

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 03/18/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054</p> <p>Based on interview, observation, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one resident (Resident#1) of 5 residents reviewed for ADLs.</p> <p>-The facility failed to provide showers or bed baths for Resident #1 according to the facility's ADL schedule.</p> <p>This failure could place all residents who require assistance with ADL care at risk for poor personal hygiene, odors, and a decline in their quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet, dated 03/18/25, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: osteomyelitis of vertebra, sacral and sacrococcygeal (inflammation caused by infection to tail bone), pressure ulcers, heart failure, hypertension (high blood pressure), type II diabetes, and paraplegia (loss of voluntary movement to lower parts of the body).</p> <p>Record review of Resident #1's care plan, dated 12/31/24, reflected the resident had an ADL self-care performance deficit r/t wound, hypertension, congestive heart failure, and diabetes with interventions that included giving the resident sufficient time to accomplish each task and encourage the resident to use bell to call for assistance.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 12/16/24, reflected the resident had a BIMS score of 15 which indicated cognition was intact. The MDS Assessment also reflected Resident #1 was dependent on staff for all ADLs and mobility.</p> <p>Record review of Resident #1's ADL tasks in the electronic health record, dates 02/01/25-03/18/25, reflected the following:</p> <p>Bathing Task:</p> <p>-02/01/25-02/08/25-activity did not occur</p> <p>-02/09/25-total dependence (activity occurred)</p> <p>(continued on next page)</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>02/10/25-02/12/25- activity did not occur</p> <p>-02/13/25- physical help limited to transfer only (activity occurred)</p> <p>-02/14/25-02/26/25- activity did not occur</p> <p>-02/27/25- physical help in part of bathing activity (activity occurred)</p> <p>-02/28/25-03/13/25- activity did not occur</p> <p>-03/14/25- physical help in part of bathing activity (activity occurred)</p> <p>-03/15/25-03/17/25- activity did not occur</p> <p>-03/18/25- physical help in part of bathing activity (activity occurred)</p> <p>Record review of Resident #1's shower sheets, 02/01/24-03/18/25, provided by the DON reflected the following:</p> <p>-02/14/25- [Resident #1] refused shower</p> <p>-03/14/25- [Resident #1] received a bed bath</p> <p>There were no shower sheets provided for other days during this time period.</p> <p>In an interview and observation on 03/18/25 at 12:00 PM, Resident #1 was lying in bed. He was dressed and appeared to be well-groomed with no odors. Resident #1 stated he was happy because he finally received a bed bath this morning after about 2 weeks. Resident #1 stated he had been at the facility since 12/2024 and only received 3-4 bed baths and had never been in the shower. He stated he would beg for a bath at least once a week and the staff would always give an excuse like the water was not hot or there were no towels available. Resident #1 stated his family had to buy him some personal hygiene wipes and would visit almost daily to wipe him off the best she could as she was unable to move him completely. Resident #1 stated he became so frustrated with the staff that he stopped asking for a bath and would just wait for them to offer it, which rarely happened. Resident #1 stated not receiving regular baths made him feel ashamed, uncomfortable, and frustrated. Resident #1 stated he believed he was not receiving baths because he needed a lot of assistance due to his paralysis. He stated his roommate received his baths with no issues. He stated he was just waiting for his insurance to approve home health so that he could return home .</p> <p>In an interview on 03/18/25 at 12:45 PM, Resident #1's family stated her biggest complaint about the facility was that they did not shower the resident. She stated she would ask the staff why Resident #1 was not being bathed and she could never get a straight answer. The family stated the staff would always pass the blame to others stating Resident #1 was not scheduled for a bath during their shift or they would state he refused, which was not true. She stated Resident #1 would always say he wanted a bath and she tried to visit daily to assist him with his hygiene. She stated she bought wet wipes and other toiletries because the facility was also always out of supplies.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/18/25 at 04:27 PM, CNA A stated he worked at the facility for about 3 years. CNA A stated he worked with Resident #1 and the resident was scheduled to receive his showers during the morning shift on Mondays, Wednesdays, and Fridays. CNA A stated Resident #1 never refused a shower with him; however, he did not always receive them because the facility would not have clean towels available. CNA A stated he found that towels were available today, so he made sure Resident #1 received a bed bath today and the resident was very thankful. CNA A stated the staff have to document all showers and baths on shower sheets and in the electronic health records.</p> <p>In an interview on 03/18/25 at 04:45 PM, CNA B stated she worked at the facility for 3 years. She stated she worked with Resident #1, but she did not shower or bathe him because his baths were scheduled during the week, and she did weekend showers. She stated Resident #1 sometimes looked disheveled and had an odor and she would report to the nurse that it seemed he was not getting his scheduled showers. CNA B described Resident #1 as alert and able to express wants and needs. She stated Resident #1 was mostly quiet and did not ask for much. She stated he never refused care from her.</p> <p>In an interview on 03/18/25 at 05:41 PM, the DON stated staff were expected to shower/bathe all residents on their scheduled days. The DON stated if a resident refused, the staff were expected to notify the nurse and if the refusals were continuous the family would also be notified. The DON stated all showers/baths were expected to be documented on shower sheets and in the POC in the electronic health records, including refusals. She stated the shower sheets were supposed to match the POC; however, she found that staff were not documenting consistently, and she was starting an in-service on it. The DON stated Resident #1 received bed baths due to mobility issues, but he often refused them. She stated residents had the right to refuse showers. She stated refusing care was included in Resident #1's care plan. The DON stated the resident's refusals should have been documented; however, she could not provide documentation of all the refusals. The DON stated the risk of residents not receiving regular showers/baths could be uncleanliness and infections.</p> <p>The facility's policy on ADL Care was requested from the Administrator and he stated that he could not find one.</p>		