

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675932	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Arbor Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 609 Rio Concho Dr San Angelo, TX 76903	

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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility to ensure that the residents had the right to self determination and that the facility promoted and facilitated resident self-determination for 1 (Resident #33) of 7 resident who were reviewed for resident rights.</p> <p>-</p> <p>The facility failed to ensure Resident #33's right to make choices about aspects of his life that were significant to the resident by failing to honor Resident #33's request to be sent to the hospital for evaluation on 05/02/2025 at approximately 3 pm.</p> <p>This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that were important in their life and decrease their quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #33's face sheet dated 05/22/2025 revealed the resident was a [AGE] year-old female admitted to the facility 04/11/2019. The resident had diagnosis that included Acute recurrent sinusitis (inflammation of mucous membranes), Shortness of breath, Hemiplegia (one sided paralysis), and hemiparesis (one sided muscle weakness).</p> <p>Record review of Resident #33's Minimum Data Set, dated [DATE] revealed BIMS of 12, suggesting intact cognition.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA A on 05/22/25 at 12:49 pm, CNA A stated that on a day in early May 2025, unable to give exact date, she remembers Resident #33 using her call light and informed CNA A that she wanted to go to the hospital because she was not feeling well. CNA A stated that she informed LVN B after leaving the resident's room. CNA A stated about 2 hours later the resident used her call light again and informed CNA A that the nurse had not been in her room. CNA A stated she then went back to LVN B who informed CNA A that she would assess the resident. An unknown amount of time passed, and the resident used the call light again and CNA A went in and the resident had informed CNA A that the nurse had not been in the room and that she still wanted to go to the hospital. CNA A stated she went to LVN B again to inform her the resident was wanting to be sent to the hospital. CNA A stated that LVN B informed her that she had taken the residents vitals but would go back in to speak with her. CNA A stated that she thought LVN B had assessed and addressed Resident #33's concerns. CNA A stated that the resident did not go to the hospital during her shift but when CNA A returned the next day, she was informed that Resident #33 had gone to the ER. CNA A did not know that the Resident #33 had to call her Significant Other (SO) to take her to the hospital.</p> <p>Record review of Resident #33's progress notes and vital sign log revealed there was no notes regarding the Resident #33's request to go to the hospital, nor vital signs documented on 05/02/2025.</p> <p>During an interview on 05/22/2025 at 1:20 pm the DON stated that she was unaware that the resident had not being sent out to the hospital after requesting to be sent out. The DON stated she knew Resident #33 had gone to the hospital with her SO but did not know she had requested the staff to send her out first. The DON stated if there is a resident that was stating they are not feeling well she would expect her nurses to evaluate the resident, obtain vital signs, and contact the doctor to attempt to treat in house if non-emergent. The DON stated that if a resident is was refusing to be treated in house or insisting to be sent out, the staff are expected to contact emergency services to send them out. The DON stated the emergency services in town have denied nonemergent transfers in the past so they would have to have the van driver transport resident to the emergency room.</p> <p>During an interview with LVN B on 05/22/25 at 2:51 pm, LVN B stated she did not remember being informed of any resident wanting to go to the hospital. LVN B stated that she (LVN B) does not have a good memory. LVN B stated that if a resident was not feeling well, she would assess the resident and obtain vital signs. LVN B stated that if the resident was not stable, she would call 911 but if they were stable, she would call the doctor for treatment orders. LVN B stated that if a resident was wanting to be sent out regardless of the doctors' orders, she would just call for transport to the emergency room.</p> <p>During an interview with Resident #33 on 05/22/2025 at 3:20 pm, when Resident #33 stated that on 05/02/2025 she was not feeling well and wanted to go to the emergency room. Resident #33 stated she informed CNA A about this on multiple occasions that day and that CNA A was informing the resident that she was telling the nurse on shift. Resident #33 stated that no one other than CNA A had returned to check on her during this time. Resident #33 stated that she first asked to go to the hospital around 3 pm and finally called her SO to take her around 8 pm that night. Resident #33 stated she signed out and informed staff she was going to the hospital. Resident #33 stated that she was not admitted to the hospital but was diagnosed with a urinary tract infection and acute inflammation of the air passages. The resident stated that she was prescribed antibiotics for the urinary tract infection. Resident #33 stated that she has never had a situation prior where a nurse did not evaluate her after informing staff that she was not feeling well.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled Requesting, Refusing and/or Discontinuing Care or Treatment dated revised February 2021, revealed in part, 4. The resident/representative has the right to request treatment or care that the resident wishes. However, this facility is not obligated to provide medical treatment, or medical services deemed medically unnecessary or inappropriate.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure that residents received treatments and care in accordance with professional standards of practice and the residents' choices for 1 of 7 residents (Resident #33) reviewed for quality of care.</p> <p>-</p> <p>The facility failed to ensure Resident #33 received treatment immediately after she requested to be sent to the hospital for evaluation on 05/02/2025 at approximately 3 pm.</p> <p>This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, harm and/or the need for hospitalization and prolonged treatment.</p> <p>Findings included:</p> <p>Record review of Resident #33's face sheet dated 05/22/2025 revealed the resident was a [AGE] year-old female admitted to the facility 04/11/2019. The resident had diagnosis that included Acute recurrent sinusitis (inflammation of mucous membranes), Shortness of breath, Hemiplegia (one sided paralysis), and hemiparesis (one sided muscle weakness).</p> <p>Record review of Resident #33's Minimum Data Set, dated [DATE] revealed BIMS of 12, suggesting intact cognition.</p> <p>During an interview with CNA A on 05/22/25 at 12:49 pm, CNA A stated that on a day in early May 2025, unable to give exact date, she remembers Resident #33 using her call light and informed CNA A that she wanted to go to the hospital because she was not feeling well. CNA A stated that she informed LVN B after leaving the resident's room. CNA A stated about 2 hours later the resident used her call light again and informed CNA A that the nurse had not been in her room. CNA A stated she then went back to LVN B who informed CNA A that she would assess the resident. An unknown amount of time passed, and the resident used the call light again and CNA A went in and the resident had informed CNA A that the nurse had not been in the room and that she still wanted to go to the hospital. CNA A stated she went to LVN B again to inform her the resident was wanting to be sent to the hospital. CNA A stated that LVN B informed her that she had taken the residents vitals but would go back in to speak with her. CNA A stated that she thought LVN B had assessed and addressed Resident #33's concerns. CNA A stated that the resident did not go to the hospital during her shift but when CNA A returned the next day, she was informed that Resident #33 had gone to the ER. CNA A did not know that the Resident #33 had to call her Significant Other (SO) to take her to the hospital.</p> <p>Record review of Resident #33's progress notes and vital sign log revealed there was no notes regarding the Resident #33's request to go to the hospital, nor vital signs documented on 05/02/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/22/2025 at 1:20 pm the DON stated that she was unaware that the resident had not being sent out to the hospital after requesting to be sent out. The DON stated she knew Resident #33 had gone to the hospital with her SO but did not know she had requested the staff to send her out first. The DON stated if there is a resident that was stating they are not feeling well she would expect her nurses to evaluate the resident, obtain vital signs, and contact the doctor to attempt to treat in house if non-emergent. The DON stated that if a resident is was refusing to be treated in house or insisting to be sent out, the staff are expected to contact emergency services to send them out. The DON stated the emergency services in town have denied nonemergent transfers in the past so they would have to have the van driver transport resident to the emergency room.</p> <p>During an interview with LVN B on 05/22/25 at 2:51 pm, LVN B stated she did not remember being informed of any resident wanting to go to the hospital. LVN B stated that she (LVN B) does not have a good memory. LVN B stated that if a resident was not feeling well, she would assess the resident and obtain vital signs. LVN B stated that if the resident was not stable, she would call 911 but if they were stable, she would call the doctor for treatment orders. LVN B stated that if a resident was wanting to be sent out regardless of the doctors' orders, she would just call for transport to the emergency room.</p> <p>During an interview with Resident #33 on 05/22/2025 at 3:20 pm, when Resident #33 stated that on 05/02/2025 she was not feeling well and wanted to go to the emergency room. Resident #33 stated she informed CNA A about this on multiple occasions that day and that CNA A was informing the resident that she was telling the nurse on shift. Resident #33 stated that no one other than CNA A had returned to check on her during this time. Resident #33 stated that she first asked to go to the hospital around 3 pm and finally called her SO to take her around 8 pm that night. Resident #33 stated she signed out and informed staff she was going to the hospital. Resident #33 stated that she was not admitted to the hospital but was diagnosed with a urinary tract infection and acute inflammation of the air passages. The resident stated that she was prescribed antibiotics for the urinary tract infection. Resident #33 stated that she has never had a situation prior where a nurse did not evaluate her after informing staff that she was not feeling well.</p> <p>Record review of facility policy titled Requesting, Refusing and/or Discontinuing Care or Treatment dated revised February 2021, revealed in part, 4. The resident/representative has the right to request treatment or care that the resident wishes. However, this facility is not obligated to provide medical treatment, or medical services deemed medically unnecessary or inappropriate.</p>		