

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: 675930	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Arbrook Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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 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 3 (Resident #1, Resident #51, Resident #111) of 5 residents reviewed for care plans. The facility failed to ensure the Care Plans for Resident #1, Resident #51, and Resident #111 reflected the use of grab/assist bars, the goal of having the grab/assist bars on the resident's beds, and the interventions previously attempted. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and the implementation of personalized plan of care developed to address their specific needs. Findings included: Record review of Resident #1's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE] with pertinent diagnoses of Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery (stroke that affects the right side of the brain and often results in left-sided paralysis or neglect, impulsive behavior, and facial weakness), Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (chronic condition where the body either does not produce enough insulin or cannot use insulin effectively, leading to high blood sugar levels that have damaged the kidneys' filters leading to reduced waste removal, often accompanied by high blood pressure), Paroxysmal Atrial Fibrillation (irregular heartbeat where episodes start and stop on their own, typically within seven days, though they can last shorter or longer and often become more frequent or persistent over time), Dysphagia Following Other Cerebrovascular Disease (when damage disrupts the brain's swallowing control network, leading to risks like pneumonia, malnutrition, and dehydration, with symptoms including choking or food getting stuck), Pneumonitis Due To Inhalation Of Food And Vomit (lung inflammation/infection from breathing foreign material like gastric contents into the airways, causing cough, fever, chest pain, and shortness of breath), Spontaneous Tension Pneumothorax (rare, life-threatening condition where air leaks into the space between the lung and chest wall from a ruptured air-filled sac on the lung's surface, forming a one-way valve that traps air, rapidly increasing pressure, collapsing the lung, and compressing the heart and major blood vessels), Acute and Chronic Respiratory Failure with Hypoxia (sudden worsening of the chronic low blood oxygen, often needing oxygen, ventilation, and treatment for breathlessness, confusion, and rapid breathing), Muscle Weakness (Generalized), Abnormal Posture, Unspecified Displaced Fracture of Second Cervical Vertebra (break in the axis bone of the neck where the fragments have shifted from their normal alignment), Subsequent Encounter for Fracture with Routine Healing, Unspecified Fracture of Upper End of Left Humerus (broken upper arm bone near the shoulder joint), and Subsequent Encounter for Fracture with Routine Healing . Review of Resident #1's MDS assessment (admission), dated 12/05/2025, revealed the resident had a BIMS (assessment of cognitive functioning that is performance-based) score of 11 (a score of 8-12 indicates moderate cognitive impairment), is noted to not have been assessed for prior functioning: everyday activities. Resident #1 is noted to have functional limitation in range of motion with both (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lower extremities and used a manual wheelchair. Resident #1's mobility assessment indicated partial/moderate assistance needed for sit to lying, lying to sitting on side of bed, toileting hygiene, shower/bathe self, and upper body dressing; substantial/maximal assistance for tub/shower transfer, lower body dressing, putting on/taking off footwear, and personal hygiene; and dependent for sit to stand, chair/bed-to-chair transfer, toilet transfer, car transfer, and any walking. Record review of Resident #1's Care Plan, dated 1/14/2026 as reviewed, revealed no indication of grab/assist bar discussion of risks and benefits with Resident or responsible party. Resident #1's Care Plan has no reference to an assessment that was completed for bed rails or grab/assist bars. Record review of Resident #51's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE] with diagnoses of Wedge Compression Fracture of First Lumbar Vertebra Subsequent Encounter for Fracture with Routine Healing (when the front part of the vertebra has collapsed forward, taking on a wedge shape, often from osteoporosis r trauma falls, causing pain, height loss, and a stooped posture); Muscle Wasting and Atrophy not Elsewhere Classified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase (difficulty moving food from the mouth to the esophagus leading to choking, coughing, nasal regurgitation, and a feeling of food sticking), Other Lack of Coordination, Cognitive Communication Deficit (difficulty speaking, listening, reading, or writing due to underlying thinking problems like poor memory, attention, problem-solving, or social understanding), Need For Assistance With Personal Care, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance (cognitive decline that does not fit a specific dementia type), Paroxysmal Atrial Fibrillation (irregular heartbeat where episodes start and stop on their own, typically within seven days, though they can last shorter or longer and often become more frequent or persistent over time), Heart Failure Unspecified, Neuralgia and Neuritis Unspecified (nerve pain or inflammation when the specific nerve or cause is not identified, causing sharp pain, numbness, or weakness along the nerve pathway), and Unspecified Fall Subsequent Encounter. Review of Resident #51's MDS assessment (entry), dated 1/02/2026, revealed only identification information for the resident the resident as the full assessment had not been completed on 1/14/2026. Record review of Resident #51's Care Plan, dated 1/13/2026 as reviewed, revealed no indication of grab/assist bar discussion of risks and benefits with resident or responsible party. Resident #51's Care Plan has no reference to an assessment that was completed for bed rails or enabler bars. The care plan does have a focus area of Exhibits ADL Self Care Performance Deficit, requires assistance with interventions of Bathing: requires assist x 1 staff participation; Eating: requires assist x 1 staff participation assist; Toileting: requires assist x 1 staff participation assist; Transfer: requires assist x 1 staff participation assist; Praise resident for all efforts made; Refer to OT for any change in ADL self- performance. Focus area of at risk for falls with interventions of Anticipate and meet needs; Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance; Ensure a safe environment: floors even and free from spills or clutter, adequate light, bed in low position, personal items within reach. Record review of Resident #111's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE], with diagnoses of Malignant Neoplasm of Head, Face and Neck (cancerous tumors developing in the mouth, neck, throat, voice box, sinuses, or lymph nodes, often starting from mucous membranes presenting as non-healing sores, lumps, or voice changes), Critical Illness Myopathy (severe muscle weakness and wasting condition developing in critically ill patients), Acute Respiratory Failure with Hypoxia (life-threatening condition where the lungs can not get enough oxygen into the blood, causing low blood oxygen and severe shortness of breath and confusion), Unspecified Osteoarthritis Unspecified Site (degenerative joint disease but specific joint or type is not documented), Acute Kidney Failure Unspecified, Syncope and Collapse (syncope is fainting or a temporary loss of consciousness due to a brief drop in blood flow to the brain, characterized by sudden limpness and quick recovery, while collapse can include syncope but also other serious events like seizures, strokes, or cardiac issues). Review of Resident #111's MDS assessment (preliminary), undated and unsigned, revealed the resident had a BIMS score (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 14 (a score of 13-15 indicates intact cognition). Information on functional ability was not available on 1/14/2026 when information was reviewed. Record review of Resident #111's Care Plan, dated 1/12/2026 as reviewed, revealed no indication of grab/assist bar discussion of risks and benefits with Resident or responsible party. Resident #111's Care Plan has a focus area of at risk for falls d/t poor balance, use of psychoactive meds with interventions of Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Focus area of ADL Self Care Performance Deficit, requires assistance: limited mobility with interventions of Bathing: requires assist x 1 staff participation. Eating: requires assist x 1 staff participation assist. Toileting: requires assist x 1 staff participation assist. Transfer: requires assist x 1 staff participation assist. Praise resident for all efforts made. Allow resident time to complete tasks. Refer to OT for any change in ADL self performance. Focus area of (chronic) pain with interventions of Administer analgesia as per orders. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care. turn and reposition for comfort. Resident #111's Care Plan has no reference to an assessment that was completed for bed rails or grab/assist bars. Review of Bed Bar/Side Rail Assessment for Resident #111, dated 1/07/2026, revealed an assessment for use of grab/assist bars or bed rails that stated No to the Current Bed Bar/Side Rail question: Are bed rails/bar currently utilized by resident or indicated at this time?. Review of Informed Consent for Use of Bed Rails form, dated 1/08/2026, for Resident #111 revealed a grab/assist bar consent for the 1/8 bed rails/grab/assist bars signed by the resident or resident's responsible party. Observations on 01/13/2026 at 11:06 AM, revealed Resident #1, Resident #51, and Resident #111's rooms had the resident's bed with grab/assist bars raised on both sides of the beds and residents were resting in those beds. Observations on 01/14/2026 at 4:18 PM, revealed Resident #1, Resident #51, and Resident #111's rooms continued to have the resident's bed with grab/assist bars raised on both sides of the beds with Resident #51 and Resident #111 resting in those beds. Resident #1 was not observed in the bed on 1/14/2026 as they had discharged earlier that day and the grab/assist bars remained on the bed. In an interview with the ADON on 1/15/2026 at 10:55 AM, revealed that before grab/assist bars could be placed on a resident's bed, resident or family consent, resident assessment for appropriateness, and care planning had to happen first. The care planning was entered by the DON when the assessment triggered for it or when the interdisciplinary team met and discussed the resident's admission; when the assessment was answered yes to the question of Are bed rails/bar currently utilized by resident or indicated at this time? it also prompted the care plan entry. Care plans were the responsibility of the DON, ADON, and other members of the interdisciplinary team to review for accuracy and completeness. Interview with the ADM on 01/15/2026 at 11:15 AM, revealed that the facility required for consent, assessment, and care planning to be done before grab/assist bars could be added to a resident's bed. The expectation was for the required tasks to be completed correctly and timely. The facility conducts morning meetings with managers where they, among other topics, discuss any new admits from the previous day including what equipment was needed, any items not working properly, observations of concerns the staff noticed overnight. The staff responsible for completing care plans, RN's and other members of the interdisciplinary team, make sure the grab/assist bars are entered in the care plan and then for the ADON to review for accuracy. The ADM stated the risks to the residents by having grab/assist bars placed inappropriately on a bed varies from the resident may not have the ability to use correctly and get hurt. Interview with the DON on 01/15/2026 at 11:45 AM, revealed that consent, an assessment, and care planning are required for grab/assist bars to be placed on a resident's bed. The consent and assessment are completed by the nursing staff and should be done on admission of the resident or before any type of bars are added to the resident's bed. The assessment for appropriateness triggers the care planning portion to be completed. The DON stated that the risks to the residents that grab/assist bars could create are falls or incorrect positioning. Record review of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility's provided policy Care Plans- Comprehensive, (Revised December 2009), revealed the policy statement 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 her person-centered plan of care. Policy Interpretation and Implementation item #1, highlighted as Developing the Comprehensive Care Plan, states Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a person-centered comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain through establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and other factors related to effectiveness of the plan of care. Policy Interpretation and Implementation item #2, highlighted as Basis of Comprehensive Care Plan, states The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Policy Interpretation and Implementation item #3, highlighted as Purpose of Care Plan, states Each resident's comprehensive care plan is designed to:a. Incorporate identified problem areas;b. Incorporate risk factors associated with identified problems;c. Build on the resident's strengths;d. Reflect the resident's expressed wishes regarding care and treatment goals.f. Identify the professional services that are responsible for each element of care;g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. Reflect currently recognized standards of practice for problem areas and conditions. Policy Interpretation and Implementation item #5, highlighted as Revisions, states The 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 a hospital stay; andd. At least quarterly.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to assess the resident for appropriateness and review the risks and benefits of grab/assist bars (smaller bars used by the person in bed to reposition themselves), with the resident or resident representative and obtain informed consent prior to installation or assess for appropriateness for 4 (Resident #1, Resident #32, Resident #51, and Resident #111) of 5 residents observed and reviewed for grab/assist bars. The facility failed to have evidence of informed consent for Resident #1 and Resident #32's grab/enabler bars to be placed on the bed. The facility failed to have evidence of assessment for Resident #1, Resident #51, and Resident #111 for risk of entrapment and ability to safely use the grab/enabler bars. These failures could affect residents who used grab/assist bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, and assessments not being completed for appropriateness. Findings included: Record review of Resident #1's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE] with pertinent diagnoses of Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery (stroke that affects the right side of the brain and often results in left-sided paralysis or neglect, impulsive behavior, and facial weakness), Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (chronic condition where the body either does not produce enough insulin or cannot use insulin effectively, leading to high blood sugar levels that have damaged the kidneys' filters leading to reduced waste removal, often accompanied by high blood pressure), Paroxysmal Atrial Fibrillation (irregular heartbeat where episodes start and stop on their own, typically within seven days, though they can last shorter or longer and often become more frequent or persistent over time), Dysphagia Following Other Cerebrovascular Disease (when damage disrupts the brain's swallowing control network, leading to risks like pneumonia, malnutrition, and dehydration, with symptoms including choking or food getting stuck), Pneumonitis due To Inhalation of Food And Vomit (lung inflammation/infection from breathing foreign material like gastric contents into the airways, causing cough, fever, chest pain, and shortness of breath), Spontaneous Tension Pneumothorax (rare, life-threatening condition where air leaks into the space between the lung and chest wall from a ruptured air-filled sac on the lung's surface, forming a one-way valve that traps air, rapidly increasing pressure, collapsing the lung, and compressing the heart and major blood vessels), Acute and Chronic Respiratory Failure with Hypoxia (sudden worsening of the chronic low blood oxygen, often needing oxygen, ventilation, and treatment for breathlessness, confusion, and rapid breathing), Muscle Weakness (Generalized), Abnormal Posture, Unspecified Displaced Fracture of Second Cervical Vertebra (break in the axis bone of the neck where the fragments have shifted from their normal alignment), Subsequent Encounter for Fracture with Routine Healing, Unspecified Fracture of Upper End of Left Humerus (broken upper arm bone near the shoulder joint), and Subsequent Encounter for Fracture with Routine Healing. Review of Resident #1's MDS assessment (admission), dated 12/05/2025, revealed the resident had a BIMS score of 11 (a score of 8-12 indicates moderate cognitive impairment), was noted to not have been assessed for prior functioning: everyday activities. Resident #1 is noted to have functional limitation in range of motion with both lower extremities and used a manual wheelchair. Resident #1's mobility assessment indicated partial/moderate assistance needed for sit to lying, lying to sitting on side of bed, toileting hygiene, shower/bathe self, and upper body dressing; substantial/maximal assistance for tub/shower transfer, lower body dressing, putting on/taking off footwear, and personal hygiene; and dependent for sit to stand, chair/bed-to-chair transfer, toilet transfer, car transfer, and any walking. Record review of Resident #1's Care Plan, dated 1/14/2026 as reviewed, revealed no indication of (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grab/assist bar discussion of risks and benefits with Resident or responsible party. Resident #1's Care Plan has no reference to an assessment that was completed for bed rails or grab/assist bars. Review of Bed Bar/Side Rail Evaluation, dated 11/30/2025, for Resident #1 revealed no assessment for use of grab/assist bars or bed rails or any other interventions attempted. Review of electronic health records on 1/14/2026 for Resident #1 revealed no grab/assist bar consent for the 1/8 bed rails/grab/assist bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Record review of Resident #32's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE] with diagnoses of Cerebral Infarction Due to Embolism of Left Middle Cerebral Artery (stroke that affects the left side of the brain and often results in right-sided weakness/paralysis, speech/language issues, and sensory loss), Localization-Related (Focal) (Partial) Idiopathic Epilepsy and Epileptic Syndromes with Seizures of Localized Onset, Not Intractable, Without Status Epilepticus (seizures that start in one brain area, are not drug-resistant, and do not lead to prolonged seizures), Aphasia Following Cerebral Infarction (language disorder caused by brain damage, most often in the left hemisphere, leading to difficulties with speaking, understanding, reading, or writing, though intelligence remains intact), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (occurs after stroke in the dominant hemisphere of the brain leading to difficulty moving the right arm, leg, and sometimes face requiring intensive rehabilitation), Apraxia Following Cerebral Infarction (neurologic condition where the brain loses the ability to plan and execute learned, purposeful movements, despite having the physical ability and desire to do so, affecting daily tasks, gestures, and speech), Dysphagia Following Cerebral Infarction (difficulty swallowing after a stroke), Other Lack of Coordination, and Aphasia (language disorder, often sudden after a stroke or head injury, that impairs speaking, understanding, reading, and writing due to brain damage). Review of Resident #32's MDS assessment (quarterly), dated 12/26/2025, revealed the resident had a BIMS score of 00 (a score of 0-7 indicates severe cognitive impairment), was noted to have a functional limited range of motion for both upper and lower extremities on one side and uses a manual wheelchair. Resident #32's assessment indicated partial/moderate assistance needed with oral hygiene; substantial/maximal assistance needed with toileting hygiene, shower/bathe self, upper and lower body dressing, roll right and left, sit to lying, and personal hygiene; and dependent with putting on/taking off footwear and tub/shower transfer. Functional mobility activities of lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and walking any distance not attempted due to medical condition or safety concern. Record review of Resident #32's Care Plan, updated 11/05/2025 as reviewed, revealed a focus area of Utilizes bed bar/assist rail while in bed to aid with turning/repositioning and transitioning into or out of bed and interventions of Assess the use of bed bars/assist rails at least quarterly and prn as appropriate, Encourage the use of the bed bar/assist rails for independence and assist resident when needed, Ensure call light is within reach, Monitor resident during rounds for proper use of bedside device. Review of Bed Bar/Side Rail Evaluation dated 11/06/2025, for Resident #32 revealed an assessment for use of grab/assist bars or bed rails initially on 4/05/2023 and most recent assessment was on 11/06/2025 with recurrent assessments in between. Review of electronic health record on 1/14/2026 for Resident #32 revealed no grab/assist bar consent for the 1/8 bed rails/grab/assist bars signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Record review of Resident #51's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE] with diagnoses of Wedge Compression Fracture of First Lumbar Vertebra Subsequent Encounter for Fracture with Routine Healing (when the front part of the vertebra has collapsed forward, taking on a wedge shape, often from osteoporosis r trauma falls, causing pain, height loss, and a stooped posture); Muscle Wasting and Atrophy not Elsewhere Classified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase (difficulty moving food from the mouth to the esophagus leading to choking, coughing, nasal regurgitation, and a feeling of food sticking), Other Lack of Coordination, Cognitive Communication Deficit (difficulty (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speaking, listening, reading, or writing due to underlying thinking problems like poor memory, attention, problem-solving, or social understanding), Need For Assistance With Personal Care, Unspecified Dementia Unspecified Severity with Other Behavioral Disturbance (cognitive decline that does not fit a specific dementia type), Paroxysmal Atrial Fibrillation (irregular heartbeat where episodes start and stop on their own, typically within seven days, though they can last shorter or longer and often become more frequent or persistent over time), Heart Failure Unspecified, Neuralgia and Neuritis Unspecified (nerve pain or inflammation when the specific nerve or cause is not identified, causing sharp pain, numbness, or weakness along the nerve pathway), Unspecified Fall Subsequent Encounter. Review of Resident #51's MDS assessment (entry), dated 1/02/2026, revealed only identification information for the resident the resident as the full assessment had not been completed on 1/14/2026. Record review of Resident #51's Care Plan, dated 1/13/2026 as reviewed, revealed no indication of grab/assist bar discussion of risks and benefits with Resident or responsible party. Resident #51's Care Plan has no reference to an assessment that was completed for bed rails or enabler bars. The care plan does have a focus area of Exhibits ADL Self Care Performance Deficit, requires assistance with interventions of Bathing: requires assist x 1 staff participation; Eating: requires assist x 1 staff participation assist; Toileting: requires assist x 1 staff participation assist; Transfer: requires assist x 1 staff participation assist; Praise resident for all efforts made; Refer to OT for any change in ADL self performance. Focus area of at risk for falls with interventions of Anticipate and meet needs; Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance; Ensure a safe environment: floors even and free from spills or clutter, adequate light, bed in low position, personal items within reach. Review of Bed Bar/Side Rail Evaluation, dated 1/02/2026, for Resident #51 revealed an assessment for use of grab/assist bars or bed rails that stated No to the Current Bed Bar/Side Rail question: Are bed rails/bar currently utilized by resident or indicated at this time? Review of Informed Consent for Use of Bed Rails, undated, for Resident #51 revealed a grab/assist bar consent for the 1/8 bed rails/grab/assist bars initialed by the resident who is their own responsible party. Record review of Resident #111's face sheet, dated 1/14/2026, revealed resident was originally admitted on [DATE], with diagnoses of Malignant Neoplasm of Head, Face and Neck (cancerous tumors developing in the mouth, neck, throat, voice box, sinuses, or lymph nodes, often starting from mucous membranes presenting as non-healing sores, lumps, or voice changes), Critical Illness Myopathy (severe muscle weakness and wasting condition developing in critically ill patients), Acute Respiratory Failure with Hypoxia (life-threatening condition where the lungs cannot get enough oxygen into the blood, causing low blood oxygen and severe shortness of breath and confusion), Unspecified Osteoarthritis Unspecified Site (degenerative joint disease but specific joint or type is not documented), Acute Kidney Failure Unspecified, Syncope and Collapse (syncope is fainting or a temporary loss of consciousness due to a brief drop in blood flow to the brain, characterized by sudden limpness and quick recovery, while collapse can include syncope but also other serious events like seizures, strokes, or cardiac issues). Review of Resident #111's MDS assessment (preliminary), undated and unsigned, revealed the resident had a BIMS (Brief Interview for Mental Status; assessment of cognitive functioning that is performance-based) score of 14 (a score of 13-15 indicates intact cognition). Information on functional ability was not available on 1/14/2026 when information was reviewed. Record review of Resident #111's Care Plan, dated 1/12/2026 as reviewed, revealed no indication of grab/assist bar discussion of risks and benefits with Resident or responsible party. Resident #111's Care Plan has a focus area of at risk for falls d/t poor balance, use of psychoactive meds with interventions of Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Focus area of ADL Self Care Performance Deficit, requires assistance: limited mobility with interventions of Bathing: requires assist x 1 staff participation. Eating: requires assist x 1 staff participation assist. Toileting: requires (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist x 1 staff participation assist. Transfer: requires assist x 1 staff participation assist. Praise resident for all efforts made. Allow resident time to complete tasks. Refer to OT for any change in ADL self performance. Focus area of (chronic) pain with interventions of Administer analgesia as per orders. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care. turn and reposition for comfort. Resident #111's Care Plan has no reference to an assessment that was completed for bed rails or grab/assist bars. Review of Bed Bar/Side Rail Evaluation, dated 1/07/2026, for Resident #111 revealed an assessment for use of grab/assist bars or bed rails that stated No to the Current Bed Bar/Side Rail question: Are bed rails/bar currently utilized by resident or indicated at this time? . Review of Informed Consent for Use of Bed Rails, dated 1/08/2026, for Resident #111 revealed a grab/assist bar consent for the 1/8 bed rails/grab/assist bars signed by the resident or resident's responsible party. Observation on 01/13/2026 at 11:06 AM revealed Resident #1, Resident #32, Resident #51, and Resident #111's rooms had the resident's bed with grab/assist bars raised on both sides of the beds and residents were resting in those beds. Observation on 01/14/2026 at 4:18 PM revealed Resident #32, Resident #51, and Resident #111's rooms had the resident's bed with grab/assist bars raised on both sides of the beds and residents were resting in those beds. Resident #1 was not observed in the bed on 1/14/2026 as they had discharged earlier that day and the grab/assist bars remained on the bed. In an interview with LVN I on 1/15/2026 at 9:25 AM, revealed the facility trained staff that the policy was that before bed rails or grab/assist bars could be placed on the bed there must be a signed consent form, a discussion on risks of the grab/assist bars with resident and responsible party, the DON must approve the grab/assist bars be put on the bed, therapy needed to conduct an assessment, and either the DON or SW added the use of the grab/assist bars to the care plan. LVN I stated that the risks to the resident of grab/assist bars on the bed inappropriately would place the resident at risk for hitting their head, the bars could be considered a restraint, or for injury, skin tear, or bruising. In an interview with CNA J on 1/15/2026 at 10:04 AM, revealed that in order for grab/assist bars to be placed on a resident's bed, consent was needed from the resident or responsible party and that maintenance installed after required items were obtained. The facility required vendors to remove any full or half rails when leaving beds as only grab/assist bars were allowed in this facility. CNA J also stated that an assessment of the resident was needed for the grab/assist bars. Any CNA was to let the nurse know if a resident asked for or had the ability to use grab/assist bars. CNA J stated that the risks of grab/assist bars could have been strings from call light/overbed light getting caught and risk strangulation of the resident, the grab/assist bars could have posed a hazard for resident getting in/out of bed, entrapment of resident, resident could have hit head, or resident may have tried to get up out of the bed without assistance when they actually needed help or supervision to avoid injury. In an interview with CNA K on 1/15/2026 at 10:15 AM, CNA K stated that if a resident requested grab/assist bars they would have to talk with the nurse about the process for grab/assist bars and make sure the resident had the right bed, that the resident or family as well as the doctor needed to approve the addition of grab/assist bars, and that an assessment needed to be done. CNA K stated that the risks to a resident who was not appropriate for grab/assist bars was that the resident could have fallen and got hurt, received skin tears or bruising. In an interview on 1/15/2026 at 10:20, CNA L stated that consent from the residents or their family was required for grab/assist bars to be added to a bed and was not aware of anything else required. CNA L stated that the nurse or DON was the one who would review that any required things were obtained before grab/assist bars were placed on a bed. CNA L stated that grab/assist bars or bed rails could be considered a restraint. CNA L stated that assessments were done when a resident admitted . CNA L stated that risks of grab/assist bars to residents could range from the resident taking off the grab bar and using it to hurt others, could provide a false sense of safety and cause a fall, could worsen situation like feeling trapped, the cords (of call light or overbed light) could get wrapped up and get hurt the resident, the resident could break something (like a bone if hits the bar), or could sustain bruising. In an interview with the ADON on (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/15/2026 at 10:55 AM, revealed that before grab/assist bars could be placed on a resident's bed, resident or family consent, resident assessment for appropriateness, and care planning had to happen first. Consent was obtained when the assessment was completed showing the resident was appropriate to use the grab/assist bars; this was the responsibility of the admitting nurse. The care planning was entered by the DON when the interdisciplinary team met and discussed the resident's admission; when the assessment was answered yes to the question of Are bed rails/bar currently utilized by resident or indicated at this time? it also prompted the care plan entry. Care plans were the responsibility of the DON, ADON, and other members of the interdisciplinary team to review for accuracy and completeness. Interview with the ADM on 01/15/2026 at 11:15 AM, revealed that the facility required for consent, assessment, and care planning to be done before grab/assist bars could be added to a resident's bed. The expectation was for the required tasks to be completed correctly and timely. The facility conducts morning meetings with managers where they, among other topics, discuss any new admits from the previous day including what equipment was needed, any items not working properly, observations of concerns the staff noticed overnight. The expectation was that nursing staff complete assessments and obtain any consents required and then move to next assessment the resident needed to have completed. The staff responsible for completing care plans, RN's and other members of the interdisciplinary team, make sure the grab/assist bars are entered in the care plan and then for the ADON to review for accuracy. The ADM stated the risks to the resident by having grab/assist bars placed inappropriately on a bad varies from the resident may not have the ability to use correctly and get hurt. The timeframe for the assessment to be done was assigned to the admission nurse who works during the afternoon shift and, depending on number of admissions, charge nurses will also assist with the assessments. If there were too many new admits, the assessments would have fallen to the next shift and would have been done on next day (goal of within 24 hours of admit to have all assessments done). Interview with DON on 01/15/2026 at 11:45 AM, revealed that consent, an assessment, and care planning are required for grab/assist bars to be placed on a resident's bed. The consent and assessment are completed by the nursing staff and should be done on admission of the resident or before any type of bars are added to the resident's bed. The assessment for appropriateness triggers the care planning portion to be completed. The DON stated that the risks to the resident that grab/assist bars could create are falls or incorrect positioning. Record review of the facility's provided policy Bed Safety, (C)2001 MED-PASS, Inc. (Revised December 2007), revealed the policy statement Our facility shall strive to provide a safe sleeping environment for the resident. Policy Interpretation and Implementation item #1, highlighted as Assessment of Resident Sleeping Environment, states The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Policy Interpretation and Implementation item #2, highlighted as Hospital Bed System Safety Review, states e. Identify additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.). Policy Interpretation and Implementation item #5, highlighted as Side Rail Use and Interdisciplinary Assessment, states If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. Policy Interpretation and Implementation item #6, highlighted as Consent for Use of Side Rails, states The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. Policy Interpretation and Implementation item #8, highlighted as Side Rails to Help Support Medical Needs, states Side Rails May be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. Policy Interpretation and Implementation item #9, highlighted as Risk-Benefit Assessment (continued on next page)		

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

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Use of Side Rails, states Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with the side rails. Policy Interpretation and Implementation item #10, highlighted as Reducing Related Risks, states When using side rails for any reason, the staff shall take measures to reduce related risks.		

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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, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for three of six (Med Cart #1, Med Cart #2, and Med Cart #3) medication carts reviewed for storage of medication 1. LVN B left Med Cart #1 unlocked and unattended on 01/13/26. 2. Med Aide D failed to secure 5 medications before leaving Med Cart #2 unattended outside Resident #3's room on 01/13/26. 3. Med Aide E failed to ensure Med Cart #3 was free of brown and black sticky substance and brown dust particles in the compartment that had medicine cups and water cups in it on 01/14/26. These failures could place residents at risk of their medications being stolen or misused and health complications related to accidental ingestion of drugs and/or biologicals, including hospitalization. Findings included: 1. During an observation on 1/13/26 between 08:50 AM to 09:10 AM, Med Cart #1 was unlocked and unattended on the 400 hallway, the drawers was facing out into the hallway. Med Cart #1 was accessible to anyone walking by, three staff members walked by the unlocked and unattended medication cart. LVN B was observed walking towards the cart, upon reaching the cart she pushed the lock mechanism in to indicate locked position. In an interview with LVN B on 01/13/26 at 09:10 AM, revealed Med Cart #1 belonged to her, she said s it was a nurse medication cart. LVN B said Med Cart #1 contained insulins (medications that can lower blood sugars), prescription medications pills, over the counter medications, and breathing treatments inhalers containing albuterol, (a medication that causes nervousness, shakiness, throat/nasal irritation, muscle aches, and trembling). LVN B said she forgot to lock the cart when she pulled the key out of the lock. She said the lock mechanism might have opened, and she was not aware of this before walking away. LVN B stated the expectation was that the medication cart was always locked when no one was using it to prevent anyone from getting into the medication cart. 2. Record review of Resident #3's face sheet, dated 01/14/26, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included unspecified encephalopathy (this is a brain disease that alters brain function or structure), hyperlipidemia (elevated level of lipids, like cholesterol in the blood), Type 2 diabetes (a problem in the way the body regulates and uses sugar as fuel). During a medication observation and interview on 01/13/26 at 12:40 PM, Med Aide D administered medications to Resident #3 in her room. The medications was Eliquis 5 mg tablet (blood thinner), Clopidogrel tablet 75 mg (blood thinner), Furosemide 40 mg tablet (medication used for fluid overload, Glimepiride 4 mg tablet (this medication is used to regulate/lower blood sugar), and Carvedilol 3.125 mg tablet (used to treat high blood pressure). Med Aide D popped the pills out of the bubble pack into a medication cup. She then locked the medication cart however she left the medication bubble cards with medicines on top of Med Cart #2 and went into Resident #3's room. The door to Resident #3's room was open, but Med Aide D had her back towards Med Cart #2, and the cart was not in her line of view. Two staff and a resident walked by Med Cart #2. Resident #3 dropped one of her pills and Med Aide D bent down to look for it. She did not have direct eye contact to the medications on top of Med Cart #2. Med Aide D said that she left the medications out thinking the surveyor was keeping an eye on her cart for her. She did not see the staff that had walked by the cart. She said that if medication is not in direct eye view, it should be locked inside the cart. She said that anyone could have access to the medications that were left on top of Med Cart #2. She said the risk was drug diversion or accidental ingestion by a resident. 3. Observation on 01/14/26 at 08:10 AM, revealed Med Cart #3 with two medication cup compartments, one had smaller medicine cups and the one below it had bigger medicine /water cups. Outside both compartments was brown and black sticky substance. Inside both compartments with (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cups facing downwards were brown dust particles inside the compartment that had medicine cups and water cups in it and a belonging bag in the bottom compartment next to the cups. The trash bag and lid to trash can underneath the medicine cup compartment had brown and black substances stuck on the medication cart. Interview with Med Aide E on 01/14/26 at 08:11 AM, he said he had cleaned Med Cart #3 yesterday (1/13/26) and he did not know who or why the person that used it overnight did not clean it. He said he did not clean it this morning before using it. He said all med aides and nurses was responsible for the cleanliness of the medication cart to prevent the risk of cross contamination and infection control. In an interview with the ADON on 01/14/26 at 09:45 AM, she said she would go and assist Med Aide E to clean the cart. She said all staff that used the medication carts was responsible for the cleaning the carts and maintaining cleanliness. She said the ADON's was responsible for monitoring that medication carts was kept clean and sanitary. She said the risk of having a dirty medication cart was cross contamination. The ADON stated she had just completed an in-service with LVN B for medication safety and that she would also do an in-service for clean, safe, and sanitary medication carts. Interview with the DON on 01/15/26 at 09:53 AM, he said they had started in-servicing the current staff and was still working on oncoming staff which included all nurses and medication aides on medication safety. He revealed names on the in-service sheet that had already completed the in-service, including the one-on-one sheet that was completed with LVN B on 01/13/26. He said all medications should not be left unattended, and the medication cart should be locked when not in use and out of sight. He said all medication carts should be kept clean for infection control. In an interview with the Administrator 01/15/26 at 1:33 PM, the administrator said that they had written up LVN B for leaving medication cart unlocked and unattended. She stated that they would in-service all the staff on different shifts regarding medication safety. She said the risk was unauthorized access to medications; medication can go missing and harm if ingested. She said the expectation was that all medication carts were kept clean for infection control. She said all nursing staff were responsible for medication safety. Record review of the facility's policy titled Storage of Medications, with a revision date of April 2007, reflected, in part, The medication cart shall be secured during medication passes ., when it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall and drawers facing the wall. The cart must be locked before the nurse enters the room . medications carts must be securely locked at all times when out of the nurses view		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviewed the facility failed to ensure appropriate care and services to prevent complications of enteral feeding for one (Resident #75) of three residents reviewed for enteral tube feeding, in that; LVN C failed to ensure Resident #75 was not flat in bed during repositioning while his enteral feeding was still connected and running. This failure placed residents with enteral feedings at risk of receiving inappropriate care and maintenance which could result in fluid overload, vomiting, aspiration (entering the airways or lungs), and hospitalization. Findings Included: Record review of Resident #75's face sheet dated 01/14/26 revealed a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included cerebral palsy (this is a congenital disorder of movement, muscle tone and posture) and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing). Review of Resident #75's quarterly MDS dated [DATE], reflected no record of Resident #75's BIMS. Cognitive patterns included memory problems and severely impaired cognitive skills for daily decision making. Further, MDS revealed a functional status assessment that Resident #75 required extensive two-person assistance with bed mobility and was totally dependent on two-person assistance for dressing, toilet use, and personal hygiene. MDS also revealed that Resident #75 had a g-tube and obtained 51 percent or more of total calories and 501 cc of fluid through the feeding tube. Review of Resident #75's physician orders for January 2026, on 01/14/25 revealed that he had an order to elevate his head at 30-40 degrees except to allow for ADL care. Order started on 09/27/18.-Order flush g-tube with 300 cc water every 4 hours. Start date 5/14/25.-Order Pump [brand name of feeding] 40 cc/hr per g-tube for 22 hours every shift. Order start date 07/23/25. Review of Resident #75's care plans initiated on 09/27/18 reflected a focus of Resident #75 requiring a tube feeding related to difficulty swallowing (dysphagia). The goal was to make sure the insertion site was free of signs and symptoms of infection. The interventions included keeping the Head of Bed elevated (up) 30-45 degrees during feeding and thirty minutes after tube feeding. During a medication administration observation on 01/14/26 at 06:53 AM, Resident #75 was lying in bed with his eyes open. He had a g-tube which was connected to a feeding pump infusing at 40 ml/hr with 300 cc of water flushes. LVN C stated she was going to reposition the resident so that she could administer his medication. LVN C did not get help; she laid Resident #75's head of bed down without pausing or switching off the feeding pump. LVN C pulled him up the resident using the bed sheet until she reached the desired position and then raised the head up. In an interview with LVN C on 01/14/26 at 7:20 AM, she stated that she should have stopped the feeding before lowering Resident #75's head down. She said she was trained to stop feeding before repositioning. She said she had forgotten because she was nervous being watched. She said the risk of not holding the feeding when resident is laid flat is aspiration (backflow of feed entering the airways or lungs). In an interview with the DON on 01/15/26 at 09:53 AM, he said the expectation was for the nurse to pause the feeding when repositioning or providing incontinent care. He said that there was a risk of aspiration if the feeding is not held when the head of the bed is lowered. In an interview with the Administrator on 01/15/26 at 1:33 PM, the administrator said she was not a nurse; however, the expectation was that nursing staff follow the process and procedure in place for the safety of residents. She said she was told by the nurse managers that lying down a resident on feedings can cause the resident to aspire, which could harm them. Review of the facility policy, Medication Administration, revised 12/12 and facility policy titled Gastrostomy/Jejunostomy Care, revised 09/24, did not address resident in proper position with head of bed elevated to 45 degrees with enteral feedings as ordered.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for 1 (Residents #4) of 1 resident reviewed for refrigerator in the rooms. The facility failed to place a thermometer in Residents #4's refrigerator and monitor the temperature. This failure could affect residents by placing them at risk for food-borne illnesses. Finding included: Record review of Resident # 4's face sheet, dated 01/15/26 revealed an [AGE] year old female who was admitted to the facility on [DATE] with a primary diagnosis of unspecified sequelae of Cerebral infarction (this is a condition that is not specified but started due to long term effect of stroke such as cognitive, speech issues, emotional issues, and memory loss). Her secondary diagnosis was Dementia. Record review of Resident #4's admission MDS dated [DATE] revealed a BIMS score of 8, which indicated moderate cognitive impairment and required substantial/maximal assistance with personal hygiene. A record review of Resident #4's care plan initiated on 09/24/25 revealed Resident #4 had a focus on memory judgement, decision making and thought process related to dementia. The goal was for her to communicate basic needs daily. The interventions included maintaining as much consistency as possible with environment, routines, situations, care, and caregivers. Orient and reorient to change. Observation and interview with Resident #4 on 01/13/26 at 11:28 AM, revealed Resident #4 in her room and she had family at bedside. A small refrigerator with a glass door was observed near the window. Items inside were visible via the glass door. There was no thermometer inside, and no temperature log attached to the refrigerator. Resident #4's family member said that he had just gotten the refrigerator a few weeks ago. He stated Resident #4 needed the refrigerator to store her [Soda brand] that she loved so much. He said the refrigerator had a compressor, and he had set it to 40 degrees. He said the refrigerator was built just like a regular refrigerator, just small. He said that he monitored the temperature when he was visiting Resident #4 daily by the coolness of the items. Interview with CNA F on 01/13/26 at 12:10 PM, revealed she was not aware of any residents with refrigerators. She said that maybe housekeeping was responsible for them. Interview with the Housekeeping Supervisor on 01/15/26 at 09:10 AM, revealed the nursing department was responsible for monitoring the refrigerators' temperatures in rooms and med rooms. In an interview with the DON on 01/15/26 at 09:53 AM, revealed that per the facility admission policy residents were not allowed to have refrigerators in their rooms. He said the nursing department was responsible for the refrigerators in the medication rooms, and they monitored those. He said that the risk of not monitoring refrigerators temperatures was infection control and outdated or spoiled items in the refrigerators. In an interview with the Administrator on 01/15/26 at 1:33 PM, revealed by the facility admission policy, residents were not allowed to have refrigerators in their rooms. She said that she would speak to Resident #4 and her family regarding the violation of the admission agreement, and she would start an inservice with staff. The administrator said that the facility did not have a specific policy for personal refrigerators because they were not allowed in the facility. She said it was a food safety concern and could have an impact on their health. admission packet pending from administrator as of 01/20/26 at 7:44 PM. Record review of the facility policy titled Resident Personal Food Storage revised 12/2008 revealed 7. The nursing staff is responsible for discharging perishable food on or before the use by date .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675930	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Arbrook Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents resided and received services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #3) of fifteen reviewed for call lights. The facility failed to ensure Resident #3's call button was not broken and placed within reach. These failures could place residents at risk for needs not being met, decreased quality of life, self-worth and dignity. Findings included: Record review of Resident #3's face sheet, dated 01/14/26, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included unspecified encephalopathy (this is a brain disease that alters brain function or structure), hyperlipidemia (elevated level of lipids, like cholesterol in the blood), and Type 2 diabetes (a problem in the way the body regulates and uses sugar as fuel). Record review of Resident #3's comprehensive MDS Assessment, dated 12/02/25 reflected no record of Resident #3's BIMS. Cognitive patterns included memory problems and severely impaired cognitive skills for daily decision making. She was always incontinent of bowels and bladder and dependent on toileting, showers, and transfers. Record review of Resident #3's care plan initiated 12/01/25 reflected the following: Focus: [Resident #3] is high risk for falls. Goal: Will be free of fall. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation on 01/13/26 at 10:47 AM, revealed Resident #3 was in bed, and could not communicate well. Resident #3 did not answer questions this surveyor asked about the call button. Call light was observed tied to the bed rail with the call button missing. In an interview with CNA F on 01/13/26 at 11:08 AM, she stated she last worked with Resident #3 on Friday, and the call light had been working because the resident had used it. She said that she would report it to maintenance to have it replaced right away. She said that not having a call light that worked placed the residents at risk of not having their needs met. She stated that she was international about rounding in the residents' rooms to check on them. She said it was all staff's responsibility to ensure call lights were within reach for all residents. She said it was a resident's right to be able to call for assistance when they required it. In an interview on 01/15/2026 at 9:30 AM, with the ADON revealed the CNAs are responsible for ensuring that all the call lights are within reach to each resident. It is her expectation that each CNA who provides care to the resident's place the call light within reach before they leave the room and recheck the call light through the day. A resident could have an emergency or fall and unable to call for assistance. In an interview with the DON on 01/15/26 at 09:53 AM, the DON stated that all residents should have access to their call light. He said all staff were responsible for ensuring residents' call lights were placed in their reach to ensure they could call for assistance if they needed to. The DON stated he expected staff to check for light placement throughout the day to ensure residents could call for assistance. In an interview with the maintenance person on 01/15/26 at 11:30 AM, she said that all staff had access to an electronic reporting system for all broken items. She said she was notified before 01/13/26 that Resident #3's call light was broken. She said she was made aware on 01/13/26 when CNA F informed her that call light for Resident #3 was broken, she said once she was notified (01/13/26), she replaced it right away. In an interview with the Administrator on 01/15/26 at 1:33 PM, all call light should be in good working condition and within reach. She said the call light was important for residents to call for help. She said the expectation was that all equipment's that was broken was reported immediately. Review of policy revised October 2010 for Answering Call Lights reflected The purpose of this procedure is to respond to the resident's request and needs. Be sure that the call light is plugged in at all times. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure you check these residents frequently.		