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	02/27/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review, the facility failed to ensure each resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 (Residents #1) of 1 resident reviewed for tracheostomy care. The facility failed to ensure an extension cord was kept in Resident #1's room for use during a power outage in accordance with his Care Plan. This failure placed residents at risk of serious injury or hospitalization . Findings included: Record review of Resident #1's Admission Record dated 2/26/25 reflected a [AGE] year-old male originally admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected he was rarely/never understood and had severely impaired cognitive skills. He had range of motion impairment in all extremities and was dependent on staff for all activities of daily living. His diagnoses included stroke, aphasia (inability to talk); pneumonia; septicemia (infection in bloodstream); quadriplegia (inability to move all limbs); gastrostomy tube (surgically placed tube in the stomach for nutrition); chronic respiratory failure with hypoxia (low oxygen in the blood); and tracheostomy (surgically placed hole in throat that allows person to breathe). He had received tracheostomy care and continuous oxygen. Record review of Resident #1's Order Summary Report dated 02/27/25 reflected it included the following orders: Give 6L of oxygen-order dated 01/24/23. Suction as needed to maintain patency of trach-order dated 11/23/22. Suction every shift-order dated 08/5/24. Record review of Resident #1's Care Plan reflected the following entries: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident #1] has Tracheostomy r/t impaired breathing mechanics, injury. Keep Ambu bag [handheld device used to provide positive pressure ventilation to a patient unable to breathe adequately] in room. Interventions included: .Give humidified oxygen as prescribed. Monitor/document respiratory rate, depth, and quality . The entry was initiated 05/03/23 and revised 01/25/25. [Resident #1] has Oxygen therapy 6L continuous via trach r/t ineffective gas exchange. In the event of an emergency, use of red plugs located in closet in resident's room, if red plugs do not work, go to oxygen storage to get portable tank. Code to storage room [code number], ambu bags available on crash cart if tank not available, 911/transfer out. Intervention included: Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, pulse oximetry (measurement of oxygen level in blood), increased heart rate, restlessness, diaphoresis (sweating) . The entry was initiated 05/03/23 and revised 09/27/23. [Resident #1] has an ADL self-care performance deficit e/t Quadriplegia . Emergency Oxygen-Red plugs- in the event of a power loss to facility these plugs run off generator. All residents with orders for continuous oxygen and other medical equipment have extension cords with surge protectors for the red plugs, these items are in the closet of these rooms. The plus [sic] is located outside room [ROOM NUMBER] and room [ROOM NUMBER]. Additional red plugs can be found on the 1st four rooms of the 600 hall. Oxygen tanks are located in the oxygen storage room off main lobby, the code to this room is [code number]. Date initiated 05/03/23 and revised on 07/01/24. During an observation 2/26/25 at 11:32 AM, Resident #1 was observed in his room sleeping in bed. The head of his bed was elevated. He was receiving oxygen through his tracheostomy at 6 LPM, he had an oxygen concentrator and compressor plugged into a red outlet located near his bed. He had a suction machine and nebulizer machine (used to administer aerosolized medication) on a nightstand near his bed plugged into a white outlet. An ambu bag with trach connector was hanging on the wall near his bed. A portable oxygen tank was located near his bed. An observation on 2/26/25 at 1:20 PM revealed there was no extension cord located in Resident #1's closet or anywhere visible in his room. During an interview on 2/26/25 at 1:33 PM, LVN A stated he was Resident #1's charge nurse and was on his third week working at the facility. He stated he had not heard about Resident #1 needing an extension cord in his room and had not had any special training related to power outages or plugs. He stated he knew from experience red outlets meant those were connected to the building generator. LVN A stated, if there was a power failure, he should attempt to use red plugs for anyone on oxygen. He stated, if there was an emergency involving power outages, he needed to call for help, use the ambu bag and portable oxygen tank, and send him out to the hospital. On 2/26/25 at 2:55 PM, a discussion with Life Safety team revealed the red electrical outlet in Resident #1's room was not connected to the emergency generator. They stated the outlet on the wall outside his door was connected to the generator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 2/26/25 at 3:20 PM, RN B was standing in Resident #1's room. A long extension cord was attached to his oxygen concentrator and compressor and was plugged into the red electrical outlet outside his room, both machines were functioning. The outlet inside his room in which they were previously plugged, was white in color (previously red). RN B stated maintenance staff had informed her they were testing the generator, so she was monitoring Resident #1 to ensure his oxygen remained on. She pointed out the nearby portable oxygen tank they had available in case there was any problem with the power. RN B stated she did not know why the electrical outlet in Resident #1's room was white at that time because it was previously red. On 2/27/25 at 8:19 AM, an attempt to call Resident #1's attending physician was unsuccessful and a message was left. During an interview on 2/27/25 at 8:58 AM, the Maintenance Director stated it was his first week at the facility. He stated he did not know why the electrical outlet in Resident #1's room was red when it had not been connected to emergency power. He stated he became aware of the situation when he was informed by the State Life Safety team on 2/26/25. The Maintenance Director stated he did not know why the extension cord was not in Resident #1's room or who had removed it. He stated residents dependent on electrical power for equipment were at risk for worsened condition if the power was not available. During an interview on 2/27/25 at 10:38 AM, the Maintenance Aide stated he had previously placed an extension cord in Resident #1's room prior to November 2024. He stated he did not know why the cord was not there or who had removed it. He stated he did not know why the outlet in Resident #1's room was red because it was not connected to the emergency generator. The Maintenance Aide stated he did not know who was responsible for ensuring the cord remained in the room, but he had told staff at the time he placed it there it was to remain in the room. He stated, when he learned the cord was missing on 2/26/25, he replaced it. He stated the residents risked bad outcomes if they needed power to run their equipment. In an interview on 2/27/25 at 11:23 AM, the Administrator stated the nursing staff should have been aware of the need for the extension cord in the room, but maintenance was responsible for ensuring the cord was available to them. He stated, Ultimately I'm responsible for ensuring it's done. The Administrator stated the Maintenance Director and himself were responsible for training staff on emergency procedures and he was unsure whether the previous Maintenance Director had trained all the staff or made them aware of the electrical issue in the room. He stated Resident #1 had portable oxygen and an ambu bag available in his room and staff were to call 911 and send him out immediately in the event of a power failure. He stated the risk to residents was severe negative outcomes depending on the type of equipment used that needed electricity. During an interview on 2/27/25 at 11:35 AM, the DON stated she had no idea the red electrical outlet in Resident #1's room was not connected to the emergency generator. She stated she had been unaware of the need for an extension cord in his room as his equipment had been plugged into a red outlet. She stated Resident #1 had portable oxygen and an ambu bag in his room and staff were to call 911 in the event of a power outage. She stated she planned to add the extension cord check to the residents Treatment Administration Record to ensure checks were done every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/27/25 at 5:04 PM, the Medical Director (also Resident #1's attending physician) stated the outlet in Resident #1's room should not have been red if the connection to emergency power had not been fixed because anyone would assume it was connected to a generator. He stated the issue had previously been addressed and Resident #1 was to have had an extension cord in his room. He stated the risk to Resident #1 was minimal because portable oxygen would have been the go-to for him and call 911. He stated the ambu bag was there for safety as well, but the resident could possibly require suctioning. The Medical Director stated he knew about the plan when it was originally written but the Administrator and DON were new and probably did not know. He stated the risk to Resident #1 was minimal because his breathing had been stable. He stated 911 arrives at the facility because of their very close proximity to the facility. Record review of the facility policy, Tracheostomy Care, dated 2022, reflected: Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Compliance Guidelines: 1. The facility, in collaboration with the attending practitioner, must perform a comprehensive assessment of the resident's respiratory needs. 2. The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning. 3. Tracheostomy care will be provided according to the physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. General considerations include: a. Provide tracheostomy care at least twice daily. b. Maintain a suction machine, a supply of suction catheters, correctly sized cannulas, and an ambu bag easily accessible for immediate emergency care. 4. Based upon the resident assessment, attending physician's orders, and professional standards of practice, the facility in collaboration with the resident/resident's representative will develop a care plan that includes appropriate interventions for respiratory care .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43815 Based on observations, interviews, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for staff for 1 of 1 walk-in freezers reviewed for environment. The facility failed to ensure the kitchen walk-in freezer door was maintained to ensure the water did not drip from the vent onto the floor. This failure could affect all kitchen staff by placing them at risk for fall and slipping hazard inside the freezer. The findings included: Observation on 02/26/25 at 10:00 AM revealed a cardboard box filled with ice under the vent in the walk-in freezer. I was also on the floor around the box, and the ice covered the back corner of the floor and under one of the shelves. Interview with Kitchen Manager on 02/26/25 at 12:25 PM revealed Kitchen Manager stated the freezer had been leaking water from the vent inside the freezer for about six months. He stated he had verbally informed the previous maintenance director, and the administrator about the leakage. He stated the Administrator informed him last week that he had ordered the part to fix walk-in freezer. He stated the ice on the floor inside the put the staff at risk of falls and injury. Interview with Administrator on 02/26/25 at 1:30 PM revealed he knew there was a leak in the freezer a few weeks ago. He stated he had contacted a company to come out and fix the freezer and they would be coming out on 2/26/25, he had received confirmation of the visit. He stated he was not aware the freezer had been leaking for six months. He stated he and all the kitchen staff were responsible to ensure the kitchen is safe for all staff. He stated risk to staff would be that the staff could slip and fall, or the ice could hit them causing injury. Interview with the Maintenance Director on 02/27/25 at 10:30 AM revealed he had been made aware of the walk-in freezer leaking on 2/26/25 when the kitchen staff brought it to his attention. He stated a company was at the facility working on the vent at that time. He stated it was determined that the drain panel was clogged and caused the vent to leak. He stated the facility did not have a maintenance log for staff to record issues that needed maintenance attention. He stated the facility had a group chat the staff could use to send maintenance requests, but he had not received a request about the walk-in freezer. He stated they were working on a system for staff to send in maintenance request through an app. He stated the staff could slip and fall on the ice in the freezer and be injured. Interview with the Maintenance Aide on 02/27/25 at 10:42 AM revealed he was aware of the walk-in freezer leaking. He stated he and the previous maintenance director would go into the freezer and break up the ice and take the ice out. He stated the administrator had been told verbally because they did not have a maintenance logbook. He stated the administrator stated it would be fixed. He stated the ice on the floor in the freezer placed the staff at risk of slips, falls, and injury. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review reflected prior to exit the facility provided an invoice dated 02/26/25 reflected the service performed included the refrigeration system, de-iced the indoor coil, and drain heater repaired. Record review of the facility's Sanitization policy revised on December 2008 reflected The food service area shall be maintained in a clean and sanitary manner. 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43815 Based on observation, interview and record review, the facility failed to maintain an effective pest control program, so the facility was free from pests and rodents for 2 of 2 residents (Resident #2 and Resident #3) reviewed for pest control. The facility failed to maintain an effective pest control program to ensure the facility was free of rodents and roaches in the facility kitchen and the rooms of Resident #2 and Resident #3. This failure could place residents at risk for an unsanitary environment in the kitchen and rooms of Residents #2 and Resident #3 and a decreased quality of life. Findings included: Record review of Resident #2's Admission Record dated 02/27/24 reflected a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Record review of Resident #2's Admission MDS assessment dated [DATE] reflected a BIMS score of 13 which indicated he was cognitively intact. His diagnoses included paraplegia (inability to move the lower part of the body); peripheral vascular disease (reduced blood flow to the limbs), and Stage 4 (full thickness) pressure ulcer to right heel. He utilized a wheelchair for mobility. Record review of Resident #3's Admission Record dated 02/27/25 reflected a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Record review of Resident #3's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated he was cognitively intact. His diagnoses included Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Hypertension (a condition in which the force of the blood against the artery walls is too high), Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Crohn's Disease (a chronic inflammatory bowel disease that affects the lining of the digestive tract), Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), he was mobile without assistance. Interview on 02/26/25 at 10:55 AM with Resident #3 revealed he had seen four rats run back into the wall in his bathroom when the facility was repairing the wall in his bathroom. He stated he told the maintenance director at the time. He stated he could not remember exactly when, it was a few months ago. He stated he had two cats and the cats sometimes reacted to sounds heard in the walls of his room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 02/26/25 at 11:45 AM, Resident #2 was sitting up in his wheelchair discussing an upcoming appointment. During the conversation, a large water bug was observed crawling out from behind the resident's duffle bag situated against the wall toward the middle of the room. It turned and returned behind his bag. Resident #2 reached and moved his bag, and the bug ran out of the room. Resident #2 stated he saw them pretty often, I see those little roaches too. He stated he had complained about it a while back but no one ever did anything about it. He stated he knew nothing was done because the bugs were still there. He stated, it's pretty nasty. Interview with pest control service provider on 02/26/25 at 11:50 AM revealed the contract with the facility had been cancelled because of slow payment. He stated the last date of service was mid December 2024. Interview on 02/26/25 at 12:15 PM, the Dishwasher revealed she had seen a rodent in the kitchen on 02/24/25. She stated she had seen a rodent on the dish racks that are used to wash the dishes. She stated the rodent ran to the laundry room from the kitchen. She stated she had to disinfect the dishwasher prior to sending the dishes through the dishwasher because of the rodent droppings on the dishwasher. She stated told the Administrator and the previous Maintenance Director. She stated they said they would contact pest control. She stated rodents in the kitchen could cause infection or sickness to the residents and it was very unsanitary. Observation on 02/26/25 at 12:22 PM of the dishwashing area of the kitchen revealed under crates sitting on a cart were shavings from the crate and rodent droppings. Observation of another cart holding crates revealed rodent droppings and food particles. Interview with Kitchen Manager on 02/26/25 at 12:25 PM revealed he stated he had not seen any rodents in the kitchen. When Kitchen Manager was asked if any kitchen staff had informed him that rodents had been seen in the kitchen, he replied, that he had not seen any rodents in the kitchen. He stated the residents were at risk of sickness and disease. Interview with Administrator on 02/26/25 at 1:30 PM revealed he had asked the previous Maintenance Director about the pest control visits to the facility because he had never seen a person from a pest control company at the building. He stated he was told the pest control staff came to treat the building at 6:00 AM. He stated he instructed the maintenance director that the pest control staff should have come to the building during the day so that he could meet with him. He stated he was not aware that the contract had been terminated. He stated he was the person responsible to ensure there was a pest control contract in place. He stated the residents had been at risk of cross contamination, infection, and diseases. During an interview on 2/26/25 at 2:13 PM, the ADON stated she saw bugs occasionally and let the maintenance staff know whenever she saw anything. She stated she had seen what looked like a tiny cockroach in a resident room on 2/24/25 and immediately told maintenance in person. She stated they came and took care of it. They removed the bug and said they would treat the area. The ADON stated she had not seen any rodents. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/27/25 at 6:21 AM, CNA C stated she worked the night shift and had been there about a year. She stated she saw rats in the facility near the kitchen and laundry rooms when she took the trash out at night. She stated she saw them there a lot including the current week. CNA C stated she saw a rat in the employee break room a couple of nights ago. She entered the room and saw a rat run from near a chair and crawl under a cabined under the sink. When asked if she had reported it, she replied, No, we're just used to it, it's been like that a long time. CNA C stated she had never seen rats in the resident rooms, shower rooms or near any resident. She stated, Most of the time they are near the kitchen. Record review of the facility pest control visit log reflected service was last provided on 02/07/25. The last invoice from service provider was dated 12/12/2024. Record review reflected prior to exit facility obtained a new pest control policy dated 02/26/25. Record review of the facility Pest Control Policy review dated 12/1/22, review date 2/26/25 reflected Pest Prevention Measures: Conduct regular inspections of the facility to identify potential pest entry points and nesting sites. Seal cracks, crevices, and other openings in the building structure. Maintain cleanliness in all areas, including dining, kitchen, and resident rooms, to eliminate food sources and habitats for pests. Proper waste management practices, including regular disposal and secure containers. 1. Monitoring: Schedule routine pest inspections by qualified pest control professionals at least quarterly. Document findings and actions taken during inspections. Maintain a pest sighting log for staff to report any pest activity promptly. 2. Pest Control Treatment: Employ licensed pest control operators to handle infestations when necessary, ensuring they follow HHSC guidelines.