

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/16/2025
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews, the facility failed to protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility for 1 of 1 facility reviewed for communication with privacy. The facility failed to deliver mail to residents on Saturdays. This failure infringes on the residents' rights to receive mail and communications. Findings included: During a confidential resident council meeting, the residents in attendance were asked 26 questions. Question 19 asked residents Is mail delivered unopened and on Saturdays? All 8 residents in attendance answered no to question 19. An interview conducted on 09/16/2025 at 9:45am with the BOM revealed she sorts the mail when it arrives at the facility and then it is delivered to the residents. When asked if residents receive mail on Saturdays, the BOM stated they do not, because there is no one at the facility to sort it before it gets distributed to the residents. The BOM further stated there is a possibility of important documents, like Medicaid documents, that could get passed to the resident and then lost. When asked if there was a risk to the residents not receiving mail on Saturdays, she stated she did not think there was. A facility policy related to mail distribution was requested from the Administrator twice on 09/16/2025 and was not provided.		

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from any physical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms for 6 (Resident #70, Resident # 23, Resident # 39, Resident # 36, Resident #25, Resident #63) of 6 residents reviewed for restraints. The facility failed to ensure Resident #70, Resident #23, Resident #39, Resident #36, Resident #25 and Resident #63 were not inhibited from freedom of movement or activity in the secure unit when facility staff pushed two dining tables together and placed them in front of the single entrance to the dining area, to prevent the residents from leaving the area. This failure places the residents at risk of being restrained without medication indication. Findings Included: Record review of Resident #70's MDS, dated [DATE], revealed he admitted to the facility on [DATE]. Resident #70 had primary diagnoses of non-Alzheimer's dementia, and left side paralysis due to cerebral infarction (blood flow to the brain is interrupted, leading to tissue damage). Record review of Resident #23's MDS, dated [DATE], revealed he admitted to the facility on [DATE]. Resident #23 had primary diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion and cognitive decline) and Type 2 diabetes (condition where the body does not use insulin effectively). Record review of Resident #39's MDS, dated [DATE], revealed she admitted to the facility on [DATE]. Resident #39 had primary diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion and cognitive decline) and orthostatic hypotension (condition where blood pressure drops significantly upon standing or sitting up from a lying position.) Record review of Resident #36's MDS, dated [DATE], revealed she admitted to the facility on [DATE]. Resident #36 had primary diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion and cognitive decline) and hypertension (condition in which the force of blood against the artery walls is consistently high). Record review of Resident #25's MDS, dated [DATE], revealed she admitted to the facility on [DATE]. Resident #25 had primary diagnoses of non-Alzheimer's dementia and hypertension (condition in which the force of blood against the artery walls is consistently high). Record review of Resident #63's MDS, dated [DATE], revealed he admitted to the facility on [DATE]. Resident #63 had primary diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion and cognitive decline) and hyperlipidemia (condition characterized by high levels of fats in the blood). Observation on 09/14/2025 at 9:20am in the secure unit revealed two dining tables pushed together, blocking the single entrance to the dining area. CNA G was sitting in the hall on the outside of the dining area, while Resident #70, Resident #23, Resident #39, Resident #36, Resident #25 and Resident #63 were inside the dining area. CNA H was observed sitting in an office down the hall with line of sight for both hallways in the secure unit. During an interview with CNA G on 09/14/2025 at 09:25am, CNA G was asked why the tables were placed in front of the doorway. CNA G stated it was to keep the residents from wandering. During an interview with CNA H 09/14/2025 at 1:40pm, CNA H was asked why the tables were placed in front of the doorway to the dining room earlier in the day. CNA H stated the tables are there to keep them from wandering while they are trying to get residents to the dining room. She further stated sometimes it takes more than one aide to get a resident ready for breakfast, so the tables keep them from wandering while the aides go back to get another resident. If they (the residents) are mobile, they're more likely to have an incident or accident. During an interview with the DON on 09/15/2025 at 2:30pm, the DON stated she did not know the weekend aides in the secure unit were restraining the residents in the dining area and it was not acceptable for them to do that. The DON identified risks for the residents as detrimental in every way. If the resident has the need to use the bathroom or whatever. The DON further stated the secure unit is secure so the residents can wander freely and be safe in their (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environment. A review of the facility policy titled Identifying Involuntary Seclusion and Unauthorized Restraint revealed the following: Policy Statement: As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify involuntary seclusion and/or unauthorized restraint of residents. 1. Involuntary seclusion is defined as a separation of a resident from other residents or from his or her room or confined to his or her room against the resident's will. 2. Examples of involuntary seclusion include: a. Any attempt to keep a resident confined to a certain area by blocking the exit with furniture or a closed door. 3. Secluding or confining a resident against his or her will is prohibited.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable and in accordance with State and Federal laws, the facility stored all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for two of four medication carts (300 hall nurses cart and 400 hall Medication Aides cart) reviewed for medication storage. 1. The facility failed to ensure Resident #64's unopened liquid Lorazepam 2mg /ml was stored in the refrigerator. 2. The facility failed to ensure an opened vial of insulin Lispro 100unit/1ml was properly labeled before storing in the 300-hall medication cart. 3. The facility failed to ensure a bottle of Assure Prism Control solutions (designed to check assure prism [NAME] meter [glucometer] and assure prism test strips) was not expired. These failures could place residents at risk of compromised medication efficacy, unsafe administration and increased harm to residents. The findings include: 1. Record review of Resident #64's Quarterly MDS Assessment, dated 08/22/2025, reflected a [AGE] year-old female. Resident #61 had a BIMS score of 10, which indicated her cognitive function was moderately impaired. The resident had diagnoses which included Malnutrition, anxiety, depression, Pancytopenia (a condition marked by low levels of all three types of blood cells, white blood cells, and platelets), Cirrhosis of the liver (a chronic liver disease characterized by the formation of scar tissue [fibrosis] that replaces healthy liver tissue). Record review of Resident #64's Comprehensive Care Plan, dated 08/27/2025, reflected the [Name] uses antidepressant medication. Intervention Give antidepressant medications ordered by physicians. Monitor/document side effects and effectiveness. Record review of Resident #64's active Physicians orders, as of 09/15/2025, Lorazepam Intensol Concentrate 2 MG/ML(Lorazepam) Give 0.5 ml by mouth every 4 hours as needed for restlessness/agitation related to Anxiety Disorder, Unspecified for 14 Days Verbal Active 09/07/2025. Lorazepam Intensol Concentrate 2 MG/ML(Lorazepam) Give 0.75 ml by mouth every 4 hours as needed for restlessness/agitation related to Anxiety Disorder, Unspecified for 14 Days Verbal Active 09/07/2025. Lorazepam Intensol Concentrate 2 MG/ML (Lorazepam) Give 1 ml by mouth every 4 hours as needed for restlessness/agitation related To Anxiety Disorder, Unspecified for 14 Days Verbal Active 09/07/2025 . 2. Record review of Resident #11's Quarterly MDS Assessment, dated 07/1/25, reflected Resident #11 was a [AGE] year-old female with a BIMS score of 15, which indicated her cognitive function was intact. The resident had diagnoses which included Anxiety, Depression, Bipolar Disorder, Respiratory Failure. Record review of Resident #11's Comprehensive Care Plan, dated 5/17/24, reflected the Resident was on pain medication therapy opioid narcotics r/t pain and neuropathy. Intervention: Administer analgesic medication as ordered by physician and monitor for side effects adverse. Record review of Resident #11's active Physicians orders, as of 09/15/2025, reflected Lyrica oral capsule 75mg (Pregabalin) give 1 tab by mouth two time a day for pain related to type 2 Diabetes mellitus without complication. Observation on 09/14/25 at 1:42 PM with LVN B on the 300-hallway's medication cart revealed one vial of Insulin Pro 100unit/1ml with no label, Resident #64's Liquid Lorazepam was in the cart (not refrigerated) and Assure Prism Control with an expiration a date of 03/03/2025 and an open date of 06/25/2025. In an interview on 09/14/25 at 1:42 PM with LVN B, she stated she did not realize the Insulin Pro 100unit/ml was missing the patient's label. She also stated she did not realize Resident #64's unopened bottle of Liquid Lorazepam 2mg/ml bottle was required to be stored in the refrigerator. She stated the night shift was responsible for glucometer checks, so she did not realize the Assure prism was expired. She stated having insulin in the medication cart that did not have the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proper label could result in administering insulin to the wrong resident which may result in medication error and hospitalization. LVN B stated the risk to the residents if Liquid Lorazepam was not refrigerated was reduced effectiveness of the medication posing a significant risk of therapeutic failure and causing harm to the residents. She stated using expired Assure Prism control solution for glucometer checks could result in inaccurate readings that would affect how much insulin was administered to the residents and could lead to health complications and be fatal. 3. Observation on 09/15/25 at 1:37 PM with CMA D, on the 400-hallway's medication cart, revealed the medication blister pack for Resident #11's Lyrica 75mg oral capsule (controlled medication used for pain related to type 2 Diabetes mellitus) had one damaged blister, the pill was inside secured with tape. At the time the State Surveyor inspected the medication cart; the count for Resident#11's Lyrica 75mg was documented as 7 pills, the actual number of pills counted in the blister pack was 7 pills which included the taped blister bubble. In an interview on 09/15/25 at 1:42 PM with CMA D, she stated she did not realize Residents #11's Lyrica 75 mg had a damaged blister pack and it was secured with tape. She stated narcotic medications should not be taped and if the blister bubble was damaged, the CMA would notify the nurse so the medication could be destroyed by two nurses. She stated the risk of taping narcotics was not knowing if it was the right medication and possible exposure of the medication to contamination. She stated she was in-serviced on medication storage. An interview on 09/15/2025 at 1:47 PM with LVN G (400 hall nurse) revealed he was not aware or had not been notified Resident #11's Lyrica 75mg had a damaged blister bubble that was taped. He stated the policy on narcotics storage was if a blister bubble was broken the medication was to be wasted witnessed by two nurses. He stated the risk of taping narcotics was it could lead to drug diversion and there was no way to know if the medication in the taped bubble had not been compromised. He stated he was in- serviced on medication labeling storage. An interview on 09/15/2025 at 2:13 PM with the DON revealed all medication which included insulin vials should be labeled. She stated her expectations were the nurses and CMAs did the medication rights before administering any medication. The risk of unlabeled medication to the residents was it made it impossible to complete the medication rights checks, and the wrong medication could be given to the wrong resident. The DON stated the night shift nurse was responsible for doing the glucometer checks. She stated using an expired glucometer control solution to do glucometer checks could result in false FSBS reading. She stated the false FSBS readings would risk residents receiving the wrong dose of insulin that would not be therapeutic could lead to other health complications up to hospitalization. The DON stated no narcotic should not be taped. If a medication bubble was tampered with, medication was to be wasted by two nurses. The risk to the patient included cross contamination. The DON stated it was the responsibility of the nurse and the CMAs to ensure the medication carts were cleaned, and all medications were stored according to professional standards. She stated the staff were in-serviced on medication labeling and storage . Record review of the facility's policy titled Medication Labeling and Storage, revised on 02/2023, reflected: The facility stores all medication and biologicals in locked compartments under proper temperature, humidity, and light controls. Policy Interpretation and Implementation 1. Medication and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. Medication requiring refrigeration are stored located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. 7. Controlled substance (listed as schedule II-IV) of the comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution system in which the quantity stores is minimal and a missing does cane be readily detected. Medication Labeling 1. Labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: Medications name. prescribed name. prescribed dose. Strength. Expiration date, when applicable. Residents name. Route of administration; and Appropriate and precautions. If medication containers are missing, incomplete, improper, or incorrect labels contact the dispensing pharmacy for instructions regarding returning or destroying these items.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 facility kitchens reviewed for kitchen sanitation. The facility failed to ensure food items were properly stored in the facility's freezer. 2. The facility failed to ensure food and drink items were properly labeled. 3. The facility failed to ensure no outdated or spoiled foods were present. These failures could place residents at risk for food-borne illnesses. Findings Included: Observation of the facility's freezer on 09/14/24 at 9:12 AM revealed: - 2 bags of lettuce (each bag contained 6 heads of lettuce) visibly decomposed, brown discoloration, wilted and slimy, with liquid seepage. - 1 box lima beans were open and exposed to the air. - 2 gallon jugs of milk, were opened and were not labeled. - 1 container of instant mashed potatoes was not labeled. In an interview with the Dietary Manager on 9/14/2025, at 2:00 p.m., he stated when food deliveries arrived, staff were expected to inspect the food and had the option to reject items for credit if necessary. He reported that an in-service had been provided on dry storage, freezer management, and inspecting food upon delivery. Record review of the facility policy titled Food Storage: Cold Foods dated 2/2023 reflected the following: All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received services with reasonable accommodations for 2 of 5 residents (Resident #8, and Resident #14) reviewed for call light system access. The facility failed to ensure Resident #8 had access to their call light by allowing it to remain on the floor at the side of the bed, out of the resident's reach. The facility failed to ensure Resident #14 had access to their call light by allowing it to remain between the wall and mattress at the foot of the bed, out of the resident's reach. This failure could place residents at risk for delayed assistance and an inability to request help when needed. 1.) Record review of Resident #8's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility with an original admission date of 09/20/2024 and had severely impaired cognitive function. Diagnoses included: cerebral palsy (a neurological disorder that affects body movement and muscle coordination). Resident #8 was dependent on staff for all self-care tasks such as eating, oral and toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. He was dependent on staff for mobility tasks such as sitting to lying, lying to sitting on side of the bed, sitting to standing, chair/bed-to-chair transfers, and toilet transfers, tub/shower transfers. Record review of Resident #8's Comprehensive Care plan dated 05/15/2025 showed a medical focus: [Resident] has alteration in musculoskeletal status related to Kyphosis (excessive outward curvature of the spine). Goal: [Resident] will remain free from pain or at a level of discomfort acceptable to the resident. Interventions included: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. During an interview and observation on 09/14/2025 at 2:40 PM, Resident #8 was observed in bed. The call light was on the floor, out of the reach of the resident. He said he was not sure why it was there. He said he was unable to reach it. 2) Record review of Resident #14 annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had severely impaired cognitive function. Diagnosis included unspecified dementia (a term used when a person exhibits symptoms of dementia, but the specific type cannot be identified), chronic kidney disease (gradual loss of kidney function over time), Orthostatic hypotension (a condition characterized by a sudden drop in blood pressure when a person stands up after sitting or lying down), muscle weakness, and repeated falls. Record review of Resident #14's Comprehensive Care plan dated 5/23/2025 showed a fall focus: [Resident] is at risk of falls due to (specify: unsteady gait, decreased balance, medications and poor safety awareness). Goal: [Resident] will have no reports of injuries that requires hospitalization or fractures related to falls through next review date. Interventions included: Call light in reach in room and answered promptly. Encourage and remind resident to use call light to ask for assistance. During an interview and observation on 08/24/2025 at 9:30 AM, Resident #14 was observed in bed. Due to cognitive impairment, he was unable to provide reliable information during the interview. The call light cord was observed at the end of the bed, in between the resident's mattress and wall, hanging down toward the floor. During an interview with CNA A on 09/14/2025 at 3:00 PM, in response to the Resident's call light placements, LVN A reported responsibility for ensuring call lights were within reach of residents fell on the CNA's as well as all staff. CNA A said when she left a resident's room, she always placed the call light within reach. She reported rounds were done frequently and as needed since staff were always present in the hallway. CNA A reported the facility call light policy required staff to make sure call lights were within reach, to encourage residents to use them, and, if a call light was not working, to report it immediately and provide an alternative means for the resident to call for assistance. She reported if a call light was not within reach, the risk to residents was they might not be able to communicate their needs or obtain help in a timely manner. She added staff conducted frequent checks to help minimize that risk. During an interview with DON on 09/16/2025 at 10:50 AM, she indicated she was unsure if the facility had a formal policy regarding keeping call lights within (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for two (Resident #20 & #49) of five residents reviewed for environment. The facility failed to maintain the wall air conditioning unit in Residents #20 and #49's room free of dust buildup. This failure could place residents at risk for a diminished quality of life due to the lack of a homelike environment. Findings included: 1.) Record review of Resident #49's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Primary diagnoses included chronic congestive heart failure (a long-term condition where the heart is unable to pump enough blood to meet the body's needs for blood and oxygen), unspecified cirrhosis of the liver and (liver scarring without a clearly identified cause, leading to significant liver damage). Observation and interview on 09/14/2025 at 10:45 AM with Resident #49, he stated his in-room air conditioning wall unit needed to be cleaned. He stated he did not like the air blowing on him because it was so dirty and missing the filter. The wall air conditioning unit was observed with significant dust and debris buildup on the coils and interior components. Rust was observed along the metal frame, and the blower area contained visible accumulation of dust. A filter was not present in the unit at the time of observation. Record review of Resident #20's annual MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE] and had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Primary diagnoses included unspecified convulsions (episodes of involuntary muscle contractions and spasms that do not have a specific diagnosis or underlying cause). Observation and interview on 09/14/2025 at 10:55 AM with Resident #20, he stated he did not have any issues at this time. He said at times the cover of the unit would come off. Observation of the unit was observed with significant amounts of dust and debris on the coils. The unit had a clean filter; however, half of a broken filter covered in dust was also inside the filter slot. During an interview on 09/15/2025, at 10:00 AM, maintenance director reported air conditioning unit filters had been inspected and cleaned as needed, typically when a unit was not cooling or heating properly. He stated housekeeping was responsible for removing and cleaning filters, while maintenance pulled entire units from the wall for deeper cleaning when necessary. He stated there was no log in place to track filter changes or unit service. He stated that since starting in February, he had been trying to catch up on overdue work and was working to re-implement a preventive maintenance program that had lapsed under prior ownership due to unpaid accounts and supply cutoffs. When inspecting units, he looked for issues such as loose cords, intact screens and covers, and whether the unit was properly secured in the wall, noting that covers were frequently damaged by residents bumping into them. He reported receiving no training related to infection control or air quality risks and stated that the filters used were not specified by type or replacement schedule. If a unit was missing a filter or had heavy buildup, maintenance would remove the unit from the wall to wash it. He recalled only one recent complaint, from a resident, which turned out to be operator error due to the heat setting. maintenance director confirmed that the facility did not currently follow a preventive maintenance schedule but was in the process of reinstating one. 2.) Record review of Resident #73's Face Sheet, dated 09/16/25, reflected he was a [AGE] year-old male who originally admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and need for assistance with personal (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 Gibbins Rd Arlington, TX 76011	
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care (when an individual needs assistance with every day tasks). Record review of Resident #73's MDS Assessment, dated 09/07/25, reflected he had a BIMS score of 14, indicating he was cognitively intact. Observation of Resident #73's room on 09/14/25 at 10:35AM revealed there were several pieces of brown vinyl plank missing from the flooring, exposing the white tile underneath. During an interview with Resident #73 on 09/14/25 at 11:45AM, he stated the vinyl plank from the floor of his room had been missing for a couple of weeks. He said maintenance was supposed to be working on this issue; he was not sure what the timeframe would be, but he wanted the flooring repaired. During an interview with the Maintenance Director on 09/15/25 at 10:09AM, he stated he was not aware of the missing vinyl plank from the flooring of Resident #73's room. He stated he felt as though this must have occurred within the past couple of weeks, as he had been in Resident #73's room two weeks ago to fix his call light and did not note any issues with the flooring. The Maintenance Director stated the risk of the vinyl plank flooring being missing was the potential for an environment that was not homelike. 3.) During an observation and walk through of the secure unit on 09/14/2025 at 9:30am, the sink and vanity unit in the bathroom of room [ROOM NUMBER] were observed to be on the floor. The unit and sink were broken apart, with broken cabinet pieces on the floor, and two screws were observed to be sticking up. Additionally, the rough edges of the cabinet were exposed. room [ROOM NUMBER] is not used by residents, and the room was empty. The door to the room and the bathroom were both observed to be closed. An interview with CNA H on 09/14/2025 at 9:40am revealed she did not know the sink was broken in the bathroom. CNA H was asked if it was possible a resident could wander into the room, and she said it was unlikely because they always have a CNA posted in the corner office, and the aide can see both halls and the entrance to the unit, and it is so close to room [ROOM NUMBER]. During an interview and observation with the administrator on 09/14/2025 at 2:30pm, the administrator was shown the broken sink in room [ROOM NUMBER]. The administrator revealed he did not know the sink was broken and immediately called the maintenance director to remove the vanity and sink. An observation of room [ROOM NUMBER] on 09/15/2025 at 9:30am revealed the broken sink and vanity had been removed, and there no longer appeared to be a potential hazard for a resident. During an interview with CNA I on 09/15/2025 at 9:45am, CNA I was asked if she knew the sink and vanity were broken in room [ROOM NUMBER]. CNA I stated she did not know it was broken and was unaware there was a potential hazard in the bathroom. CNA I further stated they usually have 3 aides on shift, and one is always placed in the corner office with a view of both hallways, which included room [ROOM NUMBER]. CNA I stated she has not ever seen a resident try to go into room [ROOM NUMBER]. During an interview with the maintenance director on 09/15/2025 at 10:15am, the maintenance director revealed he did not know the sink and vanity in room [ROOM NUMBER] were broken and was informed of it the previous afternoon. He reported he had done rounds on the unit; he was not sure when or how the sink broke. The maintenance director was asked if there was a risk to residents and he stated yes and no. He further stated he doesn't think there is because he knows staff are always monitoring the hallway and staff are right there, but if a resident were to wander into that room unnoticed, then there would be a risk for injury. During observations of the secure unit between 09/14/205 to 09/16/205, an aide was always observed to be in the corner office watching both halls. No residents were observed entering or trying to enter room [ROOM NUMBER] over this same period. Record review of the facility's policy titled, Quality of Life - Homelike Environment, revised August 2009, reflected, Residents are provided with a safe, clean, comfortable, and homelike environment .The facility staff and management shall, maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order .		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on interviews and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for one (Resident #55) of five residents reviewed for PASRR services. The facility failed to ensure Resident #55 was properly screened for PASRR services. This failure could place residents at risk of not receiving specialized PASRR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: Record review of Resident #55's quarterly MDS Assessment, dated 06/13/25, revealed a [AGE] year-old-female admitted to the facility on [DATE] and had severe cognitive impairment. Diagnoses included Major Depressive Disorder, Recurrent, Moderate (severe, persistent sadness and loss of interest that interferes with daily life). Record review of Resident #55's Comprehensive Care plan dated 08/30/2025 showed a mental health focus: [Resident] has mood problem. Goal: [Resident] will have improved mood state (Specify: happier, calmer, appearance, no symptoms of depression, anxiety or sadness) through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Antidepressant Medication Focus: [Resident] uses antidepressant medication Lexapro (antidepressant medication used to treat certain mental health conditions by balancing serotonin levels in the brain). Goal: [Resident] will be free from discomfort or adverse reactions related to antidepressant therapy through the next review date. Interventions: Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. An interview on 09/16/25 at 11:46 AM with MDS Nurse, she reported she was responsible for entering PASRR information. The MDS Nurse reported the PASRR Level 1 for Resident #55 was received from a hospital upon admission to the facility and was documented as it was. The MDS Nurse reported the resident did not receive an updated evaluation based on his diagnosis and she did not receive a PASRR Level 2 screening. The MDS Nurse stated the resident was at risk of not receiving PASRR services. On 09/17/2025 at 3:18 PM, the Administrator reported the facility did not have a policy for resident PASRR process.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one (Resident #72) of five residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #72. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services. Findings included: Review of Resident #72's Face Sheet, dated 09/16/25, reflected she was a [AGE] year-old female who originally admitted to the facility on [DATE], with diagnoses including schizoaffective disorder, bipolar type (a condition in which a person can experience several days of extreme highs as well as severe lows); chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body); and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids). Review of Resident #72's electronic medical records on 09/15/25 reflected a baseline care plan had been initiated by RN J following Resident #72's admission, but the baseline care plan was never completed. During an interview with the DON on 09/15/25 at 2:28PM, she stated the admitting nurse was responsible for completing the baseline care plan for newly admitted residents. The DON stated the risk of a newly admitted resident not having a baseline care plan completed was the potential for the resident to not have a plan of care. During an interview with RN J on 09/15/25 at 2:55PM, he stated baseline care plans were required to be completed within 48 hours of a resident's admission. He stated he initiated Resident #72's baseline care plan for another nurse (who was the admitting nurse for the resident), but he could not recall whom. He stated the other nurse should have completed the baseline care plan. RN J stated the risk of a newly admitted resident not having a baseline care plan completed was the potential for staff to overlook something within that resident's plan of care. Review of the facility's Care Plans - Baseline policy, dated 03/2022, reflected, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 2 of 5 residents (Resident's #49 and #61) reviewed for ADL care. The facility failed to provide Residents #49, and #61 with showers based on their weekly shower/bathing schedule. This failure could place residents at risk of not receiving the care they require to maintain their highest practical well-being, and could result in low self-esteem, anxiety, embarrassment, and a decline in their quality of life. Findings include: 1) Record review of Resident #49's annual MDS dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #49 had intact cognitive functioning, meaning they were alert, oriented, able to understand and process information, make decisions, and communicate their needs appropriately. Resident #49's primary diagnoses included chronic congestive heart failure (a long-term condition where the heart is unable to pump enough blood to meet the body's needs for blood and oxygen) and unspecified cirrhosis of the liver and (liver scarring without a clearly identified cause, leading to significant liver damage). The resident was fully dependent on staff for shower/bathing and personal hygiene. Record review of Resident #49's Comprehensive Care Plan dated 05/22/2025, reflected an ADL self-care performance deficit. The plan stated Resident #49 required ADL self-care performance assistance. Record review of facility shower documentation dated September 2025 reflected Resident #49's shower/bath days were Tuesdays, Thursdays, and Saturdays. The shower/bathing documents between 09/01/2025 and 09/16/2025 reflected he was bathed/showered on 09/09/2025. The documentation reflected he did not receive a shower/bath on 09/02/2025, 09/04/2025, 09/06/2025, 09/11/2025, and 09/13/2025. Record review of Resident #49's progress notes dated between 09/01/2025 and 09/15/2025 reflected the resident did not have any documented shower/bathing refusals. During an observation and interview on 09/14/2025 at 10:45 AM with Resident #49, revealed he appeared well-groomed. He stated he typically would only get a bed bath twice a week and last week he only had one. He stated he could not recall getting any baths this week. He stated he was not given a reason why he did not get one. He stated he would prefer to have his baths as scheduled. 2) Record review of Resident #61's annual MDS assessment dated [DATE], reflected a [AGE] year-old female who was admitted to the facility on [DATE] and had moderate cognitive impairment. Primary diagnoses which included unspecified dementia (a term used when a person exhibits symptoms of dementia, but the specific type cannot be identified), hypertension (high blood pressure), and Hyperlipidemia (too much fat [like cholesterol or triglycerides] in the blood, which can raise the risk of heart disease and stroke). The resident required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently). The resident was independent for personal hygiene tasks. Record review of Resident #61's Comprehensive Care Plan dated 06/30/2025, reflected an ADL self-care performance deficit. The plan stated Resident #49 required ADL self-care performance assistance. The plan stated the residents preferred showers at least 3 times a week. Record review of the facility shower documentation dated September 2025 reflected Resident #61's shower/bath days were Tuesdays, Thursdays, and Saturdays. The shower/bathing documents reflected between 09/01/2025 and 09/16/2025 she had not been bathed or showered during those dates. Record review of Resident #61's progress notes dated between 09/01/2025 and 09/15/2025 reflected the resident did not have any documented shower/bathing refusals. During an observation and interview on 09/14/2025 at 11:00 AM with Resident #61, she appeared well-groomed. She stated everything was going fine except the facility kept forgetting to give her showers. She stated she could not remember when her last shower was but that it was over a week ago. During an interview on 09/16/2025 at 11:00 AM with CNA E, he stated he was (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for the care of Resident #61. He stated residents received three showers or baths per week, and to, his knowledge, the schedule was being followed. He stated after providing a resident shower or bath, staff would document it on the shower sheet in the shower binder, and if a resident refused a bath or shower, the refusal was documented in the residents' electronic chart under progress notes. He stated there were no challenges in preventing him from giving residents' showers or baths. He stated the only reason a resident might not receive one was due to refusal. During an interview on 09/16/2025 at 10:00 AM with CNA F, he stated completed showers were documented on the shower sheet and residents were supposed to be given three showers per week. He reported no challenges in providing baths or showers and reported if a shower was not given, he would notify the nurse. He stated if a resident refused a shower, he would tell the nurse about the refusal. During an interview on 09/16/2025 at 11:50 AM with the DON, she stated residents were scheduled to receive three showers or baths per week and refusals were documented in the residents' electronic record under progress notes. She reported once a shower was provided, the CNA's completed a shower sheet, and one would also be completed for refusals. She reported she was not made aware of any residents not receiving showers or baths. She identified risks of missed showers or baths as potential physical issues leading to infection as well as impacts on residents' mental well-being. Record review of the facility's policy titled Bath, Shower/Tub, dated February 2018 reflected: Staff should document date/time the shower shower/tub bath was performed, individual who assisted the resident, how the resident tolerated the shower/tub bath, and if the resident refused the shower/tub bath and the reason. Staff are to notify the supervisor if the resident refuses the shower/tub bath and report other information in accordance with facility policy and professional standards of practice.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #17) of 5 residents reviewed for accidents and supervision. The facility failed to prevent Resident #17 from cleaning his fingernails with a rusted nail. This failure could place the resident at risk of injury or infection. Findings Include: Record review of Resident #17's MDS, dated [DATE], revealed a male resident who was admitted to the facility on [DATE]. Resident #17 had a BIMS score was 11, which indicated a moderate cognitive impairment. Resident #17's primary diagnosis which included acute and chronic respiratory failure with hypoxia (a sudden onset of severely low blood oxygen levels). Resident #17 had additional diagnoses which included chronic obstructive pulmonary disease (chronic inflammation and narrowing of airways making it difficult to breathe), peripheral vascular disease (a condition that affects the blood vessels in the extremities) and Type 2 diabetes (a condition where the body does not use insulin properly). Record review of Resident #17's Comprehensive Care Plan revealed the following: Focus: Risk for Wandering/Elopement Identified (date initiated: 08/13/2025) Goal: The resident will not leave facility unattended (date initiated: 08/13/2025 target date: 09/11/2025) The resident's safety will be maintained (date initiated: 08/13/2025 target date: 09/11/2025) Interventions/Tasks: Clearly identify Resident's room and bathroom (date initiated: 08/13/2025) Engage Resident in purposeful activity (date initiated: 08/13/2025) Provide care in a calm and reassuring manner (date initiated: 08/13/2025) Provide clear, simple instructions (date initiated: 08/13/2025) Observation of Resident #17 on 09/15/2025 at 11:15 AM revealed Resident #17 sitting outside in a central, secure courtyard by himself. Resident #17 was observed cleaning his fingernails with what appeared to be a rusted nail. Resident #17 stated he was using a nail to clean his nails. Resident #17 refused to state from where he obtained the nail and stated, I'm as tough as this nail, leave me to my business. Interview with LPN A on 09/15/2025 at 11:22 AM revealed LPN A approached the resident and saw the nail on the windowsill. LPN A stated she asked Resident #17 where he got the nail, and he refused to give her an answer. LPN A stated she asked Resident #17 if he would prefer to use a nail file or something else to clean his nails, he refused. LPN A stated she asked Resident #17 if he would like a CNA to help him clean his fingernails and he refused. LPN A reported she would speak with social services to make sure Resident #17 was on the list to see podiatry during their next visit to the facility. LPN stated there was a risk of injury and resident safety if the resident cleaned his nails with a rusty nail. During an interview with the DON on 09/15/2025 at 2:35 PM, the DON stated she spoke with Resident #17 about using a nail to clean his fingernails and educated the resident that this was not an appropriate device to clean his fingernails. The DON stated the risks for the resident could be infection, tetanus, or another resident could get the nail. The DON stated there were many different scenarios for risk. Record review of the facility's policy titled, Quality of Life - Homelike Environment, revised August 2009, reflected, Residents are provided with a safe, clean, comfortable, and homelike environment. The facility staff and management shall, maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review 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 2 of 6 residents (Resident #6, Resident#64) reviewed for infection control. 1.The facility failed to ensure CMA C sanitized the blood pressure cuffs to prevent the spread of infections. 2.LVN B failed to don PPE prior to performing high contact resident care activities on Resident #6 who was on enhanced barrier precaution. These failures could place residents at risk for healthcare associated cross contamination and infections. Findings include: 1. Record review of Resident #6's Quarterly MDS Assessment, dated 08/6/25, reflected a [AGE] year-old female. Resident #6 had a BIMs score of 15, which indicated she had no cognitive issues. The resident had diagnoses which included Ulcerative Colitis, Crohn's disease (an inflammatory bowel disease that causes chronic inflammation of the GI tract, which extends from your stomach all the way down to your anus), viral hepatitis C (an inflammation of the liver caused by the hepatitis C virus), Fistula of intestine (an abnormal tunnel or opening that forms between the intestine and another organ or the skin, allowing digestive fluids to leak out), borderline personality disorder . Record review of Resident #6's Comprehensive Care Plan, dated 08/20/25, reflected the potential/actual impairment to skin integrity interventions included: Monitor for s/s of infection. Record review of Resident #6 Physicians orders, dated 5/20/2025, reflected: Enhanced barriers precaution every shift for preventative measure related to Cellulitis of abdominal was non-pressure chronic ulcer of skin other sites with unspecified severity. An observation on 09/14/2025 at 10:30 AM revealed CMA C checked Resident #4's Blood Pressure. CMA C did not sanitize the blood pressure cuff placed it in the cart before going to administer medication on another resident. An interview on 09/14/25 at 10:36 AM revealed CMA C knew she was supposed to sanitize the blood pressure cuff after use with each resident. She stated she did not have the sanitizing wipes, but she was going to ask the central supply for some wipes. She stated the failure to sanitize the blood pressure cuffs could put the residents at risk for infection and contamination of other items in the medication cart. 2. Record review of Resident #4's Quarterly MDS Assessment, dated 07/27/25, reflected was a [AGE] year-old female. Resident #4 had a BIMs score of 14, which indicated she had cognitive function was intact. The resident had diagnoses which included Hypertension, Peripheral Vascular disease, malnutrition, and Asthma. Record review of Resident #4's Comprehensive Care Plan, dated 08/27/2025, reflected the potential for elevated B/P r/t HTN. Interventions: Monitor/ document abnormalities for urinary output. Report significant changes to the MD. Record review of Resident #4's active Physicians orders, as of 09/15/1025, reflected Amlodipine Besylate Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN Prescriber Written Active 06/23/2025 start date 06/24/2025. An observation on 09/14/25 at 11:30 AM revealed Resident #6's had Enhance Barrier Precaution signage outside her room, and the cart set up with PPE. LVN B entered the residents' room, LVN B did not perform hand hygiene before donning clean gloves. LVN B cleaned Resident #6's abdominal wound then stopped to medicate Resident #6 with pain medication before continuing with wound care. LVN B did not don PPE when cleaning the wound. An interview on 09/14/25 at 1:32 PM revealed LVN B knew Resident #6 was on enhanced barrier precaution, and she should have donned PPE before cleaning Resident#6's abdominal wound. She stated failure to use PPE could put the resident at risk for infection. She stated she was in-serviced on enhanced barrier precautions. An interview on 09/15/25 at 2:39 PM with DON revealed her expectation that the staff should use appropriate PPE while providing high contact care to residents on enhanced barrier precautions. She stated the blood pressure cuffs should be sanitized after use on each resident. She stated the failure to sanitize the blood pressure cuff after each use, and the failure to use enhanced barrier precautions for residents who were on EBP would be the risk (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 09/16/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of MDOR infection. She stated the staff were in-serviced on infection control and Enhance Barrier Precautions. Record review of the facility's policy titled Cleaning and Disinfections of Residents-care Items and Equipment, dated September 2022, reflected: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA blood borne pathogens standard. Non-critical items and those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include bed pans, blood pressure cuffs, crutches, and computers. Non-critical items require cleaning followed by either low or intermediate level disinfections following manufacturer's instructions. Disinfections are performed with an EPA-registered disinfectant labeled for use in healthcare settings. Reusable items are cleaned / disinfected and/or sterilized between uses by a single resident (e.g., stethoscopes, durable medical equipment). Record review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, reflected: Enhanced Barrier Precautions Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 1.EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 2. Examples of high-contact resident care activities Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splashes or spray. 3.Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include: Dressing. Bathing/showering. Transferring. Providing hygiene. Changing lines. Changing briefs or assisting with toileting. Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing). EBP's are indicated (when contact precaution do not otherwise apply) for resident with wounds and/or indwelling devices regardless of MDRO colonization. Staff are trained prior to caring for residents on EBP's. Signs are posted in the door or wall outside the resident room indicating the type of precaution and PPE required. PPE is available outside of the resident rooms .		