STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675930	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbrook Plaza	401 W Arbrook Blvd Arlington, TX 76014

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations of abuse were reported to Health and Human for one (Resident #1) of 12 residents reviewed for abuse and neglect reporting. The facility failed to report an allegation of abuse when a grievance was filed by a family member on behalf of Resident #1 on 04/04/24 that a staff member (identity unknown) yelled at the resident, told her to go back to sleep, and called her stupid. This failure could place residents at risk of being abused or neglected and lack of oversight by a state agency. Findings included: Review of Resident #1's face sheet reflected a [AGE] year-old female, admitted on [DATE], and having diagnoses of dementia, cardiac pacemaker, insomnia, and an anxiety disorder. A family member was her responsible party. Review of Resident #1's Quarterly MDS assessment, dated 06/14/24, reflected she was rarely able to understand others, or be understood by others, and had long and short-term memory problems, and severely impaired decision-making ability. The document indicated no problems with sleeping. Resident #1 used a wheelchair, and was able to eat with set-up assistance, but required substantial/ maximal assistance (helper does more than half of the effort) with toileting, bathing, dressing, and hygiene. She was always incontinent of bowel and bladder. Review of Resident #1's care plans, dated 03/23/22, reflected care plans for antidepressant medication, falls, communication problems, impaired visual function, ADL self-care performance deficits, and incontinence. Review of Resident #1's care plan, dated 09/14/22, reflected she was on melatonin (a supplement to help with sleep) therapy, secondary to inability to fall asleep. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility Grievance/Complaint Report form, dated 04/04/24, reflected a grievance received by the ADON for Resident #1, from Resident #1's family member. The hand-written document reflected, Nurse Aide came into the resident's room at 3AM, yelled at the resident to go back to sleep, and called her stupid. The form reflected that the Aide was terminated/disciplined. The grievance was noted to be resolved by the RP (family member) requested to have video monitoring in the room. The document reflected that the resident and/or representative were notified in writing and with a phone conversation. The document was signed by the Social Worker. An interview on 06/28/24 at 11:22 AM with the Administrator revealed her looking at the grievance form for Resident #1. She said the family did not report abuse, they reported a customer service violation, and it did not rise to the level of abuse and did not need to be reported. She said it was very poor customer service, the family and resident did not feel it was abuse, and they terminated the staff member. An interview on 06/28/24 at 12:10 PM with CNA D revealed verbal abuse would be things like yelling or raising your voice to a resident or calling someone names. She said calling someone stupid would definitely be abuse. An interview on 06/28/24 at 12:13 PM with CNA E revealed verbal abuse would be raising your voice, calling bad names, or cussing at a resident, and that calling a resident stupid would be abuse. An interview on 06/28/24 at 12:15 PM with LVN C revealed it would be considered verbal abuse if someone yelled or said profanity at a resident or called the resident names. She said calling a resident stupid would be abuse. An interview on 06/28/24 at 12:20 PM with CNA F revealed verbal abuse would be when someone talked bad to a resident. She said talking bad to them would be things like yelling, telling the resident you were not going to take care of them, or calling them bad names. She said calling them stupid would be abusive. An observation and interview on 06/28/24 at 12:36 PM with Resident #1 revealed her to be in her room, rolling herself in her wheelchair. She was neatly dressed, and said she was doing very well. When asked how the staff treated her, she said Oh, they are lovely! When asked if anyone had ever treated her badly, she said I don't think so. An interview on 06/28/24 at 2:22 PM with the DON revealed she thought a grievance in which a staff member allegedly yelled or called someone stupid would be reported. She said any allegation would be reported to the Administrator, and it would be investigated further. She said she only vaguely remembered the grievance, and that the family member and the resident were interviewed, and the staff member suspended. She said it did not take away from the fact it was abuse if the resident did not feel abused. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/28/24 at 3:11 PM with the Administrator revealed yelling or name calling in some situations would constitute abuse. She said it would depend on factors like tone, and loudness. She said it was presented by the family member as a customer service issue, and that the staff member had been rude. She said she did not remember who the terminated staff member was and would have to contact their Human Resources person and send the information later. She said it was important to report allegations of abuse, because residents had a right to live in their homes free from issues of mistreatment. She maintained that the circumstances in the grievance were not abuse. Review of a typed statement dated 07/01/24, and signed by the Administrator, reflected the Administrator had interviewed the ADON about the 04/04/24 grievance, and the information on the grievance was not what the ADON had written. The statement reflected that the ADON had not been able to identify a staff member, and the family member had only said that the aide told the resident to go back to bed. She stated the ADON did an in-service on 04/04/24 regarding staff speaking professionally and with a clear voice and being respectful at all times. The statement reflected that the Social Worker said the family member told her about the information on the grievance, and that she was the one who documented that the staff member was terminated, because she thought that was the conclusion, but that was an error. The Administrator's statement reflected that the termination of a staff member documented by the Social Worker was incorrect, as no staff member had been identified, and that the Social Worker had misunderstood and combined two grievances. Review of a typed statement, dated 07/01/24, and signed by the ADON reflected the ADON had found a note slipped under her door to call the family member of Resident #1, and when she did the family member informed her that a staff member had told Resident #1 to go back to sleep in a loud tone. The family member was not able to tell the ADON a time or date, or identity of the staff member, so the ADON informed the family member that she would do a general in-service on proper tone of voice and the family member thanked her and had no further questions. Review of a typed statement, dated 07/01/24, and signed by the Social Worker, reflected she had documented that the employee had been terminated in error on the 04/04/24 grievance, and this conclusion had been made in error, because she misunderstood the issue. Review of the Abuse Prevention Program policy, Revised December 2016, reflected: Policy Statement: Our residents have the right to be free from abuse, (.). This includes but is not limited to freedom from (.) involuntary seclusion, verbal, mental, sexual or physical abuse (.). Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: I. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff; other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. (.) J . Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. (.) 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements;

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 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 of three (Resident #2) residents reviewed for pharmacy services. The facility failed to ensure that documentation of narcotic medications signed out on the narcotic count sheet were consistent with documentation of narcotic medications administered to Resident #2 as reflected on his MAR. Narcotic count sheets for Resident #2 one showed more doses of oxycodone signed out on Resident #2's narcotic count sheet than what was documented as administered on his MAR on 05/16/24, 05/28/24, and 05/30/24. These failures could place residents at risk for medication errors, potentially leading to overdose of narcotic pain medications, or diversion of narcotic pain medications. Findings included: Review of Resident #2's Admission Record, dated 06/28/24, reflected he was a [AGE] year-old made, admitted to the facility on [DATE], with diagnoses of infection of his right knee prosthesis, arthritis, legal blindness, and muscle spasms. The document reflected Resident #2's discharge to the hospital on 06/03/24. Review of Resident #2's 05/18/24 Admission MDS reflected a BIMS score of zero. Resident #2 was able to understand others and to be understood by others. He had verbal behavioral symptoms directed toward others every day of the seven-day lookback period, which did significantly interfere with his care. The MDS reflected Resident #2's one-sided impairment of both upper and lower extremities, and that he used a wheelchair. Resident #2 received scheduled pain medications, non-pharmaceutical interventions for pain, and received PRN pain medications or was offered and declined them. Resident #2's MDS pain assessment indicated he frequently experienced pain, which had frequently limited his participation in rehab therapy. His pain occasionally interfered with his sleep and limited his day-to-day activities. He rated his pain over the past five days of the assessment period as a seven out of ten. Resident #2 had a knee replacement which had an infection or inflammatory reaction at the location of the prosthesis. Review of Resident #2's MAR for May of 24 reflected the following: - oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl)-Give 1 tablet by mouth every 4 hours as needed for pain -Start Date- 05/15/24 [9:45 AM] -D/C Date- 06/19/24 [1:01 PM] The document reflected the resident was administered the following: -05/16/24- Oxycodone was administered to Resident #2 twice, at 8:47 AM, and 12:49 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-05/28/24- Oxycodone was administered to Resident #2 four times, at 3:15 AM, 8:49 AM, 12:44 PM, and 4:22 PM. -05/30/24- Oxycodone was administered to Resident #2 three times, at 7:00 AM, 11:00 AM, and 3:40 PM. Review of Resident #2's Narcotic Record (count sheet) for 10 MG oxycodone HCl tablets for 05/14/24 through 05/17/24 reflected the following: -05/16/24- one tablet was signed out five times, at each of the following times: 12:00 AM, 4:00 AM, 8:47 AM, 12:49 PM, and 4:XX PM (X numbers are illegible.) Review of Resident #2's Narcotic Record (count sheet) for 10 MG oxycodone HCl tablets for 05/18/24 through 06/01/24 reflected the following: -05/28/24- one tablet was signed out five times, at each of the following times: 3:20 AM, 8:45 AM, 12:45 PM, 4:00 PM, and 9:00 PM. -05/30/24- one tablet was signed out five times, at each of the following times: 2:12 AM, 7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM. An interview on 06/27/24 at 3:57 PM with LVN A revealed it was standard practice to document in both the EMR and on the narcotic count sheet. The narcotic sheet was filled out when the pill was dispensed, so the time on the electronic MAR might not match up exactly, but that was the live time (the medication was administered.) She said they documented in two places because the count sheet was where the amount of medication removed by the staff member was tracked. She said it was important to document in the electronic MAR as well, because if the resident asked for pain medication, and the nurse only checked the electronic clinical record for the last time it was given, before providing the medication, the resident could end up getting too much narcotic. She said Resident #2 was very hard and demanding about his medications, and other care, and often would say he wanted one thing, and when you went to give it to him, he would want another. She felt the documentation in the MAR was probably just overlooked at the time due to the staff having to deal with his behavior. An interview on 05/28/24 at 11:00 AM with RN B revealed the procedure for controlled medications was to document the quantity dispensed, and date and time and signature. She said they also documented in the MAR and the progress notes. She said the narcotic count sheet was for keeping track of how much of the controlled substance was given. She said if it was not documented in the MAR that the medication was given, they would need to follow up to see why the medication was not given, or it would be a medication error. She said it was important to document in both places, to keep track of the medication, and so nobody overdosed on their narcotics. An interview on 05/28/24 at 11:15 AM with LVN C revealed it was important to document in both the MAR, and on the narcotic count sheet, because if someone only looked in the MAR to see what a resident had been given and a dose was not documented there, they could accidentally give them an overdose of the medications, and the narcotic count sheet was where they kept track of how much medication had been removed from the bottle. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/28/24 at 2:22 PM with the DON revealed they went by the five rights of medication administration (right patient, drug, time, dose, and route) and she expected staff to correctly document the medications. She said narcotic pain medications should be documented in the MAR, and signed off on the log, because not doing so could cause possible problems. She said not documenting could throw off the medication count, and cause medication errors. She said in the worst case, they would have to look into possible drug diversion. Review of the facility policy for Controlled Substances, dated 2001, revised December 2012, reflected instructions for the receipt and dispensing of controlled medications, including the narcotic count sheets, but did not address documentation in the electronic MAR. Review of the facility policy for Charting and Documentation, dated 2001, revised July 2017, reflected: Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. (.) Policy Interpretation and Implementation: 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: (.)b. Medications administered; (.)