STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675112	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review, the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency in accordance with state law through established procedures for one of two incidents (Resident #1) reviewed for abuse, neglect, and misappropriation. 1. The facility failed to report to the State Survey Agency when Resident #1 eloped from the facility on 12/31/24. This failure could place the residents in the facility at risk of continued abuse and neglect. Findings included: 1. Record review of Resident #1's Face sheet, dated 02/20/25, reflected the resident admitted on [DATE]. The resident's diagnoses included cerebral infarction (stroke), Bell's Palsy (condition that causes sudden weakness in the muscles on one side of the face), and dementia. Record review of Resident #1's discharge MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure) and chronic obstructive pulmonary disease (disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough). Resident #1 did not have a BIMS score documented. Resident #1 did not have a care plan. (New admit) Review of Resident #1's progress notes reflected: 12/30/25 9:25 AM (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was a [AGE] year-old male admitted from the hospital accompanied by two ambulance attendants via stretcher with diagnoses atrial fibrillation (abnormal heart rhythm), coronary artery disease (heart disease), cerebrovascular accident (stroke), altered mental status, and high blood pressure. Physician notified, all orders verified by physician and sent to the pharmacy. Resident was alert and oriented x2 verbally with confusion. Head to toe assessment done, PERRLA (pupils (are) equal, round, reactive (to) light and accommodation), skin warm and dry to touch, respirations even and unlabored. No shortness of breath, no cough, no congestion noted. Abdomen soft, non-tender, bowel sounds x4 quadrants noted, bladder non-distended, pedal pulses present and strong, skin intact. Resident made comfortable in bed. Resident oriented to bed and tv remote control, call light. Safety maintained, call light within reach. Resident instructed to call for assistance, verbalized understanding. Resident wanders back and forth the unit with unsteady gait. Written by RN A 12/31/24 12:58 AM At approximately 12:19 AM, resident with diagnosis of hallucination and altered mental status, was observed to have eloped from the facility. Resident was last seen at 12:17 AM walking the hall. Immediate steps were taken to locate resident by notifying 911, DON and power of attorney. Resident was located outside of facility. Tried to talk to resident to come back to facility but resident refused. Resident appeared to be very combative and screaming, You bitches trying to fucking kill me. Killers, killers. Was unable to redirect. Resident ran to another facility and got into their building. 911 was able to apprehend the resident and he was taken to hospital for further evaluation. Written by LVN B A record review of Facility In-service (Abuse/Neglect - Elopement) revealed facility staff were in-serviced on 12/31/24. An interview at on 02/20/25 at 12:25 PM with RN C revealed she admitted Resident #1 on 12/30/24. She said she admitted the resident to Hall 100 on the 2:00 PM - 10:00 PM shift, gave report, and left the facility. She said she was not at the facility when the resident eloped. An interview on 02/20/25 at 12:20 PM with LVN B revealed on 12/31/24 on the 10:00 PM - 6:00 AM shift she was assigned to Resident #1. She said that she took him with her to the Memory Care Unit on Hall 200 because he was walking up and down Hall 100. LVN B said while she and Resident #1 were in the Memory Care Unit, a resident fell and she had to go to assist the resident. LVN B said while she was assisting the resident who fell , she heard the door alarm to the Memory Care Unit and then the door alarm to the front door go off. She said she went running after the resident and she saw him outside running. He was running to the facility that was close by. She said she called 911 and the DON and the police were able to take him to the hospital. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/20/25 at 1:20 PM with the DON revealed Resident #1 was a new admit and was not exit-seeking per the family member. The DON said one second, he was in the hall and then the next minute he was gone. The DON said the nurse called her, because the staff saw him running to the facility next door. 911 was called and they picked him up. The DON said she did not know how Resident #1 eloped from the facility. She said it was possible that someone held the door open from him. The DON said she did not know why the elopement was not self-reported, but it was probably not reported because the staff had eyes on him when he was outside. An interview on 02/20/25 at 5:30 PM with the Administrator revealed he did not self-report the incident, because he thought the resident needed to be missing 4-6 hours before it was self-reported. The Administrator said Resident #1 was only missing for a matter of about two minutes. The Administrator said it was important to self-report elopements to ensure the correct procedure was followed. A record review of the facility policy and procedure, Abuse Prevention Program, revised 2016 reflected: 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51419 Based on observations, interviews, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services for 1 of 3 residents (Resident #2) reviewed for catheter care. The facility failed to ensure LVN A followed relevant clinical guidelines and provided appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. This failure could place the resident at risk of urethral tears or dislodging the catheter and urinary tract infections. Findings included: 1. Record review of Resident #1's annual MDS assessment, dated 12/17/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 13 indicating his cognitive status was intact. His diagnoses included neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage or dysfunction in the nerves that control it), paraplegia (a condition characterized by the loss of motor and sensory function in the lower half of the body, including the legs, feet, and genitals), pressure ulcer of sacral regions stage 4, and hypertension. The resident was dependent on staff for toileting. The resident was always incontinent of bowel and bladder. Record review of Resident #2's care plans, dated 02/02/25, reflected: The resident had an ADL Self Care Performance Deficit related to paraplegia. Facility interventions included: The resident required extensive assistance with toileting. Record review of Resident #2's orders, dated 08/08/24, reflected: Foley catheter to be changed monthly and as needed for malfunction. An observation on 02/20/25 at 1:00 PM revealed Resident #2 was lying in bed and his indwelling catheter drainage bag was on the floor. The catheter was not anchored to a non-moveable part of the bed. An observation 02/20/25 at 1:10 PM revealed the indwelling catheter bag was still on the floor. An interview on 02/20/25 at 1:13 PM with LVN A revealed that when LVN A went to administer the resident's IV antibiotic, the foley catheter drainage bag was on the floor. LVN A stated that she was going to finish other things and that she would return later to get the drainage bag off the floor. LVN A left the resident's room without getting the drainage bag off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/20/25 at 2:47 PM with the ADON revealed leaving the Foley bag on the floor would put the resident at risk for infection. An interview on 02/20/25 at 3:37 PM with LVN A revealed the Foley catheter drainage bag needed to be positioned below the bladder, hang on the side of the bed, and not be on the floor. LVN A stated that she did not remove the bag from the floor because it was going to take a long time to clean the catheter bag and secure it on the bedside. LVN A stated that the risk to the patient was risk for infection. An interview on 02/20/25 at 4:26 PM with the DON revealed the Foley catheter drainage bags should never be on the floor and they should be secured to the bed frame. The DON stated that placing the drainage bag on the floor could put the resident at risk of further infection and dislodgment of the catheter. Review of the facility policy, Urinary continence and incontinence -Assessment and Management and urinary tract infection/bacteriuria clinical protocol reflected: Indwelling catheters should be anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51419 Based on observations, interviews, and record review, the facility failed to ensure they followed professional standards of practice in accordance with physician orders and facility policy for care of PICC lines for 1 of 2 (Resident #2) residents reviewed for parenteral and intravenous care. The facility failed to ensure Resident #2's PICC line dressing was intact. This failure placed the residents at risk of complications with their PICC line needed for infusion therapy. Findings included: Record review of Resident #2's annual MDS assessment, dated 12/17/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 13 indicating his cognitive status was intact. His diagnoses included sepsis (sepsis is the body's extreme response to an infection), neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage or dysfunction in the nerves that control it), paraplegia (a condition characterized by the loss of motor and sensory function in the lower half of the body, including the legs, feet, and genitals), pressure ulcer of sacral regions stage 4, and hypertension. Record review of Resident #2's care plan, dated 02/20/25, revealed: Resident #2 had sepsis and was on an antibiotic. Resident #2's PICC line dressing needed to be changed every 7 days and staff were to monitor the site for signs and symptoms of infection. Record review of Resident #2's Physician Order, dated 2/20/25, reflected: Change PICC line dressing every Wednesday for Preventative Measure. In an observation on 02/20/2025 at 1:00pm the IV dressing to left arm was peeling off and the IV site was exposed. In an observation on 02/20/2025 at 1:10pm the IV antibiotic was infusing, the IV dressing remained peeled off and the IV site remained exposed In an observation and Interview on 02/20/2025 at 1: 13pm with LVN A revealed that the LVN had observed that the IV dressing was not secure, when she administered the IV antibiotic but because the IV flushed with no resistance she did not see any problem at the time. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/20/25 at 2:24 PM the ADON stated that after the state surveyor mentioned to her about the PICC dressing the ADON changed the dressing, because it was coming off. The ADON stated that LVN A should have secured the dressing, with tape but because too much dressing was coming off the dressing, it needed to be changed. The date on the dressing was 02/19/25. The ADON stated that the nurses should change PICC dressings weekly and as needed. The ADON stated that the risk to the resident was infection and the PICC line to come out. In an interview on 02/20/25 at 3:37 PM, LVN A stated that she was not familiar with the facility's PICC dressing policy. She stated that her experience was that LVN's were not supposed to change PICC line dressings. LVN A stated that she observed that the PICC dressing was coming off when she administered the IV antibiotic, but because the PICC line flushed with no problem, she thought it was okay. LVN A stated the risk associated with PICC lines was infection and the IV getting dislodged. In an interview on 02/20/25 at 4:26 PM, the DON stated nurses were expected to check the dressing every shift and during every antibiotic administration. The DON stated the primary risk associated with PICC lines were infection. Record review of the facility's Peripheral and Midline IV Dressing Changes policy read in part change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way.