.</p> <p>Monitoring of the Plan of Removal from [08/07/24 to 08/12/24] included the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of in-service titled: Exit doors and dated 08/06/24 reflected: All residents who want to go out of the facility must go through the front door. They must also notify staff when they are leaving and returning; where they are going and how long they will be out. Finally, they must sign out and in when they must sign out and in when they leave.</p> <p>Record review of EMR revealed update to residents EMR's related to nursing staff monitoring residents' whereabouts from hours of 10 PM - 6:00 AM initiated on 08/11/24.</p> <p>Record review of signed acknowledgement forms were initiated and signed by Resident #15, Resident #16, Resident #17, Resident #18, Resident #19, Resident #20, Resident #21, Resident #22, Resident #23, Resident #24, Resident #25, Resident #26, Resident #27, Resident #28, Resident #29 on 08/11/24.</p> <p>An observation on 08/07/24 at 11:15 AM revealed the one door adjacent to the piano alarm worked properly.</p> <p>An observation and record review of the leave of absence form reflected on 08/09/24 at 10:00AM revealed the leave of absence form had been amended.</p> <p>An observation on 08/12/24 at 10:00 AM revealed the latch for the back gate was in the administrator office that he purchased on 08/12/24.</p> <p>An interview on 08/06/24 at 9:04 AM with DON stated Resident#1 who eloped was transferred to the VA in psych on 07/19/24.</p> <p>An interview on 08/06/24 at 10:15 AM with Administrator revealed he purchased door alarms for side door for the door adjacent to the piano on 08/06/24.</p> <p>An interview on 08/10/24 at 1:30 PM with CNA X who stated residents must sign out in and out at the front desk.</p> <p>An interview on 08/10.24 at 1:37 PM with RN Y who stated residents cannot exit out of the back smoke area. RN Y stated residents must exit out the front doors. RN Y stated residents must let nursing staff know where they are going and plan to be back.</p> <p>An interview on 08/11/24 at 5:45 AM with Med aide S stated residents are to let staff know when they leave and come back. Med aide S stated residents are supposed to sign in and out on the leave of absence form at the front door. Med aide S stated if Residents do not come back after an hour of the listed time, then staff would start search for resident.</p> <p>An interview on 08/11/24 at 5:58 AM with LVN R who stated residents are supposed to sign in and out on the leave of absence form at the front door. LVN R stated if Residents do not come back after an hour of the listed time, then staff would start search for resident.</p> <p>An interview on 08/11/24 at 6:00 AM with CNA T who stated that residents are supposed to let staff know where they wanted to go and would return. CNA T stated residents are supposed to sign in and out at the front desk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/11/24 at 6:00 AM with CNA V who stated that residents are supposed to let staff know where they wanted to go and would return. CNA V stated residents could only sign in and out at the front desk.</p> <p>An interview on 08/11/24 at 6:03 AM with CNA U who stated residents are to sign in and out at the front desk only.</p> <p>An interview on 08/11/24 at 6:03 AM with RN W who stated residents informed the staff about where they are going and when they will be back. RN W stated residents can only leave out the front door. RN W stated residents need to sign in and out at the front desk representative area.</p> <p>An interview on 08/11/24 at 7:00 AM with Resident#16 stated he went to the store around 10:00 PM to get cigarettes and a beer. Resident #16 stated he was okay and did not have any concerns.</p> <p>An interview on 08/12/24 at 5:30 AM CNA J stated residents sign in and out at the front door.</p> <p>An interview on 08/12/24 at 6:00 AM LVN J stated residents let the nursing staff know where they are going and plan to be back. LVN J stated residents can only exit the front door and must sign in and out at the front desk.</p> <p>An interview on 08/12/24 at 6:04 AM LVN H stated residents let the nursing staff know where they are going and plan to be back. LVN H stated residents can only exit the front door and must sign in and out at the front desk.</p> <p>An interview on 08/12/24 at 8:00 AM with the Receptionist who stated residents sign in and out at the front desk. Residents should let nursing staff know where they are going and when they plan to be back. The Receptionist stated residents could document that information on the leave of absences form.</p> <p>An interview on 08/12/24 at 10:00 AM with the Administrator who stated he had purchased the latch for the back gate and would have maintenance to install. The Administrator was new to the facility and was completing training on 08/02/24.</p> <p>An observation on 08/14/24 at 9:47 AM - 9:55 AM revealed that the doors that lead to the outside, including the front door, had door alarms that operated immediately once the doors were opened.</p> <p>In an interview on 08/14/24 at 10:09 AM, Maintenance Director stated that all of the doors had alarms that operated when opened. Maintenance Director stated that Life Safety Code had instructed him to remove the latch on the gates as it interfered with egress during an emergency.</p> <p>Attempted to get police report on 08/11/24 at 10:00 AM (Report was not available).</p> <p>The administrator was notified the IJ was removed on 08/12/24 at 12:15 PM. The f [TRUNCATED]</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>45053</p> <p>Based on observation, interview and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facilities.</p> <p>The facility failed to post the daily nursing staffing information on 07/15/24.</p> <p>This failure could affect residents, facility visitors, vendors and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner.</p> <p>Findings Included:</p> <p>Observation on 07/15/24 at 11:05 AM during rounds revealed no posted nursing staffing information was anywhere in the facility.</p> <p>Observation on 07/15/24 at 1:34 PM during rounds revealed no posted nursing staffing information was anywhere in the facility.</p> <p>An interview on 07/15/24 at 2:45 PM with the ADON revealed that the DON was responsible for the scheduling and posting of the daily nursing staff information.</p> <p>An interview on 07/15/24 at 2:50 PM with the DON revealed that he was responsible for the daily nursing posting and forgot to do so on 07/15/24. The DON said the daily nursing staffing was supposed to be posted in the front of the facility each day.</p> <p>An interview on 07/15/24 at 3:30 PM with the Administrator revealed the staffing coordinator was responsible for the daily nursing staffing posting. The Administrator did not give any risks associated with not having the daily nursing staffing schedule posted.</p> <p>Record review of the facility's policy, Staffing, revised April 2007, reflected that the facility provides adequate staffing to meet needed care and services for our resident population.</p> <p>No specific policy was given regarding daily nurse staffing posting requirements.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45053</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that:</p> <p>The facility failed to ensure that food in the kitchen was labeled with the product name, dated with a opened date or use by date and sealed.</p> <p>The facility failed to ensure that kitchen equipment was clean and free of debris.</p> <p>These deficient practices could affect 69 residents who received meals and/or snacks from the main kitchen and place them at risk for food borne illness.</p> <p>Findings Included:</p> <p>Observation of the kitchen on 7/16/2024 at 2:30 PM, revealed that inside the refrigerator included: an open container of whipped topping that was on the shelf and it was not dated with an open date or use by date. The container of whipped topping had what appeared to be a white flaky substance on the lid. Inside the refrigerator was a container of strawberry topping and it was not labeled with the product name and dated with an open or use by date. The container of strawberry topping had what appeared to be a red sticky substance on the lid. An observation in the refrigerator included a package of hot dogs labeled keep frozen. The hot dogs were packaged inside of a clear plastic unsealed bag that was not dated with an open date or use by date.</p> <p>Observation of the kitchen on 07/18/2024 at 1:10 PM, revealed that there were 3 large white containers on the floor underneath the counter that stored loose sugar, corn meal and flour. All 3 large white containers were ajar and were not sealed. The 3 large white containers were not labeled with the product name and there was small white Styrofoam cup observed in the large white container with the loose sugar. There was an open container of nacho cheese was on the kitchen counter. During the observation of the kitchen, there was a large circulating industrial fan that was located on the floor that had large amounts of dust on the fan. The industrial fan was in the on position and was blowing air towards the food preparation and stove top. There was a cycling industrial fan attached to a wall near the dishwashing station and the vents of the fan had large amounts of dust.</p> <p>In an interview on 07/18/2024 at 1:16 PM with the Dietary Manager, he stated that he was responsible for ensuring that the industrial fan was clean. He stated that he was responsible for the entire kitchen including ensuring that the foods in the kitchen are labeled and dated. He stated that his duties and responsibilities as the Dietary Manager included cleaning, sanitization and maintenance. He stated that if there is a maintenance issue or concern, he will alert Maintenance, but he did not have a maintenance log to ensure that his maintenance requests are being completed. The Dietary Manager stated that he understood that the industrial fans in the kitchen should be cleaned to ensure that there are not any airborne illnesses and dust contaminating the food and items in the kitchen. The Dietary Manager stated that he would retrain and reeducate his staff in the kitchen via In-Service Trainings to prevent any future mishaps in the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/18/2024 at 1:24 PM with [NAME] G, she stated that a Styrofoam cup should not be placed in any of the 3 large plastic containers containing the loose sugar, cornmeal and flour to prevent diseases and airborne illnesses. [NAME] G stated that all food packages or containers that have been opened should be labeled, sealed and dated to prevent airborne illnesses. [NAME] G stated that the Dietary Manager is responsible for ensuring that the items are labeled with the name of the product, sealed (fasten or close securely) and dated with an open date or use by date, to prevent airborne illnesses. [NAME] G stated that the vents on the industrial fans should be cleaned often but could not provide a timeframe of how often each should be cleaned and sanitized.</p> <p>In an interview on 07/18/2024 at 1:44 PM with the Administrator, she was informed about the findings in the kitchen. The Administrator stated that she had been on maternity leave from the facility and while she was gone, several of her employees had resigned or were fired by the owner. She stated that the owner hired the staff currently at the facility and she was unfamiliar with the knowledge or experience the Dietary Manager had with the kitchen.</p> <p>Record review of the facility's policy, Sanitation & Food Safety in Food Service revised 05/01/2015, revealed The Nutrition/Culinary Services Director (NSD) will assume responsibility for the food safety and sanitation of the Nutrition Culinary Department.</p> <ol style="list-style-type: none"> 1. Infection control and sanitation practices are followed to minimize the risk of contamination of food and prevent food borne illness. Should a foodborne illness outbreak occur, the local health department is notified. 2. The NSD monitors food safety and sanitation of the Nutrition/Culinary Department on a daily basis. 3. The NSD develops, implements, and monitors a cleaning schedule that assigns specific cleaning responsibilities to specific individuals. Cleaning tasks are initialed as they are completed . 4. The Sanitation Review is completed monthly by the Dietitian and copied to the Administrator. The NSD completes the form at weekly. 5. The NSD/Dietitian reviews and evaluates the data collected and determines the plan of action necessary to resolve any problems identified. 6. The audit and the action plan are submitted to the administrator and the facility quality improvement coordinator/infection control coordinator. 7. The NSD provides written cleaning instructions for each area and piece of equipment in the kitchen . <p>Record Review of the Facility's policy, Safe Food Handling revised 05/01/2015, revealed Food acquisition, storage, and distribution will comply with accepted food handling practices. Proper food handling is essential in preventing foodborne illness.</p> <p>.Follow all local, State, and Federal Regulations when handling food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Food/Beverages Prepared and Served by Facility Staff for Patients/Residents:</p> <p>1. All Facility staff (culinary, nursing, therapy, activities, etc.) involved in the preparation and service of food adheres to safe food handling techniques .</p> <p>5. Refrigerated Time/Temperature Control for Safety (TCS) leftover foods are properly covered, labeled and dated and marked with a use by date. Foods are placed in shallow containers and immediately put in refrigerator or freezer for rapid cooling. TCS leftovers are discarded after 3. days unless otherwise indicated. Items that cannot be used within 3 days may be placed in the freezer.</p> <p>Food/Beverages Prepared with Patients/Residents Individually or Groups:</p> <p>3. All foods removed from the original packaging are stored in a closed container or tightly wrapped package and labeled with the common name of the item and the date it was opened.</p> <p>Record review of the facility's Cleaning Schedule, in Nutrition Policies and Procedures revised 05/01/2015, revealed no entries and the log was empty.</p> <p>Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>45053</p> <p>Based on observation, interview and record review the facility failed to determine and outline in the facility's, facility assessment, the necessary amount of emergency food and water necessary for their facility population during an emergency for 1 of 1 facility.</p> <p>1.The facility failed to outline in their facility assessment, the amount of food and water necessary to maintain their resident population.</p> <p>These failures placed residents at risk of not having emergency water and food.</p> <p>Findings Included:</p> <p>Record Review of the facility's, facility assessment, no date indicated on the assessment, revealed the following sections:</p> <p>Facility Profile</p> <p>Resident Population</p> <p>Care & Competency requirements</p> <p>Resident Acuity</p> <p>Workforce</p> <p>Training Evaluation</p> <p>Physical Plant</p> <p>Services</p> <p>Ethnic, Cultural, Religious Needs</p> <p>Resources</p> <p>Contracts</p> <p>Natural Hazards</p> <p>Technological Hazards</p> <p>Human Hazards</p> <p>Hazardous Materials</p> <p>(continued on next page)</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's, undated facility assessment section titled, facility profile revealed a current census of 71 and total capacity of 204.</p> <p>Record review of the facility's, undated facility assessment section titled, ethnic, cultural religious needs revealed a subsection titled, ethnic, cultural, food or religious needs identified based on resident population was, blank.</p> <p>Record review of the facility's, undated facility assessment section titled, resources revealed the heading that, the assessment must include or address the facilities resources which include, but are not limited to a facilities operating budget, supplies, equipment or other services necessary to provide the needs of residents.</p> <p>Record review of the facility's, undated facility assessment section titled, resources did not include any mention of the facilities emergency food or water supply.</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on observation, interviews, and record review, it was determined the facility did not have a functional communication system for some residents to call staff for assistance for four (100 hall, 300 hall, 400 hall, and 500 hall) of five halls in the facility.</p> <p>On 08/06/24, some of the rooms on hall 500 did not have working call lights. There was no other option put in place by the facility for all residents to call for assistance.</p> <p>On 08/07/24, some of the rooms on hall 100, hall 300, hall 400 did not have working call light. There was no other option put in place by the facility for all residents to call for assistance.</p> <p>On 09/07/24 at 3:46 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/12/24, the facility remained out of compliance at a severity level of - no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.</p> <p>This failure could have caused residents to experience feelings of hopelessness, cause a delay in assistance in the resident room/shower room, and contributed to any falls/injuries when residents did not get assistance.</p> <p>Findings included :</p> <p>Record review of Resident #15 MDS reflected: is a [AGE] year-old female with a BIMS of 13. She is a paraplegia, level of cervical spinal cord lumbar region and PTSD.</p> <p>Record review of Resident #30 MDS reflected: he was [AGE] years and has a BIMS of 15. He had breakdown (mechanical) of implanted electronic neurostimulator spinal cord electrode (Lead), fracture of unspecified part of neck of right femur, and muscle weakness.</p> <p>Record review of Resident#31 MDS reflected: he was a [AGE] year-old female with a BIMS of 14. She had muscle weakness, muscle wasting and atrophy and morbid obese.</p> <p>Record review of Resident#32 MDS reflected: he was a [AGE] year-old male with a BIMS of 14. He had muscle wasting, pressure ulcer stage 4 left heel, muscle wasting and atrophy. Record review of Resident#33 MDS reflected: he was a [AGE] year-old male and had a BIMS of 10. He had Acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary chronic disease and muscle weakness and shortness of breath.</p> <p>Record review of in-service titled: Call light and residents' care, dated 08/06/24 reflected: Call lights should be answered in a timely manner without delays by all departments. When answering the call light, please refer to the service resident is requesting. Make sure to return and update resident. Leave the call light on until residents' needs have been met.</p> <p>No staff signatures included with in services.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of grievance logs reflected: On 07/22/24 Resident #30 revealed call light was not answered, and no one answered the [facility] phone. No resolution noted.</p> <p>An interview on 08/06/24 at 6:45 AM with Resident #15 was moved to hallway 500 (only resident on the hall) between 1st and 2nd shift. On 08/06/24 at 7:21 AM Resident #15 stated no one had been in to check on her all night. Resident #15 stated she felt abandoned and alone. Resident #15's call light in her room and the bathroom light did not work.</p> <p>An interview on 08/07/24 at 2:00 PM Resident #30 stated it takes staff over an hour at night to unhook his G-Tube so that he can go use the bathroom.</p> <p>An interview on 08/07/24 at 2:10 PM with Resident #31 stated it takes staff 2 hours or so to come check on her when she presses the light. Resident#31 stated she needs help changing and repositioning.</p> <p>An interview on 08/07/24 at 2:20 PM with Resident #32 stated last night he put on his call light to get help with his CPAP machine, and it took over 2 hours for someone to come. It was unplugged and he could not reach it to plug it back up.</p> <p>An interview on 08/07/24 at 2:30 PM Resident #33 stated he had breathing problems and was afraid that he would not be able to get ahold of staff and would need to go to the hospital.</p> <p>An observation on 08/07/24 at 5:45 AM all call lights on hall 300 were not sounding at the nursing station. Not all rooms were visible from the nursing station depending on where you were standing or sitting.</p> <p>An observation on 08/07/24 at 6:30 AM all call lights on hall 400 were not sounding at the nursing station. Not all rooms were visible from the nursing station depending on where you were standing or sitting.</p> <p>An observation on 08/07/24 at 7:00 am on hallway 100 call lights were beeping at the nursing station and no lights were lighting up above the resident's rooms. The nursing station was not facing the hall.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 08/07/24 at 3:46 PM. The Administrator and DON was notified. The Administrator was provided with the IJ template on 08/07/24 at 4:00 PM.</p> <p>The following Plan of Removal was submitted by the facility and was accepted on 08/09/24 at 3:11 PM and reflected:</p> <p>Immediate Corrective Action for residents affected by the alleged deficient practice:</p> <p>Identified Immediate Jeopardy (IJ) Issues: Policy and procedure have and will be reviewed and will re-in-service if change is required.</p> <p>2. Noncompliance with S483.12 (F 600) Freedom from Abuse, Neglect, and Exploitation</p> <p>o Resident #1 was not checked on overnight.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>o Call lights and bathroom lights were not functional.</p> <p>Corrective Actions and Steps for Removal of Immediate Jeopardy:</p> <p>1. Ensuring Resident Safety and Dignity</p> <p>Immediate Staff Training:</p> <p>o Action: Conduct immediate in-service training for all staff on the importance of resident checks, especially during night shifts, and proper use of the call light system. Review of Policy and Procedure for call light and ADL's</p> <p>o Responsible Party: Director of Nursing (DON)</p> <p>o Completion Date: 08/09/2024</p> <p>2. Functionality of Call Lights and Electrical Systems</p> <p>Repair Call Lights and Electrical Issues:</p> <p>o Action: Ensure all call lights in resident rooms and bathrooms are fully functional. A certified electrician will repair any non-functional lights immediately. Review of Policy and Procedure for call light and ADL's</p> <p>o Responsible Party: Maintenance Supervisor</p> <p>o Completion Date: 08/09/2024</p> <p>Routine Maintenance Checks:</p> <p>o Action: Conduct daily checks of call light systems for two weeks, followed by weekly checks to ensure ongoing functionality.</p> <p>o Responsible Party: Maintenance Supervisor</p> <p>o Completion Date: Start immediately and continue weekly</p> <p>o Action: Inform residents and their families about the steps being taken to address the identified issues and ensure their safety and well-being.</p> <p>o Responsible Party: Administrator and Social Worker</p> <p>o Completion Date: 08/09/2024</p> <p>Monitoring and Verification</p> <p>Regular Audits:</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>o Action: Conduct weekly audits for compliance with the above actions for the next three months, then transition to monthly audits.</p> <p>o Responsible Party: Quality Assurance Team</p> <p>o Completion Date: Ongoing</p> <p>Immediate Reporting:</p> <p>o Action: Any noncompliance or issues identified during audits must be reported to the DON and Administrator immediately for corrective action.</p> <p>o Responsible Party: Audit Team</p> <p>o Completion Date: Ongoing Completion and Documentation</p> <p>Document All Actions:</p> <p>o Action: Maintain thorough documentation of all corrective actions, training sessions, maintenance checks, and communication with residents and families.</p> <p>o Responsible Party: Administrator</p> <p>o Completion Date: Ongoing</p> <p>The facility's implementation of the Plan of Removal was verified through the following:</p> <p>Record review of in-service record sheet dated 08/07/24 titled: call light/check residents. Purpose: plan of correction. Ensure resident safety and dignity: Make sure to check all residents at least every two hours every shift and as needed, especially at night. Before leaving the room make sure call light is working in room and the bathroom and within patients reach.</p> <p>Record review for in-services were initiated on 08/12/24 at 11:11 AM in a message to the team. Message reflected:</p> <p>Good morning Team! Please see in-service regarding call lights/resident rooms from DON</p> <p>We need to answer call light immediately. When we go to room, check to make sure call lights works in the room and bathroom. If it does not report it to charge nurse, DON and/or Maintenance.</p> <p>An observation on 08/08/24 at 7:30 AM revealed some call lights on hall 400 were not working.</p> <p>An observation on 08/08/24 at 7:45 AM revealed call lights on hall 500 were working.</p> <p>An observation on 08/08/24 at 8:00 AM revealed some call lights on hall 300 were not working.</p> <p>An observation on 08/08/24 at 8:15 AM revealed some call lights on hall 100 were not working.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An observation on 08/09/24 at 12:30 PM revealed call lights on hall 400 were working.</p> <p>An observation on 08/09/24 at 10:45 PM revealed call lights on hall 500 were working.</p> <p>An observation on 08/09/24 at 12:00 PM revealed some call lights on hall 300 were not working.</p> <p>An observation on 08/09/24 at 12:15 PM revealed some call lights on hall 100 were not working.</p> <p>An observation on 08/10/24 at 10:30 AM revealed call lights on hall 400 were working.</p> <p>An observation on 08/10/24 at 10:45 AM revealed call lights on hall 500 were working.</p> <p>An observation on 08/10/24 at 11:00 AM revealed some call lights on hall 300 were not working.</p> <p>An observation on 08/10/24 at 11:15 AM revealed some call lights on hall 100 were not working.</p> <p>An observation on 08/11/24 at 5:30 AM revealed call lights on hall 400 were working.</p> <p>An observation on 08/11/24 at 5:45 AM revealed call lights on hall 500 were working.</p> <p>An observation on 08/11/24 at 6:00 AM revealed some call lights on hall 300 were not working.</p> <p>An observation on 08/11/24 at 6:15 AM revealed some call lights on hall 100 were not working and observed residents with bells.</p> <p>An observation on 08/12/24 at 9:00 AM revealed call lights on hall 500 were working.</p> <p>An observation on 08/12/24 at 9:20 AM revealed call lights on hall 300 were working.</p> <p>An observation on 08/12/24 at 9:40 AM revealed call lights on hall 400 were working.</p> <p>An observation on 08/12/24 at 9:40 AM revealed some call lights on hall 100 were not working and observed residents with bells.</p> <p>An interview on 08/09/24 at 6:30 AM with Environmental services Director revealed the call lights were being worked on and will do routine checks until the system was updated. The Environmental Services Director revealed residents should be checked on every 30 minutes when the system was down.</p> <p>An interview on 08/10/24 at 9:35 AM with CNA O revealed residents were checked on every 2 hours and as needed.</p> <p>An interview on 08/10/24 at 9:40 AM with CNA L revealed residents were checked on every 2 hours and as needed.</p> <p>An interview on 08/10/24 at 9:55 AM with CNA N revealed residents were checked on every 2 hours and as needed.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/10/24 at 1:30 PM with CNA X who stated residents are checked on every 2 hours. CNA X stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/10/24 at 1:37 PM with RN Y who stated residents are checked on every 2 hours. RN Y stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 5:45 AM with Med aide S who stated residents are checked on every 2 hours. Med aide S stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 5:58 AM with LVN R who stated residents are checked on every 2 hours. LVN R stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 6:00 AM with CNA T who stated residents are checked on every 2 hours. CNA T stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 6:00 AM with CNA V who stated residents are checked on every 2 hours.</p> <p>An interview on 08/11/24 at 6:01 AM with CNA M revealed residents were checked on every 2 hours and as needed.</p> <p>An interview on 08/11/24 at 6:03 AM with CNA U who stated residents are checked on every 2 hours.</p> <p>An interview on 08/11/24 at 6:03 AM with RN W who stated residents are checked on every 2 hours. RN W stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/11/24 at 6:05 AM with CNA K revealed residents were checked on every 2 hours and as needed.</p> <p>An interview on 08/12/24 at 5:30 AM CNA J who stated residents are checked on every 2 hours. CNA J stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/12/24 at 6:00 AM LVN B stated who stated residents are checked on every 2 hours. LVN B stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>An interview on 08/12/24 at 6:04 AM LVN H who stated residents are checked on every 2 hours. LVN H stated if a resident's call light did not work then they should be given a bell until the system was fixed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 Gibbins Rd Arlington, TX 76011	
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<p>F 0919</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 08/12/24 with DON at 11:15 AM revealed PRN staff had not been in-serviced on the updated policy. The DON acknowledged that staff would not be able to work until they were in-serviced.</p> <p>The Administrator was notified the IJ was removed on 08/12/24 at 12:15 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of Pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053</p> <p>Based on observation, interview, and record review, the facility failed to establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that take into account nonsmoking residents for one (Resident #15) of three residents reviewed for smoking.</p> <p>The facility failed to ensure Resident #15 had a smoking evaluation.</p> <p>This failure could place residents at risk for injury, burns, and an unsafe smoking environment.</p> <p>Findings Include:</p> <p>1. Review of Resident #15's admission MDS assessment, dated 06/28/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Her cognition was intact. Her diagnoses included high blood pressure, diabetes, and paraplegia (inability to voluntarily move the lower parts of the body). The resident did not use tobacco.</p> <p>Review of Resident #15's Care Plan for July 2024, reflected the resident did not have a care plan for smoking.</p> <p>Review of Resident #15's Safe Smoking Evaluation reflected it was dated 07/16/24 following surveyor intervention. The evaluation indicated the resident was a smoker and was non-compliant with the smoking policy. The resident would sneak out to go smoke.</p> <p>An observation on 07/16/24 at 11:05 AM revealed Resident #15 went out the side door close to the front desk and started smoking.</p> <p>An interview on 07/17/24 at 3:00 PM with Resident #15 revealed she was awake, alert, and oriented. The resident said that she smoked in the non-</p> <p>smoking area and had been told by staff several times that she was not to smoke in the non-smoking area of the facility. She stated that she was advised by staff to only smoke during the designated smoking times in the smoking only area of the facility which was located adjacent to the Dining Hall.</p> <p>An interview on 07/17/24 at 10:30 AM with MDS E revealed she had worked at the facility for two years. She said the smoking evaluation was supposed to be completed when a resident was admitted and quarterly. MDS E said she found out Resident #15 smoked after a week of being admitted . She said for Resident #15 there was no risk if her smoking evaluation had not been completed.</p> <p>An interview on 7/17/24 at 10:40 AM with the DON revealed he was not aware that Resident #15 was a smoker and that he did not find out until 07/16/24 that she was. He said once he found out, he completed her smoking evaluation. The DON said without a smoking evaluation, the resident was at risk of burning herself.</p> <p>(continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility, Smoking Policy-Supervised and Unsupervised, revised March 2024 reflected:</p> <p>Safe Smoking Environment</p> <p>It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for Facility smoking privileges. The facility is responsible for informing residents, staff, visitors and other affected parties of facility smoking policies through verbal means, distribution and posting. This policy is intended to minimize the risks to:</p> <ul style="list-style-type: none"> o Residents who smoke, including possible adverse effects on treatment o Passive smoke to others o Fire <p>Smoking Evaluation</p> <p>Residents wishing to smoke while at the facility will have a Smoking Safety Evaluation completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely.</p> <ul style="list-style-type: none"> o If resident is determined to be a Safe Smoker and can smoke unsupervised then the resident can keep their smoking supplies, and smoke in designated areas at their leisure. o If resident is determined to be an Unsafe Smoker then they must be supervised at all times when smoking. <p>Facility staff will keep all smoking supplies and smoking times will be established by the facility and adhered to by the resident.</p> <p>A supervised smoking schedule will be posted and residents will be required to smoke with supervision only, according to the schedule.</p>		