STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676139	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Oaks Nursing & Rehabilitation	3033 W Green Oaks Blvd Arlington, TX 76016

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who required it for 1 of 8 residents (Resident #1) reviewed for pain. The facility failed to make sure that each resident's clinical record contains the physician's signed and dated orders that also were handled appropriately if any changes were made for 1 (Resident #1) of 8 Residents reviewed for physician orders in that: - Facility failed to obtain physician orders for [[NAME]] Cold Therapy Unit which was used to provide cold therapy to reduce pain and swelling for Resident #1. This failure could place residents at risk for incorrect treatment decisions, evaluation, and treatment plans compromising patient safety due to insufficient information and could cause confusion about the resident's care and place residents at risk for harm due to inaccurate records Findings included: Record review of Resident #1's admission record dated 09/04/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with the diagnosis of unspecified hyperlipidemia (this is elevated lipid levels in the body without a clearly identifiable cause). admission record did not have other diagnoses. Record review of Resident #1's hospital discharge date d 08/29/25, revealed Resident #1 was a [AGE] year-old female who had Type II Diabetes mellitus [uncontrolled blood sugars], Atrial fibrillation [heart irregularity and arrhythmia], Hyperlipidemia, GERD [heart burn/irritation], and Chronic low back pain. [Resident #1] presents with a chief complaint of left knee pain. She has had the symptoms for 2 years. She was previously diagnosed with osteoarthritis in 2006 [(a degenerative joint diseases that primary affects the left knee joint causing pain. Stiffness, and reduced mobility)] and underwent an arthroscopic debridement [(this a surgical procedure that involves removing damaged tissue from a joint)]. She had relief for 1-2 years. She has had progressive pain in the knee over time. She has had multiple steroid injections with temporary relief. Her last steroid injection was in February 2025. She did not have any relief with [name] supplementation. She has been receiving home physical therapy, which has been helping her mobility and strength, but pain persists. She still has popping in the knee, as well as deep pain. She has been receiving Oxycodone [(pain medication)] and Lyrica [(nerve pain medication)] for chronic pain from [Physician name], a pain management specialist. Record review Resident #1's admission MDS on 09/04/25, revealed document was in progress status. Record review of Resident #1's active physician orders on 09/04/25 did not reflect physician order for ICTU therapy. Record review of Resident #1's care plan initiated on 09/03/25 did not reflect focus, goals, or interventions for use of ICTU therapy. Observation and interview with Resident #1 and Medication Aide on 09/04/25 at 07:50 AM, revealed Resident #1 was in bed with both legs uncovered. The left leg had a black knee immobilizer brace on and on top of her knee opening was a blue ice pad of the [[NAME]] Cold Therapy Unit in place connected. The ICTU cooler box was placed on the floor at the end of the bed. She said that she had the ICTU since she admitted [9/2/25], and the ice was only refilled yesterday [09/03/25] at 7 pm. Resident #1 stated that the nurse had already administered pain medication, however she was still having some knee pain. At this time of observation, MA administered Aspirin 81 mg, 1 tablet, Diazepam 10 mg tablet [antianxiety], take 1 tab by mouth 2 a day, Pregabalin 75 mg capsule [nerve pain medicine], take 1 cap oral route 3 times a day- 1 cap given, Divalproex DR 250 MG [depression medication], give 1 tablet by mouth 2 times a day-1 tab given, Metformin ER 500 MG TAB [controls blood sugar], give 1 tablet by mouth one time a day-1 tab given, Trintellix 20 mg Tab [antidepressant], give 1 tab by mouth 1 time a day-1 tab given, and Vraylar 1.5 MG[antipsychotic], Capsule, take 1 cap by mouth every day, 1 tab given. The MA stated that it was the nurse and the CNAs who were responsible for the resident's equipment's such as the ICTU and she would let them know that the machine needed ice and that the resident was still in pain. In an interview with RN A on 09/04/25 at 08:00 AM, revealed she had administered pain medication at 6 AM to Resident #1. She stated she did not check the [[NAME]] to see if there was ice water in it. She said herself and the CNA were responsible for monitoring that the machine had ice water in it. She said she was not sure who had ordered the [[NAME]], but it had been on Resident #1's knee for pain management. She said the orders might have come from the hospital, but she was not sure because the resident was new to the facility. She stated the admitting nurse was responsible for entering the physician orders at admission. RN said that she was monitoring Resident #1's circulation every 4 hours. She said the risk to resident not having ice water in her [[NAME]] was increased pain. In an interview with CNA on 09/04/25 at 09:42 AM, revealed she was not responsible for monitoring for Ice water in the ICTU machine. She said that was the nurse's responsibility