STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676141	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matlock Place Health & Rehabilitation Center	7100 Matlock Rd Arlington, TX 76002

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 1 residents (Resident #1) reviewed for accidents. On 04/04/24, Resident #1 sustained a right shoulder fracture when CNA B left him unattended in his room while he was sitting in a shower chair. The noncompliance was identified as PNC. The noncompliance began on 04/04/24 and ended on 04/04/24. The facility has corrected the noncompliance before the survey began. This failure could place residents at risk for serious injuries. Findings included: Review of Resident #1's Admission Record, dated 06/04/24, reflected the resident was a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #1's quarterly MDS Assessment, dated 04/17/24, reflected he had a BIMS score of 15 indicating no cognitive impairment. Resident #1 was dependent on staff for transfers from chair/bed-to-chair transfer. Resident #1 had diagnoses of a stroke and hemiplegia or hemiparesis (weakness of one entire side of the body). Review of Resident #1's care plan, dated 05/17/24, reflected the following: Focus: [Resident #1] had a fall with/without injury. His fall risk assessment score is 17, indicating resident is at high risk for falls d/t Poor Balance .4/4/24 fall with injury .Goal: [Resident #1] will resume usual activities without further incident through the review date .Interventions/Tasks: 4/4/24 Staff to use shower bed for showering .[sic]. Review of Resident #1's progress notes for April 2024 reflected the following: (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: 676141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Matlock Place Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7100 Matlock Rd Arlington, TX 76002	

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 0689 Level of Harm - Actual harm Residents Affected - Few	- 04/04/24 at 11:30 AM, [at]1130 CNA reported that he found the resident on the floor, Upon assessment, the nurse helped the patient to lay on bed, completed HTT assessment, vitals B/P 148/81, P 92, RR 25, T 97.8 and SPO2 93, resident complained feeling pain of 7 on the right shoulder, gave tramadol. Continue with the Neuro checks. Notified the MDS. New order for X-ray STAT. Family notified. Continue to monitor. Written by LVN A - 04/04/24 at 12:57 PM, Resident had fall new order for stat right shoulder X-ray due to complaint of pain. Must be portable due to immobility high fall risk. Written by the ADON - 04/04/24 at 17:11 (5:11 PM), Resident had x-ray of the Right shoulder done, result pending. Written by LVN C - 04/04/24 18:16 (6:16 PM), X-ray to the right shoulder received,MD notified, n/o received for outpatient Ortho referral, sling to the Right shoulder .Resident is bed,awake and alert, Tramadol 50mg administered for pain.safety maintained. [sic] written by LVN C - 04/05/24 1:17 AM, .Thirdly, Incidental note is made of mildly displaced fracture at the surgical neck of the humerus. Suggest right shoulder joint radiography. Correlation, if clinically indicated. Result send to [Physician E]. Resident resting quietly at this time, no distress or discomfort noted. Nursing will continue to monitor. Written by RN D - 04/08/24 3:24 PM, New orthopedic appointment set for resident with [Physician G] for right shoulder on 4-16-2024 at 1045. Address is [Physician G's office address and phone number]. Family updated. Written by the ADON Review of Resident #1's Radiology Results Report, dated 04/04/24, reflected the following: Procedure: XR Right Shoulder 1 View .Interpretation .Examination: Right Shoulder .Clinical Indication: Pain in right shoulder .See Note: Findings: There is a nondisplaced fracture of the surgical neck of the right humerus of indeterminate age. There is no dislocation . Observation and interview on 06/04/24 at 8:45 AM with Resident #1 revealed he was in his bed resting. Resident #1 said he was not in any pain and remembered he had a fall a few months ago. Resident #1 said the aide left him in the shower chair because he was not thinking when he left the room. Resident #1 said he felt safe in the facility and now used a shower bed instead of the shower chair. Observation on 06/04/24 at 9:41 AM revealed Resident #1 was being prepped for his shower by two CNAs. The two CNAs transferred Resident #1 using the Hoyer lift from the resident's bed to the shower bed using proper technique. Observation on 06/04/24 at 10:15 AM revealed Resident #1 had finished his shower and was being transferred by two CNAs from the shower bed to his bed using the Hoyer lift using proper technique. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matlock Place Health & Rehabilitation Center	7100 Matlock Rd Arlington, TX 76002

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Provider Investigation Report, dated 04/11/24, reflected under Investigation Summary: After shower, resident was sitting up in shower chair in his room. During shower his hoyer sling was soiled, so it was taken out from under him. An aide went to go get a hoyer sling and [CNA B] was supposed to watch [Resident #1] while she did so. During this time, [CNA B] decides to look for a hoyer sling as well. During the time while [CNA B] was gone, [Resident #1] fell from the shower chair, fracturing his humerus. Review of an undated written statement by CNA B reflected the following: This morning after breakfast I was getting [Resident #1] a shower .I took him back to his room (covered). When I got to his room, I saw that the hoyer lift wasn't there in the room, cause [CNA F] took it, or somebody did .So I was trying to look for one, because no one really told me they just said go look for [CNA F] or something like that. When I brought [Resident #1] back to his room I was looking for someone to help me because I can't transfer him to the chair to the bed, not even with 2 people, so I called and texted [CNA F] if there was another one I could use but she didn't respond. So I didn't really know what to do, so I walked out the room to ask for help, and when I was in the office area, I heard him call for help, and I ran back as fast as I could and I saw him laying on the floor and I called for help. So we helped he's on his bed resting so we've taking care off that .I [CNA B] apologize for my actions to [Resident #1] [sic] . Attempted interview via telephone on 06/04/24 at 10:59 AM to CNA B was unsuccessful as they did not answer. Interview on 06/04/24 at 11:09 AM with CNA F revealed she originally helped to transfer Resident #1 to the shower chair before his shower on 04/04/24. CNA F said she was busy helping another after Resident #1 got his shower, so she was not involved in transferring Resident #1 back to bed. CNA F said after Resident #1 fell out of the shower chair, she was told to only use the shower bed from then on and no longer use the shower chair for Resident #1. CNA F said she was in-serviced on never leaving a resident alone in the shower chair or shower bed. Interview on 06/04/24 at 11:32 AM with LVN A revealed she was passing medications the morning of 04/04/24 in the hallway near Resident #1's room. LVN A said Resident #1 had a shower that morning and when the staff brought him back to the room, there was a nurse and an aide. LVN A said the aide came to her and told her Resident #1 had fallen out of the shower chair. LVN A said she went to the room and assessed Resident #1. LVN A said it appeared that Resident #1 was left alone in the room in the shower chair and slid out of it. LVN A said Resident #1 landed on his right side and had complained of pain to his right shoulder. LVN A said she called the doctor to get an x-ray order and provided him pain medication. LVN A said after the fall, staff only used the shower bed instead of the shower chair for Resident #1. LVN A said she knew to never leave a resident alone in the shower bed or the shower chair. Interview on 06/04/24 at 1:30 PM with the ADON revealed Resident #1 was given a shower and was put in a shower chair and taken back to his room where he fell out of the shower chair on 04/04/24. The ADON said CNA B and a nurse were in the room with Resident #1 when the nurse left to get the Hoyer lift. The ADON said CNA B also left the room to see where it was and what was happening. The ADON said an x-ray was ordered and showed Resident #1 had a fracture in his right shoulder. The ADON said CNA B was not supposed to leave Resident #1 in the shower chair unattended, and he was terminated the same day the incident occurred. The ADON said he completed in-services with staff regarding transfers and Hoyer lifts and stressed the importance of not leaving residents unattended in shower chairs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676141	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matlock Place Health & Rehabilitation Center	7100 Matlock Rd Arlington, TX 76002

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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/04/24 at 1:45 PM with the DON revealed she was new to the facility and was not at the facility when Resident #1 fell on [DATE]. The DON said she expected staff to never leave a resident unattended in a shower chair to ensure the resident did not fall out of the chair. The DON said any staff assisting a resident who was in a shower chair was responsible for making sure they were safe and not left alone. The DON said when a resident was in a shower chair and the staff needed help, they could use the resident's call light or holler out for help but they should never leave the resident alone. Interview on 06/04/24 at 1:53 PM with the Administrator revealed staff got Resident #1 ready for a shower and put him in the shower chair. The Administrator said Resident #1 had finished with his shower and was taken back to his room to be put back in bed. The Administrator said for some reason the staff needed a new Hoyer sling and there were two staff with the resident as there should have been. The Administrator said one staff went to look for a sling while the other one was supposed to stay with Resident #1, which was CNA B. The Administrator said he was not sure why, but CNA B also left the room to find a sling and Resident #1 fell out of the shower chair and fractured his arm. The Administrator said because CNA B left Resident #1 in the room alone in a shower chair, he was terminated. The Administrator said in-services were completed with all staff to ensure they did not leave a resident unattended in a shower chair and what the process was for getting a resident to and from a shower. The Administrator said he expected CNA B to stay in the room with Resident #1 while he was in the shower chair. The Administrator said after the fall, Resident #1's care plan was updated so that he only used the shower bed and not the shower chair anymore. Review of a Disciplinary Action Form for CNA B, dated and signed by CNA B on 04/04/24, reflected he was terminated due to a failure to follow procedures regarding resident safety in the shower chair. Review of in-service records completed on 04/04/24 regarding Showers and Shower Chair included: When giving a resident a shower and up in a shower chair they must be monitored at all times. When resident up in shower chair and stationery ensure brakes on shower chair are locked. Never leave a resident by themselves when up in shower chair completed with CNA B and 32 staff. Review of the facility's policy, dated 04/02/24, and titled Resident Showers revealed it did not address supervising a resident while seated in a shower chair.