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	01/23/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44970 Based on observation, interviews, and record reviews, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 10 (main dining room) of 25 residents served in the facility only resident dining room reviewed for environmental conditions. The facility staff failed to ensure on 01/23/25 the dining room trash was covered with a lid, and the vacuum cleaner was clean and stored away from residents that were dining for lunch. This failure could place residents at risk of living in an unsafe, unsanitary, and uncomfortable environment. The findings included: Observations on 01/23/25 from 12:30 p.m. to 1:00 p.m., of the facility dining room revealed the following: -The housekeeping vacuum cleaner (blue/black) was observed with gray cotton type particles and brown powder in placed behind 4 residents waiting to be served lunch. - The dining room trashcan was not covered with the lid on the south wall behind 3 residents waiting to be served lunch. In an interview on 01/23/25 at 3:05 PM., the HSKS stated housekeeping staff were responsible for cleaning the dining room after each meal and ensuring the lids were covering all trashcans. She stated the vacuum cleaner should have been stored immediately after using to locked housekeeping supply closet. HSKS said the failure could result in residents being exposed to bacteria, unsanitary dining, and potential illnesses from cross contamination. The HSKS said she would in-service all housekeeping staff on following sanitation for a safe and clean environment, immediate storage of vacuum equipment, and ensuring the trash cans were covered with a lid. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/23/25 at 3:05 PM., the ADMIN stated the expectation for the facility to be clean, and sanitary, at all times, with tightly covered trash containers and the vacuum stored appropriately. The ADMIN stated if facility staff observed unsanitary concerns, she expected them to report the issue, so it could be corrected. The ADMIN stated staff would be in-serviced on facility cleanliness, dining room sanitation, and proper storage of equipment. The ADMIN stated that the trash left uncovered and vacuum cleaner placed in the dining room was unsanitary. Record review of the facility's policy entitled Sanitation ., revised in December of 2008, read in part: 'The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects .Sanitizing of environmental surfaces must be performed with one of the following solutions: Kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers and shall be disposed of daily.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one (Residents #44) of three residents reviewed for parenteral fluids. The facility failed to ensure on 01/23/25 that Resident #44 received IV hydration per parental fluids professional standards by labeling and dating the solution at the time of administration. This failure placed the residents at risk for infections, wrong dose, and clinical monitoring of doses. Findings included: Review of Resident 44's face sheet dated 01/23/25 reflected he was a [AGE] year-old male that was admitted on [DATE]. The residents DX included: Kidney Failure, Chronic Pain, Cyst (cyst is a sac-like pocket of membranous tissue that contains fluid,) on Kidney, Type 2 Diabetes mellitus (Type 2 diabetes is a condition that causes high blood sugar), Anemia (Anemia is a blood disorder that occurs when the body doesn't have enough healthy red blood cells or hemoglobin, which carries oxygen throughout the body) Unspecified, Hyperlipidemia (Hyperlipidemia is a medical condition where there are abnormally high levels of lipids, or fats, in the blood.), and he was being treated for hydration via IV from low BP on 01/23/25. Review of Resident #44's quarterly MDS dated [DATE] reflected he had a BIMS score of 06, indicating he was severely impaired cognitively. His functional abilities reflected he required set up and clean up assistance for eating. Substantial assistance for toileting, bathing, dressing, and oral hygiene. He receives anticoagulant (helps to keep away blood clots) hypoglycemic (low blood sugar insulin) and diuretic (helps kidneys to make more urine). Review of Resident #44's care plan dated 01/01/25 reflected CHF (a progressive heart disease) interventions .Check breath sounds and document labored breathing, encourage nutrition He has an ADL self-care performance .He was resistive to care r/t Dementia (memory loss) deficit in memory, poor judgement, poor decision making, and poor thought process. He has mood problems AEB: trouble falling asleep, Disease process CHF, chronic pain renal insufficiency r/t kidney disease intervention monitor labs, vital signs, diet, intake, changes in electrolytes and report to MD. Review of Resident #44's MD orders dated 01/23/25 normal saline flush, intravenous solution 0.9%. monitor BP every 4 hours for X 3 days. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's dated 01/23/25 at 3:28 PM by LVN M reflected Resident alert with general weakness, Low BP, notified ISNP received orders from KUB (kidney (The kidneys are two bean-shaped organs found on the left and right sides of the body.), ureter (the ureters are tubes made of smooth muscle fibers that propel urine from the kidneys to the urinary bladder.), Bladder .A kidney, ureter, and bladder (KUB) study is an X-ray study that allows your doctor to assess the organs of your urinary and gastrointestinal systems) CBC, CMP, CXR, 2-V flu test, UA with C&S, NS 0.9 @ 75ml 1 liter N. Saline (mixture of sodium chloride. Salt water) started @ 75 ml/hr. UA (examines the visual, chemical, and microscopic properties of urine.) collected CXR and KUB completed by neighborhood x-rays. Observation on 01/23/24 at 12:10 PM revealed Resident #44 lying in bed asleep, with the IV-line fluids connected to an IV with fluids infusing. The resident's line was on his left arm and the dressing was in place undated and saline solution bag was not dated. Resident # 44 was not interviewed as he was asleep. Interview on 01/23/25 at 2:41 PM with LVN M revealed she received the order to administer the fluid today by ISNP. LVN M said she forgot to label the bag and dressing with name, date, order amount, and time. LVN M said she administered the IV, after receiving orders from MD. LVN M also said the risks of not labeling the saline bag communicates to other clinical staff the contents of the bag, dose for monitoring solution, and informs all nursing and clinical staff of the resident's name, prescriber, person administering, time administered, and correct dose. Interview on 01/23/25 at 3:37 PM with the DON revealed IV lines are administered and dispensed with clinically guided protocol. She stated that the bag would need to be labeled after 24 hours. She stated the clinical staff can check the MAR for date, dose, time, and MD. Then she stated the resident name and date should be labeled by the nurse on the bag initially then more detailed after 72 hours to monitor by shift. Review of the facility's undated policy titled Intravenous Administration of Fluids and Electrolytes . date of revision April 2009. the purpose of this procedure is to provide guidelines for the safe and aseptic administration of intravenous fluids and electrolytes for hydration. The following information should be recorded in the resident's medical record: The date and time the infusion was administered. The type of solution administered. The amount of solution administered. The route of administration. The rate of administration. The condition of the IV site before and after administration. Notification of the physician if there are any complications. Report other information in accordance with facility policy and professional standards of practice. Quote from resident stating how they tolerated the procedure. The signature and title of the person recording the data.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Residents #16 and Resident #27) of eight residents reviewed for Respiratory Care. 1. The facility failed to ensure on 01/23/25 that Resident #16's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored in a bag and labeled when not in use. 2. The facility failed to ensure on 01/23/25 that Resident #27's breathing mask used for nebulization was stored in a bag and labeled when not in use. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Review of Resident #16's Face Sheet, dated 01/23/25, reflected that the resident was a [AGE] year-old male admitted on [DATE]. Resident #16 was diagnosed with metabolic encephalopathy (a brain disorder that occurs when there's an imbalance of chemicals in the blood. This imbalance can be caused by an illness or organ failure.) Review of Resident #16's Quarterly MDS Assessment, dated 04/13/2024, reflected Resident #16 was cognitively intact with a BIMS score of 15. Resident #16's Quarterly MDS Assessment indicated that the resident had COPD . Review of Resident #16's Comprehensive Care Plan, dated 08/02/2024, reflected Resident #16 had oxygen therapy related to COPD and one of the interventions was oxygen therapy continuous. Review of Resident #16's Physician Order dated 01/15/25 O2: change and label water humidification and NC tubing weekly on Sunday and on 2-10 shift, every evening shift every Sunday. Observation and interview with Resident #16 on 01/23/25 at 12:15 PM revealed the resident's NC tubing unbagged wrapped around the portable oxygen container. In an interview with Resident #16 on 01/23/25 at 12:15 PM, he stated that he uses the portable oxygen when he was out of bed and transported to medical appointments. He stated that he used the oxygen yesterday. He stated that the oxygen concentrator and NC tubing was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's Face Sheet, dated 01/24/25, reflected that resident was a [AGE] year-old female admitted on initially on 06/30/20 and 01/08/25. Resident #27's was diagnosed with Acute respiratory failure with hypercapnia, (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection), Chronic obstructive pulmonary disease, unspecified. (Is a progressive lung disease that makes it difficult to breathe. It's caused by damage to the lungs that leads to inflammation and swelling in the airways. This inflammation narrows the airways, making it harder to move air in and out of the lungs.) Review of Resident #27's entry MDS, dated [DATE], reflecting admission. Review of Resident #27's baseline Care Plan dated 01/08/25 reflected O2 by NC 4L no care plan for oxygen therapy. Review of Resident #27's Physician Order (PO), dated 01/12/25, reflected Change and label Nebulizer Mask and tubing every week on Sunday on 2-10 shift. PO dated 01/12/25 reflected Change and label water humidification and NC tubing every week on Sunday on 2-10 shift. Order dated 01/08/25 reflected O2: O2 at 4L/minute via NC continuously. at change and label water humidification and NC tubing weekly on Sunday. Observation and interview with Resident #27 on 01/23/25 at 12:00 PM revealed that Resident #27 was lying in her bed, awake. It was observed that she had a nasal cannula tubing and water bottle was not dated. The nebulizer machine and tubing were sitting a chair next to the bed in a bag with the mask and tubing hanging out touching the chair cushion and floor. She said she last used the nebulizer machine and tubing last night 01/23/25. She said she did not remember when the NC tubing and water was changed. In an interview with RN L on 01/23/25 at 2:13 PM, RN L said she did not observe the NBM in the resident visitor chair with tubing hanging out of bag and touching the chair seat and floor, neither did she observe Resident #27's concentrator water bottled, and NC tubing were not dated during her resident rounds. RN L said she did not observe Resident #16's NC tubing coiled around the portable oxygen tank not dated and bagged when not in use. RN L stated the NBM and NC should not be exposed nor touching anything because it could cause cross contamination and infection. RN L said the NBM/NC should be bagged when not in use. In an interview with the ADON on 01/23/25 at 3:01 PM, the ADON stated the breathing mask, and the nasal cannula should be bagged when the resident was not using it to prevent cross contamination and infection. She said the staff were responsible for taking off nebulizer mask should be bagged and labeled, and the NC and water bottle should be labeled. She said that the resident could not move independently to place mask on the chair. She said the expectation was for the staff to bag the breathing mask and the nasal cannula when not in use. She said she would coordinate with the DON to conduct an in-service pertaining to bagging the nasal cannula and the breathing mask when the residents were not using them. She said she would also make a round to check if the breathing masks and nasal cannula not in used were bagged. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 01/23/25 at 3:37 PM, the DON stated the breathing mask, and the nasal cannula should be bagged when not in use to keep it clean. The DON said the proper way of storing the breathing mask and the nasal cannula was to place them inside the plastic bag when the resident was done with the breathing treatment or when the resident was not using the nasal cannula. She said if those breathing apparatus were not bagged, they were exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said the staff, were responsible for monitoring the nebulizer mask and the nasal cannula to ensure they were bagged when not in use. She said the expectation was the breathing mask and the nasal cannula would be stored properly, NC labeled when administered by the nurse. In an interview with the ADMIN on 01/23/25 at 3:43 PM, the ADMIN stated she expects all resident devices (nebulizer, NC, water bottle) ordered by MD used should be stored properly according to professional clinical standards and procedures to prevent cross contamination and potential infections. The ADMIN said she would coordinate with the DON for further monitoring and training. Review of facility policy Oxygen Administration revised March 2004 revealed the purpose of this procedure is to provide guidelines for safe oxygen administration. After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: The date and time that the procedure was performed . the policy did not address tubing storage for safe, sanitary, and clean storage when not in use.