

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

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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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Viridian Wellness & Rehabilitation		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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a discharge summary that included but was not limited to a recapitulation of the resident's stay that includes, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results, a final summary of the resident's status, and reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) for one of (Resident #59) of two residents reviewed for discharge. The facility failed to complete a discharge summary and a reconciliation of medications for Resident #59 when he planned discharge home on [DATE]. This failure could place residents at risk of a recapitulation of the stay being unavailable to help ensure continuity of care once they went back home and/or discharged from the facility. Record review of Resident #59's admission face sheet, dated 06/25/2025, reflected an [AGE] year-old male admitted [DATE]. Resident #59's active diagnoses included Spondylosis (degenerative changes in the spine such as bone spurs and degenerating intervertebral discs between the vertebrae), Alpers Disease (a rare, progressive mitochondrial disorder that primarily affects the brain, liver, and muscles, leading to seizures, liver failure, and cognitive decline), Protein Calorie Malnutrition (a serious condition resulting from insufficient intake of protein and calories), Myopathy (a group of diseases that primarily affect the muscles connected to bones that allow voluntary movement), and Hyperlipidemia (an excess of lipids or fats in your blood). Record review of Resident #59's Quarterly MDS assessment, dated 04/03/2026, reflected he was admitted from a Short-Term General hospital on [DATE]. and a BIMS score of 15, which indicated intact cognition. Record review of Resident #59's Nursing Progress Note, dated 05/24/2026, reflected, The resident discharged home with family members. Record review of Resident #59 Clinical Records reflected a progress note summary of discharge, but no Discharge Summary was in the chart. In an interview with the DON on 07/09/2026 at 12:40 PM, she acknowledged that discharge summaries should be completed for each resident that discharges from the facility. She stated that there was not a Discharge Summary for Resident #59. The DON stated when a resident is discharged, a discharge summary is necessary to make sure everything is in place for resident and services such as home health was set up, DME is ordered, and resident could meet with PCP within 7-14 days and prevent a lapse of continuity of care. In an interview with the SW on 07/09/2026 at 12:55 PM, she acknowledged that discharge summaries should be completed for each resident that discharges from the facility. She stated that there was not a Discharge Summary for Resident #59. The SW stated without a Discharge Summary, the discharged residents would not be able to meet with the staff to discuss their reconciliation of medications and their discharge plans, such as home health and care responsibilities. She stated that if a resident did not have a Discharge Summary, there was potential for there being a gap with follow-up appointments (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for medical needs. The SW stated that if there was not a Discharge Summary for discharged residents, they would miss the opportunity for any continuous care and appointments. Record review of the facility's policy titled, Transfer and Discharge, dated ??, reflected, IX. Communication with the Receiving ProviderA. To facilitate a smooth transition of care, the Facility will provide a copy of the following information to the receiving entity, as applicable:i. Contact information for the practitioner responsible for the care of the resident;ii. Resident representative information, including contact information;iii. Advance Directive information;iv. Special instructions or precautions for ongoing care, as appropriate;v. Comprehensive care plan goals; andvi. Other necessary information, including a copy of the resident's Discharge Summary, as applicable.B. This information will be provided to the receiving provider as close to the time of transfer as is practicable.XIV. DocumentationA. When the Facility anticipates a resident's discharge to a lower level of care (e.g., private residence, group home or board or care or assisted living) or to another nursing care facility, the Interdisciplinary Team (IDT), with the assistance of the resident and his/herpersonal representative, will develop a Discharge Summary and Post-Discharge Plan to assist the resident to adjust to his or her new living environment.i. Appropriate IDT members will educate the resident or his/her personal representative regarding the Discharge Plan issues and will assist the resident with discharge plans.B. The Director of Social Services or his or her designee will assist in determining:i. The resident's and/or personal representative's preferences for care;ii. Financial issues involving the post-discharge plan of care;iii. Coordination of care between various caregivers and agencies;iv. Identification of post-discharge needs (e.g., personal care, dressings, rehabilitation services, home health care, durable medical equipment);v. Follow-up medical care and appointments; andvi. Preparation needed by the resident and/or family/responsible party for discharge.Prior to discharging the resident, the Facility will prepare a Discharge Summary and will document the summary in the resident's medical record. At a minimum, the Discharge Summary will contain a summary of the resident's status, including a description of the resident's:i. Medically defined condition(s) and prior medical history;ii. Medical status measurement (objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests);iii. Physical, mental, psychosocial functional status, including but not limited to, the resident's:a. Ability to perform activities of daily living including, bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems;b. Need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; andc. Ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in day-to-day activities; andd. Attitude toward life, behavior, mood and ability to set goals;iv. Sensory and physical impairments, including neurological, or muscular deficits, e.g. a decrease in vision and hearing, paralysis, and bladder incontinence;v. Nutritional status and requirements;vi. Special treatments or procedures;vii. Discharge potential;viii. Dental condition;ix. Ability to participate in activities;x. Rehabilitation potential;xi. Cognitive status; andxii. Drug therapy, including all prescription and over-the counter medications taken by the resident with information on dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident.I. The resident or his/her personal representative will be provided with a copy of the Discharge Care Plan and Discharge Summary.[K		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #4) reviewed for comprehensive care plans. The facility failed to ensure Resident #4's comprehensive care plans addressed their goals, needs, strengths, medical, nursing, mental, and psychosocial needs. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings included: Record review of Resident #4's MDS assessment, dated 04/08/26, reflected a [AGE] year-old female, admitted [DATE] and re-admitted on [DATE]. The resident's diagnoses included: hemiplegia (complete or severe paralysis) and hemiparesis (moderate muscle weakness), hypertension (high blood pressure), aphasia (a neurological language disorder that impairs a person's ability to speak, understand, read, and write, though it does not affect intelligence or memory), muscle wasting and atrophy (involve the shrinking and weakening of muscle tissue due to injury, disease, or prolonged inactivity) and muscle weakness and dysphasia (difficulty or discomfort in swallowing food or liquids). Record review of Resident #4's Physicians Order Summary dated 07/09/26, reflected an order indicating nothing by mouth related to dysphagia. Record review of Resident #4's comprehensive care plan printed 07/09/26 and signed (dated), reflected the comprehensive care plan did not address the g-tube and contractures. Record review of Resident #4's significant change in status MDS assessment, dated 04/08/26, did not include the BIMS score, as staff selected 0, which indicated the resident was never or rarely understood. The staff assessment indicated the Resident had short and long-term memory problems and was severely cognitively impaired. The resident had feeding tube (e.g., nasogastric or abdominal (peg). Observation on 07/07/26 at 9:56 am of Resident #4 revealed she was contracted to the upper and lower extremities. She had a g-tube and it was on continuous feeding. Observations of Resident #4 on 07/07/26 and 07/08/26 between 10 am and 2pm revealed the resident did not have leg booths on while she was in bed. The booths were in the room in a plastic bag. In an interview on 07/09/2026 at 10:11 AM with CNA E she stated the resident was non-verbal. She stated Resident #4 required total assistance with activities of daily living. CNA E stated Resident #4 had contractures to her hands and legs. CNA E stated the resident used boots and therapy was responsible for putting them on and taking them off. CNA E stated there was no CNA care plan indicating the resident's contractures. In an interview on 07/09/2026 at 10:31 with LVN F revealed she was the nurse for Resident #4. LVN F said Resident #4 was non-verbal with wounds and contractures. LVN F stated therapy applied boots on the resident for about 2 hours, and she was not sure what they used on her hands. LVN F reviewed the clinical records and stated the resident did not have a care plan for the contractures and the G-tube. LVN F stated the resident was supposed to have the care plan and the ADONs or DON were responsible to make sure the care plans were completed. LVN F stated the resident not having a care plan and the staff would miss care that was required for the resident. In an interview on 07/09/2026 at 10:44 AM with the DOR she stated the resident was in therapy, and services were offered three times weekly. She stated therapy offered passive range of motions to the resident. The DOR stated physical therapy staff applied booths to the lower extremities as tolerated by the resident. The DOR stated she was not aware what nursing was doing regarding the contractures. She stated (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occupational therapy completed the passive range of motions for the resident. She stated therapy was not involved in making sure the care plan was completed. In an interview on 07/09/2026 at 12:42 PM with the DON she stated she had been in the facility for three months. Resident #4 was non-verbal and required total assistance with activities of daily living. The DON said Resident #4 was being treated for wounds. The DON said Resident #4 had contractures and a G-tube, and she was on continuous feeding. The DON reviewed the clinical records and acknowledged the resident did not have the care plans for the G-tube and contractures. She stated there was no reason why the resident did not have the care plan for the two areas. The DON stated the MDS coordinator was responsible for completing the care plan and reviewing the care plan to make sure the areas that were triggered in the MDS were care planned. The DON stated the care plan was required to be completed to guide in the resident's care. In an interview on 07/09/2026 at 1:47 PM, the MDS Coordinator stated she had worked in the facility since November 2025. She stated she was responsible for completing the care plans. She stated she was aware Resident #4 had a G-tube and had contractures to the upper and lower extremities. The MDS Coordinator stated the MDS completed in April the resident triggered for G-tube, and she could not give a reason why she did not complete the care plan for the G-tube and contractures. The MDS Coordinator stated the resident required a care plan to show what care that was to be provided to the resident. The MDS Coordinator said not having the care plan put the resident at risk of not being provided with the care that was required. Record review of the facility policy, revised 06/2020 and dated ??, titled, Care Planning, reflected, Purpose, to ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. ii. The care plan serves as a course of action where the resident, resident family/ or a guardian or other legally authorized representative), resident attending Physician and IDT work to help the resident move toward resident - specific goals that addresses the residents medical, nursing, medical and psychological needs.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 (Resident #4) of 5 residents reviewed for mobility. - The facility failed to make sure Resident #4 had heel protectors pressure relief boots on while she was in bed on 07/07/26 and 07/08/26. This failure could place residents at risk for complications that may be related to decreased ROM and/or mobility may include, pain, skin integrity issues, and decreased muscle strength and atrophy. Findings included Record review of Resident #4's MDS assessment dated [DATE], reflected a [AGE] year-old female, originally admitted to the facility on [DATE] and then re-admitted on [DATE]. The resident diagnoses included: hemiplegia (complete or severe paralysis) and hemiparesis (moderate muscle weakness), hypertension (high blood pressure), aphasia (a neurological language disorder that impairs a person's ability to speak, understand, read, and write, though it does not affect intelligence or memory), muscle wasting and atrophy (involve the shrinking and weakening of muscle tissue due to injury, disease, or prolonged inactivity) and muscle weakness and dysphasia (difficulty or discomfort in swallowing food or liquids) Record Review of Resident #4's Order Summary dated 04/27/26, reflected an order that stated resident to have bilateral heel protection pressure relief boots on at all times while in bed every shift for wound care management. Record Review of Resident #4's comprehensive care plan printed 07/09/26, reflected the comprehensive care plan did not address the use of bilateral heel protection pressure relief boots. Record review of Resident #4's significant change in status MDS assessment dated [DATE]. The Resident's MDS assessment did not include the BIMS score, as staff selected 0, which indicated the resident was never or rarely understood, which directed the assessment to skip to the staff assessment for mental status. The staff assessment indicated the Resident had short and long-term memory problems and was severely cognitively impaired. Observation on 07/07/26 at 9:56 am of Resident #4 revealed she was contracted to the upper and lower extremities. Observations of Resident #4 on 07/07/26 and 07/08/26 between 10 am and 2pm revealed the resident did not have leg boots on while she was in bed. The boots were in the room in a plastic bag. Observation on 07/08/26 at 10:43 am during wound care revealed the resident had contractures to bilateral lower extremity and had wounds to the left heel and left lateral thigh. In an interview on 07/09/2026 at 10:11 AM with CNA E she stated the resident was non-verbal. She required total assistance with activities of daily living. CNA E stated the resident used boots and therapy were the ones to apply the boots and take them off. CNA E stated the boots were to be used to prevent skin breakdown or the wounds from getting worse and for contractures. In an interview on 07/09/2026 at 10:31 with LVN F revealed she was the nurse of the resident. The resident was non-verbal, she had wounds and contractures. LVN F stated therapy applied boots on the resident for about 2 hours. LVN F stated she had not applied the boots or checked to make sure they were on. She stated the resident used boots to prevent skin breakdown, and the resident had a wound to the heel to prevent it from getting worse and to prevent the contractures from worsening. In an interview on 07/09/2026 at 10:44 AM with DOR she stated the resident was in therapy and services were offered three times weekly. She stated therapy offered passive range of motions to the resident. DOR stated physical therapy staff applied boots to the lower extremities per tolerated by the resident. Regarding the resident's order, she stated she was not aware of the order because it was initiated by the nursing department. The DOR stated the boots (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to be used to prevent the skin breakdown and due to the contractures to the bilateral lower extremities. In an interview on 07/09/2026 at 12:42 PM with the DON she stated she had been in the facility for three months. Resident #4 was non-verbal and required total assistance with activities of daily living. The resident was being treated for wounds, she had contractures. Regarding the resident's use of boots after reviewing the orders, she stated the resident was to have boots on while she was in bed The DON stated the boots were to be used to prevent skin breakdown and the resident had wounds, to prevent the wounds from getting worse and from the contractures getting worse. Record review of the facility policy, undated and titled, Contracture - Prevention reflected, Purpose. To prevent the onset and/or worsening of contractures for residents, ensuring quality care and maximizing mobility and function. The Facility will implement proactive, individualized interventions to prevent the development of contractures and to minimize the progression of existing contractures in residents. These interventions will be based on assessments, interdisciplinary planning, and ongoing monitoring to ensure effectiveness and compliance. A. The Interdisciplinary Team (IDT) will develop a Care Plan to prevent and/or minimize contracture. The Care Plan will include but not be limited to the following interventions, as indicated: . iv. Splints and support devices as appropriate.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one (Treatment Cart #1) of one treatment cart reviewed for medication storage and supplies. The facility failed to ensure Treatment Cart #1 was locked when unattended on 07/07/26. This failure could place residents at risk of having access to unauthorized medications and supplies and lead to possible harm. Findings included: In an observation on 07/07/26 at 09:55 AM, Treatment Cart #1 was observed unlocked and unattended, against the wall on the 400 hall. All drawers were unlocked, and there were bandages, gauze and prescription creams on the cart. The treatment cart was unattended for at least 15 minutes. SS #17 opened the drawers and captured photos of items inside of the cart to be a prescribed ammonium lac lot 12% (topical medication used to deeply hydrate and exfoliate dry, scaly skin and rough, bumpy conditions), adhesive remover spray, antimicrobial skin care wound gel, collagenase Santyl ointment (prescription medication used to clean away dead tissue from chronic skin ulcers and severe burns), gauze, healing ointment, iodine, Thera honey gel (a medical-grade wound dressing containing 100% sterile Manuka honey (special type of honey made by bees in New Zealand and Australia)), moisture barrier ointment, saline and wound care solution. There were no Residents near Treatment Cart #1, however, there were residents on the hall and no visible staff nearby the treatment cart. In an observation and interview on 07/07/26 at 10:10 AM, revealed the ADON pushing Treatment Cart #1 down the hall. The ADON stated she was in a resident's room treating a wound. The ADON stated Treatment Cart #1 was not in view while she was in the resident's room. The ADON stated she should have locked Treatment Cart #1 when she left it unattended to provide care. In an interview on 07/07/26 at 11:40 AM, the ADON stated Treatment Cart #1 was to always be locked except when she was retrieving items or returning items to the cart. The ADON stated it was her responsibility to ensure the treatment cart was locked and secured. The ADON stated she must take all needed supplies into the room and lock the treatment cart. The ADON stated she noticed the treatment cart was unlocked when she exited the room. In an interview on 07/07/26 at 2:15 PM, the DON stated her expectation was for the treatment cart to be locked when the ADON was providing care. The DON stated the treatment cart should be locked at all times even if the ADON was just stepping away and out of sight for a few seconds. The DON stated that the ADON told her that she failed to lock Treatment Cart #1. The DON stated she expected staff to take proper steps and follow procedures when they provided treatment. The DON stated staff should never leave medications nor supplies unattended and ensure the treatment cart was secured at all times. The DON stated the ADON should have made sure Treatment Cart #1 was locked and if not, the ADON should have never left Treatment Cart #1 out of her sight. The DON stated, You never knew when a resident may attempt to gain access to the cart. The DON stated there was potential for a resident to have accessed the treatment cart and sustained adverse effects by digesting, ingesting, or developing a rash and having to be sent out to the hospital. The DON stated she was responsible for monitoring the ADON. In an interview on 07/07/26 at 2:45 PM, the ADON stated the DON completed a one-on-one in-service with her on keeping the cart locked when unattended. The ADON stated she would take more time and triple check everything. The ADON stated the risk of an unlocked treatment cart was a confused resident could open the cart and digest or ingest something dangerous and become harmed or ill. Record review of the facility's policy titled, Medication Storage, with a revised date of 1/2026, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected the following: Procedure: This policy applies to all licensed nurses, medication aides (where permitted), pharmacy staff, providers, and facility leadership.II. Security & Access1. Medication rooms, carts, and cabinets must remain locked at all times.2. Access is restricted to authorized, licensed staff.3. Medication carts must be locked whenever they are not actively attended.III. Medication Cart Locking Requirements1. The medication cart must be locked under the following conditions:-When entering a resident's room (if the cart remains in the hallway)-When interrupted (e.g., phone calls, staff questions, emergencies)-When turning away from the cart-When more than arm's reach from the cart .		