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	01/13/2025

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

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids administered were consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for one (Resident #68) of six residents reviewed for periperal intravenous care. The facility failed to ensure Resident #68's peripheral intravenous (this is a catheter placed into the vein for short term fluids and or antibiotics use) dressing was dated with the insertion date. These failures could place residents at risk of cross-contamination and infections. Findings included: Review of Resident #68's admission record dated 01/08/25 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with an initial admission of 01/11/22. His diagnoses included unspecified dementia with agitation (this is a brain disease that alters brain function causes cognitive decline), protein calorie malnutrition, pneumonia (fluid in the lungs), diabetes (uncontrolled blood sugars), and acquired absence of left and right below the knee (amputation of both legs below the knee). Review of Resident #68's quarterly MDS dated [DATE] reflected a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Review of Resident #68's physician order for January 2025 revealed, 1.Normal Saline Flush Solution (Sodium Chloride Flush) Use 10 ml intravenously every shift for dehydration for 1 day. Administer flush after medication administration. Order dated 01/03/25. 2. Sodium Chloride intravenous Solution 0.9% (Sodium Chloride) use 75 ml/hr intravenously one time only for hydration for 1 day. Order dated 01/03/25. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's care plan on 01/07/25 revealed Resident # 68 was a potential risk for pressure ulcer development related to infection, impaired mobility, incontinence, nutritional deficit, diabetes, and malnutrition. The goal was to minimize the risk for further pressure ulcers and or deterioration of current wounds. Interventions were to keep skin clean and dry, to notify nurses immediately of any signs of skin breakdown, redness, blisters bruises and discoloration noted during bath or daily care. The care plan did not address the peripheral IV. Observation and interview with Resident #68 on 01/07/25 at 10:06 AM, revealed Resident #68 lying in bed with his right arm exposed which revealed a peripheral IV with dressing intact and undated. Resident # 68 stated he had gotten some fluid electrolytes last week. Resident #68 could not remember the exact date of the IV insertion. He stated he only had the fluids for 1 day. He stated he did not know why he still had the IV as no one had used it since last week. In an interview with LVN D on 01/07/25 at 12:52 PM she stated she was Resident #68's nurse. She stated she was aware Resident #68 had a peripheral IV and she was waiting for the physician to give her orders to discontinue the IV or to give more fluids. LVN D did not state why it was not dated and what the risk was to the resident . In an interview with RN C on 01/13/25 at 08:50 AM, he stated LVN D asked him to remove Resident #68's IV after obtaining orders from the physician to remove it on 01/07/25. He stated that all IV's should have a date on it so that you can see how long it had been in. He stated it was infection control to make sure that IV dressing was dated with an insertion date. RN C stated it was good nursing practice to get clarifications on IV orders to avoid medication errors . In an interview with ADON A on 01/13/25 at 10:56 AM, she stated she was the infection control preventionist. She stated all IVs were expected to have a date on them when they were inserted. She stated IVs were to be checked daily for infection and to note when the dressing needed to be changed, which for peripheral intravenous, was 72 hours. She stated the nurse that inserted the IV should have written the date on the IV so that another nurse can just look at the date and know when to change it. She stated the risk was infection and infiltration. In an interview with the DON on 01/13/25 at 12:55 PM, she stated the expectation was that all IV's were dated with the insertion date, were clean, intact, dry and no signs and symptoms of infection. She stated the nurses were responsible for making sure that the IV's were dated. She stated the nurse that inserted the IV should have put the date on the dressing. She stated dating IV helped to reduce infection. Review of facility policy titled Peripheral IV Catheter Insertion revision date April 2016, reflected: Definition 1. A peripheral short catheter is defined as a catheter that is less than 3 inches (7.5cm) in length. The tip of a peripheral short catheter ends in the peripheral vein. Dressings 1. Use sterile dressings (transparent or gauze, as appropriate) to cover the insertion site. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Label on dressing should include date and time of dressing placement, initials, gauge size, and length of catheter .

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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 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** 44894 Based on observations, interviews, 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 permitted only authorized personnel to have access for one of eight residents (Resident #67) reviewed for storage of medication and 1 of 6 medication storage carts (Nurses' Treatment Cart) observed for drug security. 1. Nurses' Treatment Cart was left unattended and unlocked outside the women's bathroom on 01/08/25. 2. The facility failed to ensure medications were not left at bedside for Resident #67. This deficient practice could affect residents at risk of lost medications, drug diversion, or harm due to accidental ingestion of unprescribed medications. The findings included: In an observation on 01/08/25 at 06:25 AM and at 07:51 AM, the Nurses' Treatment Cart was observed unlocked and unattended with the lock mechanism out (indicating it was unlocked) outside the women's bathroom. The cart did not contain narcotic medications. The Nurses' Treatment Cart included over the counter and prescription topical medications, multiple over the counter medications for wound care, and one bottle of betadine antiseptic cleaner. Staff and residents were observed in the immediate vicinity. In an interview on 01/08/25 at 07:51 AM, RN C stated the Nurses' Treatment Cart was his responsibility. RN C stated the Nurses' Treatment Cart was an extra one of 2 that he used. He stated he did not know who had left it unattended and unlocked. RN C stated the Nurse's Treatment Cart should not be left unlocked when unattended. He stated the risk was that a resident could get into it and have adverse effects to medications in the cart. In an interview on 01/08/25 at 07:51 AM, the DON stated all medication carts and treatment carts were to be secured when not in use. The DON stated one of the floor nurses might have left the cart unlocked after getting some wound care supplies out of the Nurses Treatment Cart. The DON stated she would initiate staff In-Servicing. The DON stated residents could have been negatively impacted if one had obtained medication from the unattended Nurses Treatment Cart and used it inappropriately. Record review of Resident #67's face-sheet dated 01/10/2025, revealed a [AGE] year-old male, initially admitted to facility on 10/26/2023, and readmitted on [DATE]. Resident's diagnosis included: Unspecified dementia severe without behavioral disturbance, and psychotic disturbance, mood disturbance, and anxiety (a person is presenting signs and symptoms of dementia and has a dementia diagnosis, but they lack any symptoms of behavioral disturbances); essential (primary) hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause); and unspecified atrial fibrillation (a chronic heart condition where the upper chambers of the heart beat irregularly). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #67's quarterly MDS (Minimum Data Set) dated 11/09/2024 revealed Resident's cognitive status intact. Further review of MDS revealed Resident's BIMS (Brief Interview of Mental Status) score was 15/15. Record review of Resident #67's Medication administration record dated 01/14/2025 revealed: Biofreeze Professional External Gel 5 % (Menthol (Topical Analgesic)) Apply to Neck, Shoulders, and BUE topically every 12 hours as needed for pain. -Start Date- 08/19/2024 In an observation and interview on 01/07/2025 at 11:03 AM, Resident #67 was observed in her room and in bed. Observed resident's overbed table placed over her in bed and next to her water picture was a bottle of AZO Dual Protection Urinary & Vaginal Support (over-the-counter pills designed to help restore bacterial balance to support urinary and vaginal health) and Biofreeze Roll-On gel (fast acting and long lasting, cooling menthol formulation delivers penetrating pain relief for sore muscles and joints). Resident #67 revealed that her family member brought in the urinary pills for her because she has problems with UTIs and the Biofreeze was for her stiff neck and shoulders. She revealed the staff did not know her brought in the medication. Interview with LVN E on 01/14/2024 at 11:15 AM, revealed that LVN E was not aware of the bottle of AZO Dual Protection Urinary & Vaginal Support medication and Biofreeze Roll-On gel on Resident #67's over-bed table. LVN E immediately went to to room and removed the medication. LVN E revealed that Resident #67 did not have orders to self-medicate. There were orders for the Biofreeze every 12 hours. No orders for the AZO Dual Protection Urinary & Vaginal Support medication. LVN E revealed a negative outcome would be Resident #67 could over-dose on the AZO Dual Protection Urinary & Vaginal Support medication. LVN E was not aware of a negative out-come to resident with having the Biofreeze at bedside. A dementia resident could wander into resident's room and take the pills and Biofreeze off the over-bed table. Interview with the DON on 01/14/2025 at 11:30 AM revealed that the DON was unaware that Resident #67 had AZO Dual Protection Urinary & Vaginal Support medication and Biofreeze Roll-On gel on the over-bed table. The DON reviewed Resident #67's physician orders and revealed there were orders for the Biofreeze, but not at the bedside. The DON revealed a negative outcome would be that a dementia resident could have wondered into resident's room and taken the medication by mistake. The DON revealed that she informed Resident #67's family member that he was not allowed to bring in any medications to the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 01/13/2025 at 4:00 PM revealed he was aware of medication on Resident #67's over-bed table. The DON informed the ADM of the medication mistake. The ADM revealed that several negative outcomes could have occurred with this mistake. A confused resident could have wondered into room and taken the medication by mistake and taken the Biofreeze off the over-bed table. Record review of the facility's policy, Security of Medication Cart, revised April 2007, revealed 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2.The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. Record review of facility's policy General guidelines - Storage of Medications, Procedures revealed in part . Administration: 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. 48520

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure the standby refrigerator temperature measured at 41F or less. 2. The facility failed to ensure walk-in refrigerator food items were dated and labeled. 3. The facility failed to ensure dry storage food items were dated, labeled, and stored securely. 4. The facility failed to ensure canned goods were free of dents. 5. The facility failed to ensure prepared foods items were covered and utilized separate utensils to ensure the food was free of cross-contamination. Findings included: Observation on 01/07/2025 at 9:09 AM upon entry to the kitchen revealed the following: Bread rolls sitting in uncovered muffin pans on counter tops. Interview on 01/07/2025 at 9:09 AM with the Dietary Manager revealed that the bread rolls had not been baked and that they had to rise before baking. Observation on 01/07/2025 at 9:12 AM of the stand-by refrigerator revealed the following: The digital thermometer on the outside door displayed it was in defrost cycle mode and prepared fruit cups were stored on the shelves. No thermometer on the inside to read the temperature. Observation on 01/07/2025 at 9:13 AM revealed the Dietary Manager placing a thermometer gauge in the refrigerator. Observation on 01/07/2025 of the walk-in refrigerator at 9:17 AM revealed the following: A plastic bag with sliced cheese dated 12/15/24 with no use by date. A box of cream cheese dated 12/31 with no use by date. A container of yellow mustard dated 5/15 with no use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/07/2025 at 9:17 AM with the Dietary Manager, he stated that the date written on the food item references the delivery date. Observation on 01/07/2025 of dry storage at 9:19 AM revealed the following: An open package of pancake mix in an unsealed zip closure bag and dated 5/15, with no use by date. An open package of spaghetti noodles in an unsealed zip closure bag and dated 12/26/24, with no use by date. Toasted oats in a large bin with an unsealed lid and dated 9/6/24, with no use by date. Multiple dented canned goods. Observation on 01/07/2025 at 9:27 AM of the stand-by refrigerator thermometer gauge revealed a temperature reading of 49F. Observation on 01/08/2025 at 11:33 AM upon entry of the kitchen revealed the following: Uncovered metal pans with lunch food items on the steam tray table. Food items included pork, mashed potatoes, brussels sprouts, Salisbury steak, brown gravy, pasta noodles, and mechanically altered forms of these foods. Uncovered small metal pans of mashed potatoes and gravy sat in a large metal pan with simmering water heated by cooking stove top. Observation on 01/08/2025 at 11:44 AM of steam tray service line revealed the following: [NAME] A used one serving tong to pick up slices of bread and pick up slices of pork. Interview on 01/08/2025 at 12:26 PM with [NAME] F, she stated that she knew each food item should have its own utensil when serving and that she did not have a separate utensil for the bread. [NAME] F stated that using the same serving utensil for different food items was a cross-contamination risk . Interview on 1/13/2025 at 9:04 AM with the Dietary Manager revealed that he did not know how often the stand-by refrigerator went into defrost cycle mode. If he noticed the stand-by refrigerator was not holding the maximum safe temperature, he would throw away the food and report it to maintenance. He stated that the prepared fruit that was stored in the standby refrigerator could cause the residents to get sick and the food could grow bacteria. He stated that sticker labels were only used on food items that were put into containers without labels to be able to tell (identify) the food items. The refrigerators had signs on the doors for staff to use to know how to label foods, what days the foods were prepared on and when to use the food by. He stated that food items should have a received on and opened on date on them and should be labeled as they come off the (delivery) truck. He stated that dents can compromise the seal of the can and cause botulism. He stated that the serving tongs [NAME] A used for both the bread and meat was only for the bread and there were usually separate tongs for the meat. He stated that two separate tongs were used to prevent cross contamination . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy, Food Preparation and Service policy dated 2019 revealed, . Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices . Appropriate measures are used to prevent cross contamination. These include . cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses, following food code guidelines . Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness . When food is delivered to the facility it will be inspected for safe transport and quality before being accepted . Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date) . All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) . Refrigerated foods must be stored below 41 F unless otherwise specified by law . Other opened containers must be dated and sealed or covered during storage . Record review of the U.S. FDA Food Code 2022 reflected: 3-501.16 Time/Temperature Control for Safety Food, Hot, and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained . (2) At 5 C (41 F) or less. 4-204.112 Temperature Measuring Devices . temperature measuring device must be placed in a location that is representative of the actual storage temperature of the unit to ensure that all time/temperature control for safety foods are stored at least at the minimum temperature required in Chapter 3 . A permanent temperature measuring device is required in any unit storing time/temperature control for safety food because of the potential growth of pathogenic microorganisms should the temperature of the unit exceed Code requirements . 3-304.11 Food Contact with Equipment and Utensils. FOOD shall only contact surfaces of . (B) Single-service and single-use articles . 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 48520 Based on observations, interviews, and record reviews 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 infections for 1 of 6 Residents (Resident #82) observed for infection control and 4 of 4 quarters reviewed for water management. 1. The facility staff failed to use proper technique when flushing Resident #82's IV while the resident was on enhanced barrier precautions. 2. The facility failed to implement a water management program per facility policy. These failures could place residents at risk of cross-contamination and infections. Findings included: 1. Review of Resident # 82's admission record revealed [AGE] year-old male was admitted to the facility on [DATE] with an initial admitted [DATE]. Primary diagnosis included metabolic encephalopathy (alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism). Review of Resident #82's Care Plan, undated, reflected resident was on Enhanced Barrier Precautions-resident was at risk for infection related to indwelling medical devices. Interventions wear gloves and gown during high-contact care activities for with indwelling medical devices, wounds, and colonized or infection with a CDC targeted MDRO (Multi drug-resistant Organism). Review of Resident #82's Minimum Data Set (MDS) Comprehensive Set dated 12/28/2024 reflected a BIMS score of 15 which indicated an intact cognitive response and suggested that the resident was capable of normal cognition. Review of Resident # 82's Treatment Administration Record dated 01/10/2025 reflected Cefazolin Sodium Intravenous Solution Reconstituted 2 GM . Use 2 grams intravenously every 8 hours for bacteria in the blood. Observation on 01/07/2025 at 3:45 PM reflected signage posted outside resident #82's room stated Permissions Based Precautions. LVN G wore latex gloves and used an alcohol wipe to clean resident #82's IV port, then LVN allowed the port to lay on Resident #82's skin while she prepared the saline flush. LVN F then attached Saline flush with 5cc to the port. After she administered the saline, she then placed the syringe directly on the bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LVN G on 01/07/2024 at 3:53 PM reflected she was in-serviced on EBP before Christmas. She stated that she was in-serviced to wear a gown when in direct contact with the resident. She stated that she did not look at the sign at the door and she did not see the PPE outside the resident's room. She stated that the risk of not wearing PPE while performing high-contact resident care was the spread of infection. She stated that she should have thrown the sterile saline in the resident's trash cans since he was on isolation. The risk of leaving it on the bedside table was cross contamination. Interview on 01/13/2025 at 11:02 AM with ADON A reflected the LVN G should have gowned and gloved up prior to entering the room to administer IV medication. The reason for the procedure was to prevent any additional bacteria from coming in to the resident. She stated that once the porst was sterilized it should not have come into contact with the resident's skin again because it was dirty. The risk was it could become more septic and the risk of additional bacteria. 2. Interview on 01/13/25 at 01:33 PM with the Administrator revealed the current Maintenance Director was new. The Administrator stated he requested information from corporate, who said another company was managing water. No documentation was provided by the facility that a water management program was developed or implemented. Review of facility policy titled Peripheral IV Catheter Insertion revision date April 2016, reflected: Definition 1. A peripheral short catheter is defined as a catheter that is less than 3 inches (7.5cm) in length. The tip of a peripheral short catheter ends in the peripheral vein. Dressings 1. Use sterile dressings (transparent or gauze, as appropriate) to cover the insertion site. 2. Label on dressing should include date and time of dressing placement, initials, gauge size, and length of catheter . Record review of the facility policy titled, Legionella Water Management program revised July 2017, reflected in part: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team .6. The water management program will be review at least once per year .