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	05/08/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews 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 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 8 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7 and Resident #8 and Resident# 9) of 9 residents reviewed.The facility failed to update each resident person-centered comprehensive care plan to reflect the need for EBP. This failure could place residents at risk of infection.Findings included:Record review of Resident #1's face sheet, dated [DATE] reflected he was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. He was diagnosed with epilepsy, unspecified not intractable without status epilepticus (a neurological disorder characterized by recurrent, unprovoked seizures), unspecified fracture of the right femur, subsequent encounter for closed fracture with routine healing(healing normally without complications), unspecified Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a progressive cognitive disorder characterized by a decline in intellectual abilities sufficient to interfere with social or occupational functioning, affecting memory, judgement, attention, language and ither executive functions. Record review of Resident #1 ?s order summary dated [DATE], revealed no active order for EBP.Record review of Resident #1's care plan undated, revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] at reflected, Resident#1 had incision with staples (stitch together tissues following an injury or surgical procedure) Record review of Resident #2's face sheet, dated [DATE] reflected she was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with cerebral [NAME] unspecified. (group of nonprogressive neurological disorders that affect movement, posture, and coordination).Record review of Resident #2 order summary dated [DATE] revealed no active order for EBP.Record review of Resident #2's care plan undated revealed no notation of EBP. Record review of EBP list provided by Administrator on [DATE] at reflected, Resident#2 had a G-Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine). Record review of Resident #3's face sheet, dated [DATE] reflected he was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE] and diagnosed with presence of urogenital implant s (surgically placed devices in the urinary or reproductive system).Record review of Resident #3's Order summary dated [DATE] revealed no active order for EBP.Record review of Resident #3's care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] reflected, Resident#3 had a dialysis port (a surgically created access point, such as a catheter, fistula, or graft, that allows blood to flow to and from a dialysis machine for kidney replacement therapy). Record review of Resident #4's face sheet, dated [DATE] reflected she was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. She was diagnosed with Epilepsy, unspecified, intractable with status epilepticus (a neurological disorder characterized by recurrent, unprovoked seizures).Record review (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #4's Order summary dated [DATE] revealed no active order for EBP.Record review of Resident #4's care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] at reflected, Resident#4 had a dialysis port (a surgically created access point, such as a catheter, fistula, or graft, that allows blood to flow to and from a dialysis machine for kidney replacement therapy). Record review of Resident #5's face sheet, dated [DATE] reflected he was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. He was diagnosed with unspecified Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a progressive cognitive disorder characterized by a decline in intellectual abilities sufficient to interfere with social or occupational functioning, affecting memory, judgement, attention, language and ither executive functions. Record review of Resident #5's order summary dated [DATE] revealed no active order for EBP.Record review of Resident # 5's care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] at reflected, Resident#5 had a G-Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine). Record review of Resident #6's face sheet, dated [DATE] reflected she was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. She was diagnosed with Type 2 Diabetes Mellitus with diabetic neuropathy, unspecified (common complication characterized by nerve damage due to prolonged high blood sugar levels)Record review of Resident #6's order summary dated [DATE] revealed no active order for EBP.Record review of Resident #6 care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] reflected, Resident #6 had a dialysis port (a surgically created access point, such as a catheter, fistula, or graft, that allows blood to flow to and from a dialysis machine for kidney replacement therapy).Record review of Resident #7's face sheet, dated [DATE] reflected she was a [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. She was diagnosed with dependence of renal dialysis (refers to the condition where an individual requires ongoing dialysis treatment due to compromised kidney function, rendering them incapable of effectively filtering waste products from their blood).Record review of the Resident #7 Order summary dated [DATE] revealed no active order for EBP.Record review of Resident #7 care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] reflected, Resident#7 had dialysis port (surgically created access point that allows blood to flow from a dialysis machine for kidney replacement therapy.) Record review of Resident #8's face sheet, dated [DATE] reflected he was a -year-old male who was admitted on [DATE]. He was diagnosed with pressure ulcer of sacral region stage 3 (full-thickness skin loss extending into the subcutaneous tissue, often with granulation tissue and rolled wound edges, requiring specialized wound care and pressure management) and gastrostomy status (surgically placed G-tube providing direct access to the stomach for nutrition, hydration, or medication).Record review of Resident #8 order summary dated [DATE] revealed no active order for EBP.Record review of Resident #8 the care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] reflected, Resident #8 had G-Tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine). and foley (medical device that helps drain urine from your bladder Record review of Resident #9's face sheet, dated [DATE] reflected he was an [AGE] year-old male who was initially admitted on [DATE] and readmitted [DATE].Resident #9 was diagnosed with gastrostomy status (indicated that a person has a surgically created opening into the stomach, typically for a feeding tube (G-tube), to provide nutrition, fluids, or medications when oral intake is insufficient). Record review of Resident #9 order summary dated [DATE] revealed no active order for EBP.Record review of Resident #9 care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on [DATE] at reflected, Resident#9 had G-tube (surgically placed device used to give direct access to the stomach for supplemental feeding, hydration or medicine) and wound. During an observation on [DATE] that started at 11:26 AM, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident#1's, Resident #2's, Resident #3's, Resident #4's, Resident #5's, Resident #6's's's, Resident #7, Resident #8 and Resident #9's rooms were observed for EBP signs.Surveyor attempted to interview Resident#1 at 11:30 Am, Resident #1 was not able to answer questions about care plan. During an interview on [DATE] at 12:15 PM, the Medical Director stated most facilities have standing orders for EBP. The Medical Director stated care plan helps the staff to provide care for the residents.During an interview on [DATE] at 1:40 PM, the MDS nurse stated when the nurse determined what necessary care that the residents need would go into the care plan. The MDS nurse stated he is responsible for updating the care plan on initial admission, quarterly and annually. The MDS Nurse stated nursing would update care plan throughout resident stay as well. The MDS nurse stated the care plans were patient specific for each resident.During an interview on [DATE] at 2:30 PM, ADON D stated staff used to put in orders for EBP. ADON D stated care plans were updated to address residents' needs. ADON D stated MDS nurse was responsible for updating care plans.During an interview on [DATE] at 3:00 PM, the DON stated corporate stated residents did not have to have specific orders and care planned for EBP. The EBP list provided was the current residents on EBP. The DON stated care plans let nurses know what care residents need. The DON stated the entire nursing staff are responsible for care plan updated.During an interview over the phone on [DATE] at 3:25 PM, the Nurse Consultant stated CMS updated policy and procedures for EBP on [DATE], stated the facility did not have to specific orders for EBP. During an interview on [DATE] at 3:35 PM, ADON E stated that IDT meetings would address concern for residents and add to care plan. ADON E stated care plans were a way to communicate and know everything that went on with a resident.Record review of CMS ref:QSO-24-08-NH, titled EXPIRED: Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO) dated [DATE] reflected, expired on [DATE]. Source was found on website qso-24-08-nh-expired-2025-04-28.pdfRecord review of facility titled care plan, dated reflected An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The facility will ensure the resident has the right to participate in the development and implementation of his or person -centered plan of care.5. Care planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: a, when there has been a significant change in the resident's condition b. when the desired outcome is not met; C. When the resident has been readmitted to the facility from hospital stay, .

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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 infection for 1 (Resident #1) of 2 residents reviewed for infection control.The facility failed on 05/08/26 to ensure infection control procedures were followed when CNA A and RA B provided perineal care to Resident #1, who was on enhanced barrier precautions, without donning appropriate PPE. This failure could place residents at risk of infection.Findings included:Record review of the Nursing Home Infection Preventionist Training course (web-based) certificate, revealed LVN C completed training on 05/20/2021.Record review of Resident #1's face sheet, dated 05/08/26 reflected he was an [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. He was diagnosed with epilepsy, unspecified not intractable without status epilepticus (a neurological disorder characterized by recurrent, unprovoked seizures), unspecified fracture of the right femur, subsequent encounter for closed fracture with routine healing(healing normally without complications), unspecified Dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (a progressive cognitive disorder characterized by a decline in intellectual abilities sufficient to interfere with social or occupational functioning, affecting memory, judgement, attention, language and ither executive functions Record review of Resident#1's order summary dated 05/08/26 revealed, no active order for EBP.Record review of Resident #1's care plan undated revealed no active notation of EBP.Record review of EBP list provided by Administrator on 05/08/26 at reflected, Resident#1 had incision with staples (stitch together tissues following an injury or surgical procedure)During an observation on 05/08/26 at 8:25 am Resident#1 had EBP sign outside of his room that stated: STOP:Everyone Must:Clean hands with alcohol-based hand rub (ABHR) when entering and leaving the room. Doctors and Staff Must:Wear gloves and a gown for the following high-contact resident care activities:DressingBathing/showeringTransferring (e.g., bed to wheelchair)Changing linensProviding hygieneChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomy.Wound care: any skin opening requiring a dressing During an observation on 05/08/26 at 11:26 AM, CNA A and RA B provided perineal care to Residnt#1 with no gowns. During an interview on 05/08/26 at 12:15 PM, the Medical Director stated staff needed to wear gowns and gloves to prevent the transmission of infection from staff to residents and residents to staff.During an interview on 05/08/26 at 1:20 PM, RA B stated she should have worn a gown, gloves and mask to protect herself and the resident from any illness they may have. RA B stated she always wore gloves when she provided care to residents. RA B shrugged her shoulder when asked why she did not wear thr proper PPE.During an interview on 05/08/26 at 1:29 PM, CNA A stated Resident#1 wound was covered the whole time when she changed the residents brief. CNA A stated she just saw the sign today after she changed Resident#1. CNA A stated that when provided care to residents on EBP staff need to wear gowns and gloves to prevent spread of infections. During an interview on 05/08/26 at 2:17 PM, LVN C stated when care was provided to residents on EBP staff were required to wear gloves and gowns to prevent spread of infection. LVN C stated signs were outside door to remind staff to wear PPE.LVN C stated she is the infection preventionist and she oversees infection control concerns and made sure staff followed policy and procedures.During an interview on 05/08/26 at 2:30 PM, ADON D stated gowns and gloves were worn when direct care was provided to residents on EBP. ADON D stated residents on EBP had internal devices and wounds and PPE was worn to reduce the spread of infection.During an interview on 05/08/26 at 3:00 PM, the DON stated he expected staff to follow the CDC guidelines for EBP to prevent the spread of infection.During an interview over the phone on 05/08/26 at 3:25 PM, the Nurse Consultant stated PPE was worn for residents with EBP to prevent the spread of infection between (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff and residents.During an interview on 05/08/26 at 3:35 PM, ADON E stated staff should gown up and put on gloves before care was provided to residents on EBP to prevent infection.Record review of facility policy, titled Enhanced Barrier Precautions Policy dated 04/2024 reflected: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following:Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressingWounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid(R)) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.