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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of 3 residents medication (Resident#4, Resident #200's and Resident#99) medications on 2 of 4 medication carts,(200 hall nurses cart and 200 hall medication aides cart) reviewed for pharmacy services.1. The facility failed to ensure proper disposal of Resident#4's Tylenol 300/30mg (controlled medication) by taping the blister pack of a narcotic medication. 2. The facility failed to ensure proper disposal of Resident#4's Tylenol 300/30mg (controlled medication) medication that was discontinued. 3. The facility failed to ensure proper disposal of Resident #99's Lyrica capsule 300mg (controlled medication) when the blister pack was damaged.4.The facility failed to ensure Resident #200's (deceased and discharged) expired Bactroban Cream 2 % (Mupirocin Calcium) (a topical antibiotic ointment or cream used to treat bacterial skin infections) was removed from the medication cart and properly disposed.5. The facility failed to ensure an expired opened Hemorrhoid cream expired 01/2026 was removed from the 400 hall nurses' medication cart and disposed of.6. The facility failed to ensure an expired 2026 Argiment (supplement specialized, non-digestible plant fibers that act as fertilizer to nourish and stimulate the growth of beneficial bacteria in the gut) expired [DATE] was removed from the 400 hall nurses' medication cart and disposed of.This failure could place residents at risk of drug diversion, medication errors, and risk of pills contamination due to broken seals.Finding included:1. Record review of Resident #4's MDS Assessment, dated [DATE], reflected Resident #4 was a [AGE] year-old female, admitted [DATE] and readmitted [DATE].She had a BIMS score of 15, indicating intact cognition. The resident had diagnoses including Peripheral Vascular Disease (a slow, progressive circulation disorder characterized by narrowing, blockage, or spasms in blood vessels outside the heart, commonly affecting the legs and feet). Record review of Resident #4's Comprehensive Care Plan, Date Initiated [DATE] reflected [Resident #4] has an UNAVOIDABLE pressure injury to LEFT HEEL STAGE 3 with potential for further pressure injury development r/t fragile skin, Hx of skin breakdown, Hx of ulcers. Interventions included pain meds as ordered, report unrelieved pain to MD.Record review of Resident #4's active physician orders, dated [DATE], reflected the resident had no orders for Tylenol with codeine #3 tablet 300-30mg (Acetaminophen-Codeine). The order was discontinued [DATE].2. Record review of Resident 99's Comprehensive MDS Assessment, dated [DATE], reflected the Resident #99 was a [AGE] year-old female, admitted [DATE]. She had a BIMS score of 11, indicating moderate cognitive impairment. The resident had diagnoses including Respiratory failure (a life-threatening condition where the lungs cannot adequately supply oxygen to the blood), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life), and Post Traumatic Stress Disorder (PTSD).Record review of Resident #99's Comprehensive Care Plan, dated [DATE], reflected Resident #99 has (acute/chronic) pain. Interventions included pain meds as ordered, report unrelieved pain to MD .Record review of Resident 99's active physician orders, dated [DATE], reflected Lyrica capsule 300mg. Give 1 capsule by mouth (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

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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	twice daily for pain order date [DATE].3. Record review of Resident #200's Discharge MDS assessment, dated [DATE], reflected he was a [AGE] year-old female admitted to the facility on [DATE] readmitted on [DATE] and was discharged [DATE]. No BIMs was recorded (indicating no interview was conducted). Resident #200's discharge status indicated she was deceased .Record review of Resident #200's care plan, Initiated [DATE], revealed: RESOLVED [NAME] has rash to face requiring topical Bactroban x 7days. Facility Interventions included RESOLVED: Administer antibiotic ointment as per MD orders.Record review of Resident #200's Discontinued Physician Order, dated [DATE], reflected: Bactroban Cream 2 % (Mupirocin Calcium) Apply to Face topically two times a day for Rash until [DATE]. Discontinued [DATE].An observation on [DATE] at 1:30 PM with MA C of the 200 Hall Medication Aide Cart station, revealed Resident #99's Lyrica capsule 300mg had a damaged blister bubble and the capsule still inside, at the time the surveyor inspected the medication cart.During an interview with MA C on [DATE] at 1:40 PM, she stated she did not notice the blister was damaged before the surveyor brought it to her attention. She stated the nurses and medication aides were responsible for inspecting the blister packs at every shift change when they did the narcotic count.An observation on [DATE] at 2:22 PM of the 200 Hall Nurses Cart station, revealed Resident #4's Tylenol with codeine #3 tablet 300-30mg (Acetaminophen-Codeine) had 2 blister seals broken and taped , and Resident #200's expired Bactroban Cream 2 % (Mupirocin Calcium) expired 08/2025.The damaged blister had the pills still inside secured with tape at the time the surveyor inspected the medication cart. During an interview on [DATE] at 2:32 pm with RN E revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that were discontinued, were removed from the cart for proper disposal. RN E stated she did not notice the blister was damaged before the surveyor brought it to her attention. She stated the nurses and medication aides are responsible for inspecting the blister packs at every shift change when they do the narcotic count. She stated Resident #4's Tylenol with codeine #3 tablet 300-30mg was discontinued [DATE]. She stated discontinued narcotics should be removed from the cart immediately and given to the DON. RN E stated if a narcotic blister seal was broken, the medication should be discarded wasted and witnessed by two nurses. She stated that the risk of a damaged blister would be the potential for drug diversion and contamination of medication. She stated the risk to the resident was medication error and medication not being effective if it was expired. She stated that she had been in-serviced on medication storage. In an interview on [DATE] at 2:50 pm, LVN D stated she was unaware Resident#99's Lyrica capsule 300mg blister pack seal was broken. She stated that the risk of a damaged blister would be the potential for drug diversion and contamination of the medication. She stated the nurses and medication aides were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated she had been in-serviced on medication storage.An Interview on [DATE] at 9:12 am with MA F revealed that when a narcotic bubble seal was broken, he would notify the charge nurse so that the medication could be discarded. He stated all discontinued narcotics should be removed from the medication cart and given to the DON. He stated the risk of a damaged blister and discontinued medication would be the potential for drug diversion and contamination of the medication. He stated he was in-serviced on medication storage, and damaged narcotic blisters should never be taped.In an interview on [DATE] at 11:00am, the DON stated if a narcotics was discontinued, the nurses and medication aides were supposed to remove the medication from the cart and take it to her office to be secured properly until the pharmacist consultant disposed it. She stated if the blister pack seal was broken on any controlled medications, the pill should be discarded and witnessed by two nurses. The DON stated it was not acceptable to keep a pill in a blister pack that was opened. She stated that if a blister pack seal was broken it should not be taped. The DON stated the risk would be losing the medication because the seal was broken. She stated nurses and Medication Aides were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON audit the medication carts bi-weekly, (continued on next page)

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	03/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then the pharmacy consultant audits the medication room and the medication carts every month. She stated the nurses and the MAs had been in-serviced on medication storage, and narcotics were not to be taped if the blister seal was broken.Review of the facility's policy Storage of Medication Revised [DATE] reflected the following: Drugs and biologicals are stored in the packaging containers or other dispensing systems they are received in . The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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	03/12/2026

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 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 secure,label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for five residents(Resident#10, Resident #33, Resident#13's , Resident#122, and Resident#19's) on two medication carts (100 and ,200 hall nurses medication carts) of four medication carts reviewed for medication storage. 1. The facility failed to ensure Resident #33's Naphcon A Eye drop was secured in the medcart.2. The facility failed to ensure Resident#10's: Fiasp FlexTouch 100 UNIT/ML Solution pen-injector (a rapid-acting mealtime insulin) was dated after opening and before it was stored in the medication cart.3. The facility failed to ensure Resident#13's Insulin Lispro Protamine &Lispro (is a rapid-acting insulin given at mealtimes) was dated after opening and before it was stored in the medication cart.4. The facility failed to ensure Resident#122's Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (a long-acting human insulin) was dated after opening and before it was stored in the medication cart.5. The facility failed to ensure Resident#19's Insulin Degludec Subcutaneous Solution 100UNIT/ML (Long-acting insulin) was dated after opening and before it was stored in the medication cart.6. The facility failed to ensure an open Lyumjev (a fast-acting mealtime insulin). had the patient's label and was dated after opening and before it was stored in the medication cart.These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents.Based on observation, interview, and record review, the facility failed to secure, label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for five residents (Resident#10, Resident #33, Resident#13's , Resident#122, and Resident#19's) on two medication carts (100 and ,200 hall nurses medication carts) of four medication carts reviewed for medication storage. 1. The facility failed to ensure Resident #33's Naphcon A Eye drop was secured in the medcart.2. The facility failed to ensure Resident#10's: Fiasp FlexTouch 100 UNIT/ML Solution pen-injector (a rapid-acting mealtime insulin) was dated after opening and before it was stored in the medication cart.3. The facility failed to ensure Resident#13's Insulin Lispro Protamine &Lispro (is a rapid-acting insulin given at mealtimes) was dated after opening and before it was stored in the medication cart.4. The facility failed to ensure Resident#122's Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (a long-acting human insulin) was dated after opening and before it was stored in the medication cart.5. The facility failed to ensure Resident#19's Insulin Degludec Subcutaneous Solution 100UNIT/ML (Long-acting insulin) was dated after opening and before it was stored in the medication cart.6. The facility failed to ensure an open Lyumjev (a fast-acting mealtime insulin). had the patient's label and was dated after opening and before it was stored in the medication cart.These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents. Findings included: 1. Record review of Resident #33's Quarterly MDS Assessment, dated [DATE], reflected he had a BIMS score of 10, which indicated moderate cognitive impairment, suggesting potential issues with memory and thinking skills. Resident #33 was identified as having adequate vision and no corrective lenses. Record review of Resident #33's Care plan active as of [DATE] did not indicate any goals or interventions related to the medication that was at bedside or self administration.Record review of Resident #33's active Physician's Orders, dated [DATE], reflected there were no orders for Naphcon A Eye drop.Record review of Resident #33's Physician's Orders, dated [DATE], reflected there were no orders for Resident #33 to self-administer medications.An observation on [DATE] at 10:10 am revealed Resident #33 was in his bed a bottle of Naphcon A Eye (continued on next page)

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	03/12/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drop on his bedside table.During an interview on [DATE] at 10:10 am with Resident #33, revealed he self-administered his eye drops.During an interview on [DATE] at 10:20am with MA C, revealed she was not aware Resident #33 had eye drops in his room. She stated Resident#33 was not supposed to have any medication at bedside. She stated the risk of leaving medication at beside was that the resident would self-administer inappropriately, another resident could have access to medication that is not properly secured. She stated she had been serviced on medication administration and storage in the room During an interview on [DATE] at 10:22am with LVN D, she stated she was not aware Resident #33 had eye drops in his room. She stated Resident #33 may be at risk of infection, drug overdose, and use of expired medication by unauthorized self-medication. During an interview on [DATE] at 11:00am with the DON, revealed Resident #33 was unable to safely self-administer medications. The DON stated the bottle of eye drops on Resident #33's bedside table should have been appropriately secured and stored in the facility's medication cart. The DON stated the risk of unsecured medications included the potential for drug interactions and overdose.2. Record review of Resident #10's MDS assessment, dated [DATE], reflected he was a [AGE] year-old female re-admitted to the facility on [DATE]. Her BIMS score was 12, indicating her cognitive status was moderately impaired. Her diagnoses included Diabetes Mellitus.Record review of Resident #10's active care plan, Initiated [DATE], revealed Resident #10's has Diabetes Mellitus. Facility interventions: Check all of body for breaks in skin and treat promptly as ordered by doctor. Dietary consult for nutritional regimen and ongoing monitoring. Fasting Serum Blood Sugar as ordered by doctor. Observe/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing,Record review of Resident #10's active Physician Order, dated [DATE], reflected: Fiasp FlexTouch 100 UNIT/ML Solution pen-injector. Inject as per sliding scale: if 151 - 200 = 2 Units; 201 -250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8Units; 351 - 400 = 10 Units; 401 - 450 = 12 Units, subcutaneously before meals for Diabetes HOLD if BS LESS than 70. USE Humalog until Fiasp arrives. order start date [DATE].3. Record review of Resident #13's MDS assessment, dated [DATE], reflected she was a [AGE] year-old female re-admitted to the facility on [DATE]. Her BIMS score was 11, indicating her cognitive status was moderately impaired. Her diagnoses included Diabetes Mellitus. Record review of Resident #13's active care plan, Initiated [DATE], revealed: [NAME] as the potential for hypo/hyperglycemia related to Diabetes Mellitus. Facility Interventions included: Accu-Chek (is a brand of blood glucose monitoring devices for diabetes management) with sliding scale coverage as ordered. Administer diabetes medication as per MD ordersRecord review of Resident #13's active Physician Order, dated [DATE], reflected: Humalog Mix 75/25 Subcutaneous Suspension (75-25) 100 UNIT/ML (Insulin Lispro Protamine &Lispro) Inject 22 unit subcutaneously every morning and at bedtime for DM start date [DATE].4. Record review of Resident #122's annual MDS assessment, dated [DATE], reflected he was an [AGE] year-old female re-admitted to the facility on [DATE]. Her BIMs score was 07, indicating her cognitive status was severely impaired. Her diagnoses included Diabetes Mellitus.Record review of Resident #122's active care plan, Initiated [DATE], revealed: [NAME] as the potential for hypo/hyperglycemia related to Diabetes Mellitus. Facility Interventions included: Accu-Chek (is a brand of blood glucose monitoring devices for diabetes management) with sliding scale coverage as ordered. Administer diabetes medication as per MD ordersRecord review of Resident #122's active Physician Order, dated [DATE], reflected: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously at bedtime for Diabetes start date [DATE].5. Record review of Resident #19's annual MDS assessment, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Her BIMs score was 07, indicating her cognitive status was severely impaired. Her diagnoses included Diabetes Mellitus.Record review of Resident #19's active care plan, Initiated [DATE], revealed: [NAME] has the potential for hypo/hyperglycemia related to Diabetes Mellitus. Facility Interventions included: Accu-Chek (is a brand of blood glucose monitoring devices for diabetes management) with sliding (continued on next page)

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	03/12/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scale coverage as ordered Administer diabetes medication as per MD orders.Record review of Resident #19's active Physician Order, dated [DATE], reflected: Insulin Degludec Subcutaneous Solution 100UNIT/ML (Insulin Degludec) Inject 15 unit subcutaneously at bedtime related to start date [DATE].An observation on [DATE] at 9:21 am with LVN D on the 100 nurses' medication cart revealed Resident#10's Fiasp FlexTouch 100 UNIT/ML Solution pen-injector, Resident#13's insulin pro, Resident#122's Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML, Resident#19's insulin aspart were all opened with no with no opening dates. The Lyumjev had no patient's label and no opening date. During an interview on [DATE] at 9:32 am with LVN D revealed the nurses were responsible for checking that all insulin pens and vials had patient labels and open dates. LVN D stated that she did not realize the opened insulin pens did not have labels and opened dates. She stated that it was important to date opened insulins, because once opened, insulin expired after 28 days. LVN D stated that the risk to the resident receiving expired insulin could cause negative drug effects that due to reduced effectiveness of the medication. She stated having insulin in the medication cart that did not have the proper label could result in administering insulin to the wrong resident which may result in hospitalization. She stated she knew that he was supposed to check and ensure all medications were not expired before administering to the residents. LVN D stated she had been in-serviced on medication storage and dating all opened insulin and medication. She stated that she would remove the unlabeled and undated insulin from the cart immediately. An interview on [DATE] at 2:32 pm with RN E revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were within date, and all medication that were discontinued, were removed from the cart for proper disposal. She stated the risk to the resident was medication error and medication not being effective if it was expired. She stated that she had been in-serviced on medication storage. An interview on [DATE] at 11:00am with the DON, revealed all insulin pens and vials should be labeled, and they should have an open date. She stated that it was the responsibility of every nurse to check the label and open date before the administering insulin to a resident. The DON stated insulin was supposed to be dated because opened insulin expired 28 days after opening. She stated that failure to have open dates on insulin could result in administrating medication that was expired and could not be effective or that could have negative side effects to the residents. The DON stated all expired medication, discontinued medication, and medication of discharged residents should immediately be removed from the medication cart. She stated the risk to the residents was medication error administering expired medication could lead to adverse side effects and or not be effective. She stated that the DON and the ADON audited the medication carts biweekly and as needed, but there was no set schedule. She stated that the pharmacist audited the medication carts monthly. Review of the facility's policy Storage of Medication Revised [DATE] reflected the following 1.Medications and biologicals are stored in the packaging containers or other dispensing systems they are received in. Only the issuing pharmacy is authorized to transfer medications between containers. Drug containers that have missing, incomplete, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.Compartments containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Drugs shall be stored in an orderly manner in cabinets, drawers' carts, or automatic dispensing systems. Each resident's medication shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents

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	03/12/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a Comprehensive Assessment within 14 calendar days after admission, as well as at least once every 12 months, for one (Resident #124) of seven residents reviewed for Comprehensive Assessments and timing. The facility failed to ensure a Comprehensive MDS Assessment for Resident #124 was completed within 14 days after his admission to the facility. This failure could place residents at risk for improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.Findings included: Review of Resident #124's Face Sheet, dated 03/12/26, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including seizures (a sudden surge of abnormal electrical activity in the brain, leading to changes in behavior, movements, feelings, and levels of consciousness), morbid (severe) obesity due to excess calories (having a body mass index of 40 or over), pain (physical suffering or discomfort caused by illness or injury), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation.). Review of Resident #124's MDS Assessment, dated 02/20/26, reflected the assessment was completed on 03/02/26 (17 days after admission). During an interview with the MDS/PPS Nurse on 03/11/26 at 10:25 AM, she stated Resident #124's MDS Assessment was not completed within the required timeframe due to her being on vacation when the assessment was due. She stated she did not believe MDS Assessments, not being completed within the required timeframe, posed a risk to residents, as necessary care was still provided for residents. Review of the facility's Electronic Transmission of the MDS policy, dated December 2009, reflected, .All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's computer MDS informational system and transmitted to the State database in accordance with current OBRA regulations governing the transmission of MDS data. The policy did not reflect the specific timeframe for MDS completion.

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	03/12/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for one of six residents (Resident #16) reviewed for assessments. Resident #16's PASRR Level I was negative for mental illness despite having a diagnosis of anxiety, depression, and schizoaffective disorder. This could place residents at risk of not receiving necessary specialized services to meet their individual needs.Record review of Resident #16's MDS assessment dated [DATE], reflected an [AGE] year-old female, originally admitted to the facility on [DATE], with a BIMS score of 12 which indicated moderate cognitive impairment and diagnoses that included: Anxiety Disorder (ongoing uncontrollable, and excessive worry, fear, or dread that significantly interferes with daily life), Depression (feelings of severe sadness and inability to initiate activity), and Schizoaffective Disorder (a serious mental illness blending symptoms of schizophrenia - psychosis like hallucinations/delusions, with mood disorders like depression or bipolar mania involving extreme mood swings, disorganized thinking, and disrupted reality perception.) Record review of Resident #16's Care Plan dated 11/28/2026, reflected she received antipsychotic medication to treat symptoms of schizoaffective disorder, antianxiety to treat anxiety, and antidepressant medications to treat depression. Record review of Resident#16's PASRR Level 1 Screening dated 10/21/2025 after re-admission, reflected the resident did not have evidence of a mental illness. During an interview on 03/11/2026 at 12:45 PM, the MDS Coordinator reported she oversaw PASRR screenings for the facility. She reported that she reviewed Resident 16's PASRR Level 1 Screening dated 10/21/2025 and acknowledged it was incorrect. She stated the screening was completed by a hospital. She stated if an incoming screening was incorrectly filled out by a hospital, she was supposed to complete form 1012 (a form used by Texas nursing facilities to determine whether a resident with a negative PASRR Level I Screening requires further evaluation for mental illness or has a primary dementia diagnosis) and submit the form through the Long-Term Care Portal. The MDS Coordinator stated the 1012 form was not completed for Resident #16. The MDS Coordinator reported the resident was not at risk because the resident did not qualify for PASRR because the resident did not have an intellectual disability. She further stated the resident was not at risk because the resident received psychiatric and mental health services through a contracted mental health provider. During an interview on 03/11/2026 at 1:00 PM with the MDS/PPS Nurse, she stated Resident #16 had a diagnosis of Dementia that would override her, making her ineligible for PASRR services. She reported Resident #16's primary diagnosis upon admission was not dementia but was a urinary tract infection. She reported if a resident had an inaccurate PASRR Level I Screening, they could miss out on receiving specialized services. Record Review of the facility's PASRR Policy dated May 2014, reflected in part the following: The PASRR Level I (PL1) Screening is designed to identify persons who are suspected of having a Mental Illness (MI), Intellectual Disability (ID) of a Developmental Disability (DD) also referred to as Related Conditions (RC). The PASRR evaluation is designed to confirm the suspicion of MI, ID, or DD/RC and ensure the individual is placed in the most integrated residential setting receiving the specialized services needed to improve and maintain the individual's level of functioning.If Alzheimer/Dementia is the primary diagnosis and there is MI diagnosis, no PASRR Evaluation (PE) is needed.If Alzheimer/Dementia is not the primary diagnosis and there is MI diagnosis, PASRR Evaluation (PE) is needed.

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	03/12/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one (Resident #124) of five residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #124 within 48 hours of his admission. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services.Findings included: Review of Resident #124's Face Sheet, dated 03/12/26, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including seizures (a sudden surge of abnormal electrical activity in the brain, leading to changes in behavior, movements, feelings, and levels of consciousness), morbid (severe) obesity due to excess calories (having a body mass index of 40 or over), pain (physical suffering or discomfort caused by illness or injury), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation.). Review of Resident #124's Interim Plan of Care [baseline care plan], dated 02/13/26, reflected LVN A signed the document as completed on 02/13/26. The document was not completed as it did not address required areas such as initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, or PASARR recommendations. During an interview with LVN A on 03/11/26 at 1:30 PM, she stated she was the individual who completed the Interim Plan of Care (identified as being the same as the baseline care plan) for Resident #124. She said baseline care plans were to be completed on the day of a resident's admission. She stated she did not complete all sections of the baseline care plan for Resident #124 because she had been told it was not necessary to complete all sections, unless the resident required increased care for that specific area of the care plan. During an interview with the DON on 03/11/26 at 2:00 PM, she confirmed the Interim Plan of Care completed for Resident #124 was the same as a baseline care plan. The DON stated she was not sure of the timeframe in which the baseline care plan was supposed to be completed or the areas which were required to be included. She stated she did not believe an incomplete baseline care plan posed any risks to residents, as necessary care was still provided for residents. Review of the facility's Care Plans - Baseline policy, dated 12/2016, reflected, .1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g. dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable.

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	03/12/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #16) reviewed for comprehensive care plans. The facility failed to ensure Resident #16's comprehensive care plan was accurate and reflected the resident's PASRR status. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans.Record review of Resident #16's MDS assessment dated [DATE], reflected an [AGE] year-old female, originally admitted to the facility on [DATE], with a BIMS score of 12 which indicated moderate cognitive impairment and diagnoses that included: Anxiety Disorder (ongoing uncontrollable, and excessive worry, fear, or dread that significantly interferes with daily life), Depression (feelings of severe sadness and inability to initiate activity), and Schizoaffective Disorder (a serious mental illness blending symptoms of schizophrenia - psychosis like hallucinations/delusions, with mood disorders like depression or bipolar mania involving extreme mood swings, disorganized thinking, and disrupted reality perception.) Record Review of Resident #16's comprehensive care plan dated 11/28/2026, reflected Resident #16 PASRR assessment identified needs for specialized services. The plan stated specialized services would be provided to maintain the highest level of function for Resident #16.Record review of Resident #16's PASRR Level 1 Screening dated 10/21/2025 reflected the resident did not have evidence of a mental illness.In an interview on 03/11/2026 at 1:00 PM with the MDS/PPS Nurse, she stated she completed Resident #16's Comprehensive Care Plan. She acknowledged Resident #16 never received PASRR services. She stated the resident's Comprehensive Care Plan was inaccurate. Record Review of the facility Comprehensive Care Plan policy dated December 2016, reflected in part: The comprehensive care plan will: Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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	03/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, for 1 of 4 residents (Resident#99) reviewed for respiratory care. The facility failed to ensure that Resident #99's oxygen tubing's were bagged in a plastic bag, and which was consistent with professional standards when the nasal cannula was observed dragging on the floor.The facility failed to ensure that Resident #99 was receiving continuous oxygen per physician orders when she was observed without oxygen. These failures could place residents at increased risk of receiving inadequate oxygen support, infections that could result in a decline in health. Based on observations, interviews, and record review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, for 1 of 4 residents (Resident #99) reviewed for respiratory care.1. The facility failed to ensure that Resident #99's oxygen tubing were bagged in a plastic bag when not use, and the nasal cannula was not dragging on the floor.2. The facility failed to ensure that Resident #99 was receiving continuous oxygen per physician orders when she was observed without oxygen.These failures could place residents at increased risk of receiving inadequate oxygen support, infections that could result in a decline in health.Findings included:Record review of Resident #99's Comprehensive MDS Assessment, dated 02/07/2026, reflected she was a [AGE] year-old female, who was admitted to the facility on [DATE]. She had a BIMS score of 11, which indicated she had moderate cognitive impairment. Resident #99 was identified as requiring oxygen therapy. Her diagnosis included diagnoses including acute and chronic respiratory failure with hypercapnia (a specific type of respiratory failure characterized by elevated levels of carbon dioxide in the blood), and dependence on supplemental oxygen (a condition where an individual requires supplemental oxygen due to respiratory disorders or other medical conditions).Record review of Resident #99's Care Plan, dated 03/10/2026, reflected Resident #99's has altered respiratory status/Difficulty Breathing. Identified goals included: Resident #99 to have no signs or symptoms of poor oxygen absorption. Interventions included for Resident #99 will have no s/s of poor oxygen absorption.Record review of Resident #99's Physician's Orders, dated 02/03/2026, reflected oxygen (2 liters per minute)via nasal cannula continuously for Order start date 02/03/2026. During an observation on 03/11/2026 at 9:00AM, Resident #99 was in the wheelchair pushed by the personal care attendant. Resident #99 had a portable oxygen tank on the back of the wheelchair. The oxygen level indicator reflected the oxygen tank was empty, and the oxygen nasal canula (a flexible, lightweight tube used to deliver supplemental oxygen) was dragging on the floor while the resident was pushed on the hallway by the personal care attendant in sight of 2 other CNAs and a nurse.An interview on 03/11/2026 at 9:03AM, Resident #99 revealed she was not experiencing shortness of breath at that moment but stated she needed the oxygen tank replaced because she was supposed to be on continuous oxygen.An interview on 03/11/2026 at 09:05 AM with Resident #99's personal care attendant revealed she was taking the resident to the nurse to replace the oxygen tank that was empty, and did know that the nasal canula was dragging on the floor until the surveyor brought it to her attention. She stated the oxygen tubing should not be dragging on the floor because of possible infection.An interview on 03/11/2026 at 9:55AM with LVN D, revealed Resident #99 had a physician's order for continuous oxygen therapy. She confirmed the portable oxygen tank was empty. LVN D stated the last time she saw Resident# 99, she was receiving oxygen from the concentrator in her room. LVN D stated the risks to the residents was shortness of breath, respiratory distress (difficulty breathing, where a person struggles to get enough air, often showing rapid, shallow, or labored breathing and other signs of low oxygen), and confusion. LVN D stated the risk of a resident's nasal canula dragging on the floor was infection. She stated she had been in-serviced on infection control (continued on next page)

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	03/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory care.During an interview with the DON on 03/11/2026 at 12:10PM, she stated her expectation, for residents with physician's orders for continuous oxygen, was for those residents to always have access to oxygen. The DON stated the risk of a resident not receiving continuous oxygen, as ordered, included not getting enough oxygen and the potential for shortness of breath. The DON also stated the risk of the oxygen nasal canula dragging on the floor was infection. She stated the staff had been in-serviced on infection control respiratory care. Record review of the facility's Oxygen Administration policy, revised October 2010, reflected, .Oxygen therapy is administered by way an oxygen mask, nasal cannula, and /or nasal catheter. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head.

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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of one hydration carts observed for infection control. The facility failed to ensure proper infection control procedures were followed when Resident #49's family member utilized a metal ice scoop to obtain ice from the hydration cart, located in the residential hallway. Resident #49's family member then poured the ice into two personal cups, touching the metal scoop on the insides of each cup. This failure could place residents at risk for healthcare associated cross contamination and infections.Findings included: Review of Resident #49's Face Sheet, dated 03/12/26, reflected he was a [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including closed fracture with routine healing (a broken bone that has not pierced the skin (closed) and is recovering normally without complications (routine healing)) and pneumonia (an infection that inflames the air sacs (alveoli) in one or both lungs, causing them to fill with fluid or pus). Observation on 03/10/26 at 12:40 PM revealed Resident #49's family member utilized a metal ice scoop to obtain ice from the hydration cart, located in the residential hallway (Hall 200). Resident #49's family member then poured the ice into two personal cups, touching the metal scoop on the insides of each cup. During an interview with Resident #49's family member on 03/10/26 at 12:57 PM, she stated she frequently utilized the hydration cart to obtain ice for herself and Resident #49 and had done so since his admission to the facility. She stated she had not been advised of the need for staff to obtain the ice in order to maintain proper infection control protocols. During an interview with the Administrator on 03/10/26 at 2:30 PM, she stated residents and visitors were not supposed to use the hydration cart located on the residential hallway. She stated the hydration cart was meant for staff use; residents and visitors were encouraged to only allow staff to use the cart. When asked about the potential risk to residents, the Administrator stated it was unfortunate that the hydration cart was utilized by a visitor. The Administrator stated the facility did not have a specific policy and procedure related to hydration carts. Review of the facility's Policies and Practices - Infection Control policy, dated 07/2014, reflected, .The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.