

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 07/03/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</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

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 07/03/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program to the maximum extent practicable to avoid duplicative testing and effort, which included incorporating the recommendations from the Preadmission Screening and Resident Review level II determination and the Pre-admission Screening and Resident Review evaluation report into a resident's assessment, care planning and transitions of care for one (Resident #4) of five residents reviewed for Pre-admission Screening and Resident Review assessments. The facility failed to provide Habilitation Coordination, Independent Living Skills, Physical Therapy, Occupational Therapy, Speech Therapy, to Resident #4 as recommended and agreed upon by the Interdisciplinary Team (IDT) within the time frame set by PASRR. This failure could place residents with intellectual disabilities or mental illness at risk of not receiving services that would enhance their quality of life. Findings included: Review of Resident #4's annual Minimum Data Set, dated [DATE] reflected the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a condition caused by damage to the developing brain that affects a person's ability to control their muscles, problems with movement, coordination) kidney failure (kidneys are no longer able to properly filter waste and extra fluid from the blood), contracture (a muscle, tendon, or joint becomes permanently stiff or tight), and dysphagia (trouble swallowing). Review of Resident #4's annual Minimum Data Set assessment dated [DATE] reflected he had no speech, rarely/never made himself-understood, and sometimes was able to understand others. His Brief Interview for Mental Status was not completed. He was totally dependent on two staff for dressing, transferring, bathing and toilet use. He was totally dependent on staff for locomotion, eating, and personal hygiene. He was not ambulatory and had functional limitations in range of motion for upper extremity and lower extremity on both sides. He was indicated as always incontinent of bowel and bladder. He had a physical therapy start date of 03/29/25 with an end date of 04/21/25 with no minutes of treatment recorded during that duration. Record review of Resident #4's Comprehensive Care Plan initiated on 4/11/2018 and revised on 5/27/25 reflected Resident #4 focus area indicated Resident #4 had been identified as PASRR positive status (when a resident is found to need specialized services or supports due to a serious mental health illness, intellectual disability, developmental disability, or related condition through the PASRR screening process) related to an intellectual disability, and Cerebral Palsy. His interventions indicated his family/local mental health authority had agreed to the following PASRR services: Habilitative Physical and Occupational therapy services, Habilitation coordination, and independent living skills. Review of Resident #4's Preadmission Screening and Resident Review Comprehensive Service Plan dated 12/18/24 reflected the type of meeting held was Initial IDT. The form reflected in attendance was a representative from the local mental health authority, Registered Nurse, Minimum Data Set Nurse, Social Worker, Director of Rehabilitation, Hospice Registered Nurse, and Resident's responsible party/family member. The form reflected the Habilitation Coordinator recommended the following services for Resident #4: Habilitation Coordination, Independent Living Skills, Behavioral Enhancement Services, Physical Therapy, Occupational Therapy, Speech Therapy, and Durable Medical Equipment. The form also reflected that Habilitation Coordination, Independent Living Skills, Physical Therapy, Occupational Therapy, Speech Therapy and assessments were accepted, and all other services declined at that time. Review of Resident #4's PASRR Comprehensive Service Plan Form dated 3/12/25 reflected the type of meeting was quarterly IDT. The form reflected in attendance was Resident #4, local mental health authority, Minimum Data Set Nurse, Hospice Social Worker, Director of Rehabilitation, and Resident's responsible party/family member. The plan reflected Resident #4 would continue the following services: Habilitation Coordination, Independent Living Skills, Physical Therapy, Occupational Therapy, Speech Therapy. Review of Resident #4's Habilitative Service Plan/Form 1057 dated 3/12/25 indicated recommended services for Resident #4 were Habilitation Coordination, Independent Living Skills, Physical Therapy, Occupational Therapy and Durable Medical Equipment. Section 6 of the form titled Nursing Facility Specialized Services to be Monitored by the IDT stated to enter all Nursing Facility Specialized Services provided to the individual during the Habilitative Service Plan year. The specialized services listed for Resident #4 were Occupational Therapy with outcome/goal of: Patient will exhibit anatomically correct positioning while sitting in wheelchair with use of adaptive equipment/devices for 2 hours with fair-sitting balance during activities of daily living to reduce pressure and decrease risk of wounds and achieve proper</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 07/03/2025
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 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** Based on interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs and describes the services to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 of 5 (Resident #4) residents reviewed for care plans. The facility failed to implement Resident #4's comprehensive person-centered care planned interventions for speech and occupational therapies. Failure to implement the care plan as written could place residents at risk for unmet needs, avoidable decline, injury, or harm, as their individualized support measures are not being followed to ensure safety, health, and well-being. The findings included: Review of Resident #4's annual Minimum Data Set, dated [DATE] reflected the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a condition caused by damage to the developing brain that affects a person's ability to control their muscles, problems with movement, coordination) kidney failure (kidneys are no longer able to properly filter waste and extra fluid from the blood), contracture (a muscle, tendon, or joint becomes permanently stiff or tight), and dysphagia (trouble swallowing). Review of Resident #4's annual Minimum Data Set assessment dated [DATE] reflected he had no speech, rarely/never made himself-understood, and sometimes was able to understand others. His Brief Interview for Mental Status was not completed. He was totally dependent on two staff for dressing, transferring, bathing and toilet use. He was totally dependent on staff for locomotion, eating, and personal hygiene. He was not ambulatory and had functional limitations in range of motion for upper extremity and lower extremity on both sides. He was indicated as always incontinent of bowel and bladder. He had a physical therapy start date of 03/29/25 with an end date of 04/21/25 with no minutes of treatment recorded during that duration. Record review of Resident #4's Comprehensive Care Plan initiated on 4/11/2018 and revised on 5/27/25 reflected Resident #4 focus area indicated Resident #4 had been identified as PASRR positive status (when a resident is found to need specialized services or supports due to a serious mental health illness, intellectual disability, developmental disability, or related condition through the PASRR screening process) related to an intellectual disability, and Cerebral Palsy. His interventions indicated his family/local mental health authority had agreed to the following PASRR services: Habilitative Physical and Occupational therapy services, Habilitation coordination, and independent living skills. A focus area stated Resident #4 had ADL self-care performance deficit and limited physical mobility. The intervention/Tasks listed Physical Therapy, Occupational Therapy, and Speech Therapy evaluations and treat as indicated. In an interview on 7/1/25 at 10:50 a.m. with the Director of Nursing, she reported Resident #4 was not receiving any specialized services because he was on hospice. After checking records, the Director of Nursing stated Resident #4 had been receiving physical therapy since 5/7/25 and had been waiting approval for occupational therapy. In an interview on 7/2/25 at 10:45 a.m. with the Director of Rehabilitation, she stated they were in the process of resubmitting approval for Occupational Therapy. She stated that Speech Therapy was never recommended for Resident #4. After reviewing records, she stated she believed Resident #4's family did not want speech therapy. She agreed that the refusal of service was not documented in the residents Electronic Health Record. Review of the facility's Care Plan, Comprehensive Person Centered Policy, dated December 2016 stated in part, The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's care plan is determined to not be practicable.</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 07/03/2025
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)		
F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)		

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 07/03/2025
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)		
F 0677 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 2 residents (Residents #1) reviewed for ADL care. The facility failed to ensure Residents #1 was repositioned every 2 hours on 06/04/25, resulting in moisture associated damage to Resident #1's right and left buttocks. This failure could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. Findings included: Review of Resident #1's Annual MDS Assessment, dated 04/08/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. The resident had a supra-pubic catheter (catheter inserted into the bladder to drain urine) a colostomy (bag attached to the abdomen to collect bowel movement that excretes from the stoma), and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it open for breathing). His diagnoses included stroke, kidney failure, diabetes, and quadriplegia (inability to move arms and legs). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. The resident did not have any skin conditions listed. Review of Resident #1's Care Plans reflected: Revised 07/01/24 - Resident had an activities of daily living deficit. Facility interventions: The resident was totally dependent on staff for repositioning and turning in bed. 12/02/24 - Risk for Impaired Skin Integrity Facility interventions: Evaluate skin integrity Review of Resident #1's Care Plan, last revised 05/20/25 reflected the following focus, goal, and interventions were in place: - Focus: Resident #1 has potential/actual impairment to skin integrity to bilateral buttocks gran 100% tx per MD ORDER 05/03/23. Goal: Resident #1 Skin will remain intact 03/04/25. Interventions: . Involve/educate resident and/or family/designee Monitor for s/s of infection Monitor pain and administer pain medications/treatments as ordered and/or per pain problem- Focus: . Left buttocks clean area with NS. Pat dry with 4x4. Apply house barrier cream twice daily and PRN if soiled until resolved. 0.8 x 0.7 x 0.1 cm Right buttocks Left buttocks clean area with NS. Pat dry with 4x4. Apply house barrier cream twice daily and PRN if soiled until resolved. 2.8 x 0.8 x not measurable in CM 06/05/25. Goal: Wound Will Be Free of Signs or Symptoms of Infection Wound Will Show Signs of Improvement 06/05/25. Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown Inform the resident/family/caregivers of any new area of skin breakdown Notify provider if no signs of improvement on current wound regimen Provide wound care per treatment order- Focus: Resident #1 has an ADL Self Care Performance Deficit r/t Quadriplegia on Restorative LOW AIRLOSS MATTRESS/CHECK FOR FUNCTION EVERY SHIFT 05/03/23, revised 05/23/25. Review of Resident #1's BRADEN - Scale for Predicting Pressure Sore Risk was completed on 05/04/25 and indicated Resident #1 was at a high risk for developing pressure sores. An observation and interview on 06/04/25 at 1:45 PM with Resident #1 revealed CNA A was getting ready to perform incontinence care. The resident was awake, alert, and non-verbal. The resident had a supra-pubic catheter and a colostomy. CNA A washed her hands and put on gloves. The resident was not wearing a brief. CNA A cleaned the penis and scrotal area. The resident was rolled to his left side. His buttocks and the back of his thighs were dark red/purple. He had draining wounds on his buttocks that had drained onto the sheets down to the mattress. There was a moderate amount of tan and black drainage. CNA A cleaned the wounds and buttocks. There were 2 open areas, one on each buttock. An interview on 06/04/25 at 2:05 PM with the WCN revealed she was not aware of the wounds on Resident #1, and no one had notified her about the wounds. She said she started a skin sweep (skin assessment of residents) in the building to look for skin issues but had not assessed Resident #1. The WCN said staff were supposed to notify her about the wounds. The WCN measured the wounds: Left 1st toe 0.5 cm x 0.2 cm Right 1st toe 0.6 cm x 0.5 cm Right buttock 1.5 cm x 2.0 cm Left buttock 2.5 cm x 3.0 cm An interview on 06/04/25 at 2:10 PM with CNA B revealed she was assigned to Resident #1 for the 6:00 AM - 2:00 PM shift on 06/04/25. She said the last time she repositioned the resident was between 8:00 AM - 9:00 AM and she saw the wounds on his buttocks. She said she did not tell the nurse about the wounds, because the nurse already knew about the wounds. CNA B said she was supposed to reposition residents every two hours, but she got busy and was not able to reposition the resident after 8:00 AM - 9:00 AM. CNA B said she could ask for help, but another CNA was already helping her. CNA B said if a resident was not repositioned every two hours then they</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 07/03/2025
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 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>(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 07/03/2025
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 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities based on the comprehensive assessment and care plan, designed to meet the interests of and support the physical, mental and psychosocial well-being of one resident (Resident #4) out of five who were reviewed for activities. The facility failed to consistently provide encouragement and assistance to participate in facility provided activities for Resident #4. This failure could place residents at risk for social isolation, depression, and a decline in psychosocial well-being. Findings included: Review of Resident #4's annual Minimum Data Set, dated [DATE] reflected the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a condition caused by damage to the developing brain that affects a person's ability to control their muscles, problems with movement, coordination) kidney failure (kidneys are no longer able to properly filter waste and extra fluid from the blood), contracture (a muscle, tendon, or joint becomes permanently stiff or tight), and dysphagia (trouble swallowing). Review of Resident #4's annual Minimum Data Set assessment dated [DATE] reflected he had no speech, rarely/never made himself-understood, and sometimes was able to understand others. His Brief Interview for Mental Status was not completed. He was totally dependent on two staff for dressing, transferring, bathing and toilet use. He was totally dependent on staff for locomotion, eating, and personal hygiene. He was not ambulatory and had functional limitations in range of motion for upper extremity and lower extremity on both sides. He was indicated as always incontinent of bowel and bladder. He had a physical therapy start date of 03/29/25 with an end date of 04/21/25 with no minutes of treatment recorded during that duration. Review of Resident #4's Care Plan, initiated on 4/11/2018 and revised on 5/27/25 reflected Resident #4 would have 1:1 activity to Resident #4's likes/abilities. Activity Director to individualize activities for Resident #4 and work on getting Resident #4 to socialize with others in a group setting. The goal stated that Resident #4 would continue to participate in activities of choice to his likes/abilities through the next review date and to provide 1:1 assistance as needed to participate in activities. The Care Plan also stated that Resident #4 would have involvement related to music, therapy, and fitness each week at an unspecified number of times a week. The tasks/interventions stated Resident #4 needed a variety of activity types and locations to maintain interests. The tasks/interventions stated that Resident #4 would need assistance/escort to activity functions. The Care Plan included a Focus that stated Resident #4 was high risk for decreased quality of life related to little interest in activities. The goal stated that Resident #4 would maintain his highest practical quality of life as evidenced by attending activities of choice. The intervention/task stated that the facility would encourage Resident #4 to attend group activities as it appeared Resident #4 enjoyed singing and sports where he could participate passively. The facility would assist to/monitor individual/small group activities which included restorative exercise, watching TV, staff talking and laughing with him. Review of Resident #4's Individual Profile - Nursing Facility, dated 6/18/25 under section 4 titled These are my preferences and what is important to me reflected in part It is important for me to maintain a sense of pride and dignity. Please don't leave me in bed all day, I want to be dressed and out of bed in my chair. I love to be taken to musicals or listening to sing a long and CD's. Sometimes the social workers pull me into their office and turn up the music where I can bounce to the tunes. I can watch TV up until dinner time. I especially like to watch all the action in sport programs. [Resident #4] likes to be out of room on a daily basis. [Resident] #4 enjoys people watch in the hallways or in the lobby of the nursing facility. It is important for [Resident #4] to be around other people. The plan went on to list activities Resident #4 enjoyed: [Resident #4] likes listening to music, instrument sounds, spending time outside, instrumentals, and being around others. Review of Resident #4's Individual Profile - Nursing Facility, dated 6/18/25 under section Communication stated Resident #4 did not communicate verbally, he would follow people with his eyes and watch what was going on, at times he would say ya, most of the time when someone would ask him a question he would not respond, he would show emotion in body language, make gestures and point or look toward things, and yell out. Review of Resident #4's Habilitative Service Plan, dated 6/18/25 reflected that Resident #4 wanted to listen to music, attend musicals when the facility offered them, TV/movies, music videos, music therapy, music exercise group, and go outside. Review of Resident #4's most recent Activity Evaluation, dated 6/24/24, reflected that Resident #4 required reminders/cues, extensive verbal cuing, and could not comprehend instructions. The evaluation indicated that Resident #4 used a wheelchair with max assist. The evaluation also indicated Resident #4 had a</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 07/03/2025
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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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 07/03/2025
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 (Residents #1 and #2) of 5 residents reviewed for quality of care. 1. The facility failed to ensure Resident #1 did not develop wounds on his toes and moisture associated skin damage on his buttocks. 2. The facility failed to ensure Resident #1 and Resident #2 were repositioned every two hours on 6/4/25. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, harm and/or the need for hospitalization and prolonged treatment. Findings included: 1. Review of Resident #1's Annual MDS Assessment, dated 04/08/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. The resident had a supra-pubic catheter (catheter inserted into the bladder to drain urine) a colostomy (bag attached to the abdomen to collect bowel movement that excretes from the stoma), and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it open for breathing). His diagnoses included stroke, kidney failure, diabetes, and quadriplegia (inability to move arms and legs). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. The resident did not have any skin conditions listed. Review of Resident #1's Care Plans reflected: Revised 07/01/24 - Resident had an activities of daily living deficit. Facility interventions: The resident was totally dependent on staff for repositioning and turning in bed. 12/02/24 - Risk for Impaired Skin Integrity Facility interventions: Evaluate skin integrity. Review of Resident #1's Care Plan, last revised 05/20/25 reflected the following focus, goal, and interventions were in place:- Focus: Resident #1 has potential/actual impairment to skin integrity to bilateral buttocks gran 100% tx per MD ORDER 05/03/23. Goal: Resident #1 Skin will remain intact 03/04/25. Interventions: Elevate heels off the bed Involve/educate resident and/or family/designee Monitor for s/s of infection Monitor pain and administer pain medications/treatments as ordered and/or per pain problem- Focus: Wound Management Apply betadine toes qd shift and monitor for sign/symptoms of infection. Apply qd until resolved. right 1st toe 0.75 x 0.5 x nm in cm. Left buttocks clean area with NS. Pat dry with 4x4. Apply house barrier cream twice daily and PRN if soiled until resolved. 0.8 x 0.7 x 0.1cm Right buttocks Left buttocks clean area with NS. Pat dry with 4x4. Apply house barrier cream twice daily and PRN if soiled until resolved. 2.8 x 0.8 x not measurable in CM 06/05/25. Goal: Wound Will Be Free of Signs or Symptoms of Infection Wound Will Show Signs of Improvement 06/05/25. Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown Inform the resident/family/caregivers of any new area of skin breakdown Notify provider if no signs of improvement on current wound regimen Provide wound care per treatment order- Focus: Resident #1 has an ADL Self Care Performance Deficit r/t Quadriplegia on Restorative (having the ability to restore health, strength, or a feeling of well-being.) LOW AIRLOSS MATTRESS/CHECK FOR FUNCTION EVERY SHIFT 05/03/23, revised 05/23/25. Review of Resident #1's BRADEN - Scale for Predicting Pressure Sore Risk completed on 05/04/25 indicated Resident #1 was at a high risk for developing pressure sores. An observation and interview on 06/04/25 at 1:45 PM with Resident #1 revealed CNA A was getting ready to perform incontinence care. The resident was awake, alert, and non-verbal. The resident had a supra-pubic catheter and a colostomy. CNA A washed her hands and put on gloves. The resident was not wearing a brief (for an unknown reason) CNA A cleaned the penis and scrotal area. The resident was rolled to his left side. His buttocks and the back of his thighs were dark red/purple. He had draining wounds on his buttocks that had drained onto the sheets down to the mattress. There was a moderate amount of tan and black drainage. CNA A cleaned the wounds and buttocks. There were 2 open areas, one on each buttock. CNA A said she did not know why there was not a dressing on the wounds. CNA A finished cleaning the buttocks and grabbed a clean brief and placed it under the resident. The resident also had a wound on the tip of both his first toes. The wounds were scabbed and very small. An interview on 06/04/25 at 2:05 PM with the WCN revealed she was not aware of the wounds on Resident #1, and no one had notified her about the wounds. She said she started a skin sweep (skin assessment of residents) in the building to look for skin issues but had not assessed Resident #1. The WCN said staff were supposed to notify her about the wounds. The WCN measured the wounds: Left 1st toe 0.5 cm x 0.2 cm - Stage II Right 1st toe 0.6 cm x 0.5 cm - Stage II Right buttock 1.5 cm x 2.0 cm - Stage III left buttock 2.5 cm x</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 07/03/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #2) of 2 residents reviewed for catheter care. The facility failed to ensure Resident #2 received her Foley catheter change as ordered every month when RN E documented that he changed the Foley catheter on 05/13/25, but he only changed the bag and did not change the catheter. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #2's Annual MDS Assessment, dated 04/24/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. The resident had a Foley catheter (tube to drain urine from the bladder) and was always incontinent of bowel movement. Her diagnoses included stroke, diabetes, non-Alzheimer's disease (form of dementia), neurogenic bladder (refers to what happens when an injury or disease interrupts the electrical signals between your nervous system and bladder function) and obstructive uropathy (blockage that prevents urine from flowing naturally through the urinary system). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. Review of Resident #2's Physician Orders for June 2025 reflected the following: 04/13/25 Foley catheter to be changed monthly and as needed for malfunction every day shift starting on the 13th of every month. Review of Resident #2's Care Plans reflected the following: Revised 10/29/24 - Resident had an indwelling foley catheter that had to be changed monthly and as needed for malfunction. An observation on 06/04/25 at 1:20 PM of incontinence care for Resident #2 by CNA B and CNA D revealed both CNAs washed their hands and put on gloves. CNA D cleaned the peri-area and Foley catheter. CNA D placed a clean brief under the resident and began straightening her sheets. Interviews on 06/04/25 at 12:45 PM and 06/04/25 at 2:20 PM with the family member of Resident #2 revealed the resident was in the hospital in March 2025 and had her Foley catheter changed. She said the Foley catheter had not been changed since March 2025. The family member said she had a camera in her room and never saw staff change the Foley catheter. The family member said she was told by the DON that the Foley catheter was changed in May. She said she spoke with RN E (staff who signed the MAR that he had changed the catheter) who said he did not change the catheter on 05/13/25, just the bag. An interview on 06/05/25 at 11:20 AM with RN E revealed he documented that he changed the Foley catheter on 05/13/25, but he only changed the bag because it was leaking. RN E said he did not change the catheter because it was not dirty. RN E said not changing the Foley catheter could lead to clogging and infection. An interview on 06/05/25 at 11:30 AM with the DON revealed she would have to check the order to see how often the catheter was supposed to be changed for Resident #2. The DON said she did not know the Foley catheter was not changed on 05/13/25. The DON said the family member of Resident #2 asked if it had been changed, but she said she could not tell if had or had not been changed. The DON said failure to change a Foley catheter could lead to infection. Record review of the facility policy, Catheter Care Policy, dated 06/03/25, reflected: Purpose To provide guidelines for the appropriate management, care, and monitoring of urinary catheters to reduce the risk of complications such as urinary tract infections (UTIs), catheter-associated pain, and to ensure that the catheter remains necessary for the patient's care.</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 07/03/2025
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 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 07/03/2025
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 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #3) of three residents reviewed for pharmacy services. The facility failed to administer all physician ordered doses of Rifaximin (medication to treat liver failure) to Resident #3 between 01/09/25 - 01/20/25. The failure could place residents at risk for exacerbation of health conditions, worsening of conditions, and physical/emotional discomfort. An Immediate Jeopardy (IJ) was identified on 06/05/25. Findings demonstrate that the Immediate Jeopardy began on 01/09/25 and was removed on 01/20/25. The noncompliance continued at a Pattern of Potential for More than Minimal harm that is not Immediate jeopardy. Findings included: Record review of Resident #3's quarterly MDS assessment dated [DATE], reflected she was a [AGE] year-old female who admitted on [DATE]. She had a BIMS score of 13, which indicated she was cognitively intact. The resident's diagnoses included a diagnosis of liver cirrhosis (permanent scarring of the liver) and hepatic encephalopathy (happens when your liver is not filtering toxins as it should. These toxins build up in your blood and affect your brain, causing confusion, disorientation, and other changes.) Record review of Resident #3's January 2025 Physician Orders reflected the following: Start Date 01/09/25 Rifaximin Oral Tablet 550 milligrams two times a day for Hepatic Encephalopathy. Record review of Resident #3's January 2025 Medication Administration Record reflected she had not received Rifaximin on the following dates: 01/09/25 4:00 PM - Medication not available from pharmacy - MA H01/10/25 4:00 PM - Medication not available from pharmacy - MA H01/12/25 8:00 AM and 4:00 PM - Medication not available from pharmacy - MA F01/13/25 4:00 PM - Medication not available from pharmacy - MA H01/14/25 8:00 AM and 4:00 PM - Medication not available from pharmacy - MA G01/16/25 4:00 PM - Medication not available from pharmacy - MA H01/17/25 4:00 PM - Medication not available from pharmacy - MA H01/18/25 8:00 AM and 4:00 PM - Medication not available from pharmacy - MA F01/19/25 8:00 AM and 4:00 PM - Medication not available from pharmacy - MA F01/20/25 8:00 AM - MA G and 4:00 PM - Medication not available from pharmacy - MA H Record review of Resident #3's Hospital Records, dated 01/23/25, reflected: The patient was a 60-year-old female with history of cirrhosis came to emergency room after family member had concern for medical management at nursing home. Per family member, patient was newly admitted to this nursing home. She got a call from the nursing home that the patient was found on floor but was doing ok. The family member went to check on the patient and noticed that she had not been getting any meds for three weeks and the patient was confused. An interview on 06/04/25 at 9:45 AM with the family member for Resident #3 revealed the resident was in the hospital and while she was at the facility in January 2025, she missed doses of her medication. The resident admitted to the hospital on [DATE] and discharged on 01/27/25. The resident was sent to a different hospital on [DATE]. An interview on 06/05/25 at 10:30 with RN I revealed she did not remember issues with the Rifaximin order for Resident #3 in January 2025. She said if a medication was not available, then the staff would contact the pharmacy to deliver it. RN I said the physician had to be notified if a medication was not available to give to anyone. n interview on 06/05/25 at 10:35 AM with MA F revealed she did not remember passing medication to Resident #3 in January 2025. She said if she documented that she was waiting on the medication from the pharmacy, then she would have told the nurse. She said she only worked weekend shifts. Interviews were attempted on 06/05/2025 with the Medication Aides who were scheduled: MA H on 06/05/25 at 11:15 AM did not return call of the Surveyor. MA G on 06/05/25 at 11:45 AM when MA G hung up the phone on the Surveyor. An interview on 06/04/25 at 2:30 PM with the Physician who was no longer employed with the facility stated he did not remember Resident #3 and was no longer employed at the facility. He said if he had been notified that the Rifaximin was not available, then he would have ordered a different medicine for the resident. The physician said if the resident did not receive the medication it could result in altered mental status. An interview on 06/04/25 at 11:40 AM with the DON revealed she did not work at the facility in January 2025. Record review of the only facility's policy received and was titled, Documentation of Medication Administration, revised April 2007, reflected the following: Policy Statement The facility shall maintain a medication administration record to document all medications administered. Policy Interpretation and Implementation 1. A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR) 2 Administration of medication must be documented</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 07/03/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 07/03/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1 and Resident #2) of five residents, reviewed for infection control. 1. The facility failed to ensure CNA A performed hand hygiene during incontinence care for Resident #1 on 06/04/25.2. The facility failed to ensure CNA B and CNA D performed hand hygiene during incontinence care for Resident #2 on 06/04/25. This failure placed residents at risk for cross contamination and infections. Findings included: 1. Review of Resident #1's Annual MDS Assessment, dated 04/08/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. The resident had a supra-pubic catheter (catheter inserted into the bladder to drain urine) a colostomy (bag attached to the abdomen to collect bowel movement that excretes from the stoma), and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it open for breathing). His diagnoses included stroke, kidney failure, diabetes, and quadriplegia (inability to move arms and legs). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. Review of Resident #1's Care Plans reflected the following: Revised 01/20/25 - Resident had an activities of daily living deficit. Facility interventions: maximal assistance of one staff for all ADLs. An observation and interview on 06/04/25 at 1:45 PM with Resident #1 revealed CNA A was getting ready to perform incontinence care. The resident was awake, alert, and non-verbal. He had a tracheostomy with a tracheostomy collar (collar to deliver oxygen to the tracheostomy). The resident had a supra-pubic catheter and a colostomy. CNA A washed her hands and put on gloves. The resident was not wearing a brief. CNA A cleaned the penis and scrotal area. The resident was rolled to his left side. His buttocks and the back of his thighs were dark red/purple. He had draining wounds on his buttocks that had drained onto the sheets down to the mattress. There was a moderate amount of tan and black drainage. CNA A cleaned the wounds and buttocks. There were 2 open areas, one on each buttock. CNA A said she did not know why there was not a dressing on the wounds. CNA A finished cleaning the buttocks and grabbed a clean brief and placed it under the resident. CNA A did not change gloves or perform hand hygiene. CNA A said she should have changed gloves and performed hand hygiene after cleansing the resident and before putting on a new brief. CNA A said she did not do it this time, but she should have. She said she did not do it because she was nervous. CNA A said the risk to the residents was contamination. 2. Review of Resident #2's Annual MDS Assessment, dated 04/24/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. The resident had a Foley catheter (tube that drains urine from the bladder) and was always incontinent of bowel movement. Her diagnoses included stroke, diabetes, and non-Alzheimer's disease (form of dementia). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. Review of Resident #2's Care Plans reflected the following: Revised 08/02/24 - Resident had an activities of daily living performance deficit related to contracture to upper/lower extremities, non-verbal, history of stroke and total assist with all ADL's. Facility interventions included: Bed mobility: the resident required total assist by one staff. An observation on 06/04/25 at 1:20 PM of incontinence care for Resident #2 by CNA B and CNA D revealed both CNAs washed their hands and put on gloves. CNA D cleaned the peri-area and changed her gloves but did not perform hand hygiene. CNA D cleaned the buttocks and changed gloves but did not perform hand hygiene. CNA B changed her gloves but did not perform hand hygiene. CNA D placed a clean brief under the resident and began straightening her sheets. The resident did not have any wounds. An interview on 06/04/25 at 1:30 with CNA D who stated she only performed hand hygiene before care and after care but had been trained to perform hand hygiene during the care. She said she did not know why she did not perform hand hygiene for Resident #2, and the risk to the resident was contamination. An interview on 06/04/25 at 1:35 PM with CNA B who stated she had been trained to perform hand hygiene after changing gloves and did not know why she did not for Resident #2. An interview on 06/04/25 at 3:15 PM with the DON who stated she was the Infection Preventionist. The DON said staff were supposed to change their gloves during incontinence care and perform hand hygiene when changing gloves. Record review of the facility</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 07/03/2025
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for one, Resident #1, of five residents reviewed for environmental concerns. The facility failed to ensure Resident #1's room was free of gnats on 06/04/25 which were landing on a cloth near his tracheostomy collar. This failure could place residents at risk of having pests in their rooms and insect bites. Findings included: Review of Resident #1's Annual MDS Assessment, dated 04/08/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive skills for daily decision making were severely impaired. The resident had a supra-pubic catheter (catheter inserted into the bladder to drain urine) a colostomy (bag attached to the abdomen to collect bowel movement that excretes from the stoma), and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it open for breathing). His diagnoses included stroke, kidney failure, diabetes, and quadriplegia (inability to move arms and legs). The resident was dependent on staff for rolling on back to left and right side and return to lying on back on the bed. Review of Resident #1's Care Plans reflected the following: Revised 01/20/25 - Resident had an activities of daily living deficit. Facility interventions: maximal assistance of one staff for all ADLs. An observation and interview on 06/04/25 at 1:45 PM with Resident #1 revealed CNA A was getting ready to perform incontinence care. The resident was awake, alert, and non-verbal. He had a tracheostomy with a tracheostomy collar (collar to deliver oxygen to the tracheostomy). The resident also had a cloth with mucus drainage that was lying on his chest. Gnats were flying around the tracheostomy collar and nebulizer tubing. A cluster of gnats was observed on the cloth and flying around the room. CNA A and LVN C said she did not know why there were gnats in the room and CNA A stated she would notify maintenance. An interview on 06/04/25 at 3:15 PM with the DON who stated she was not aware that Resident #1 had gnats in his room. An interview on 06/05/25 at 11:55 am with the Maintenance Director revealed he was notified on 06/04/25 about the gnats and he cleaned the room of the gnats by washing down the walls and surfaces. He said no one had reported Resident #1 had gnats in his room. Record review of the facility policy, Pest Control, not dated, reflected: Policy Statement Our facility shall maintain an effective pest control program .</p>		