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	01/08/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for one of five residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1's medications were correctly documented on his quarterly and annual MDS assessments. This failure could place residents at risk of inadequate care due to inaccurate assessments. Findings included: Record review of Resident #1's face sheet, printed on 01/08/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included metabolic encephalopathy (brain dysfunction caused by an imbalance of chemicals in the blood), chronic embolism and thrombosis of other specified veins (blood clots), end stage renal disease (a permanent condition where the kidneys can no longer function properly), acute and chronic respiratory failure with hypoxia (condition where the lungs are not effectively delivering oxygen to the body, causing a lack of oxygen in the bloodstream), quadriplegia (the loss or severe impairment of motor function, sensation, and autonomic functions in all four limbs (arms,legs and the torso), hypotension (low blood pressure), cerebral infarction (a medical condition where brain tissue dies due to a disruption in blood flow to the brain), chronic pain, anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder(mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy (a condition that occurs when high blood sugar levels damage nerves in the body), peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked), schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and essential (primary) hypertension(a condition where a person has high blood pressure without a clear cause). Record review of Resident #1's annual MDS assessment, dated 11/12/24, reflected Resident #1 had a BIMS of 13, which indicated Resident #1 was cognitively intact. Question N0415. High-Risk Drug Classes: Use and Indication, indicated Resident #1 had taken none of the above listed medications by classification in the last seven days (prior to assessment). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's quarterly MDS assessment, dated 12/12/24, reflected Resident #1 had a BIMS score of 11, which indicated a moderate cognitive impairment. Question N0415. High-Risk Drug Classes: and Indication, indicated Resident #1 had taken antipsychotic, antianxiety, and anticonvulsants in the last seven days (prior to assessment). Record review of the physician orders tab of Resident #1's electronic health record reflected the following medication orders: - Lyrica Oral Capsule 50 MG (Pregabalin) Give 1 capsule by mouth at bedtime for Pain. -Start Date- 07/11/24 -D/C Date- 12/06/24 - Melatonin Oral Tablet 5 MG (Melatonin) Give 1 tablet by mouth at bedtime for insomnia -Start Date- 07/11/24 -D/C Date- 12/06/24 - Apixaban Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for anticoagulant -Start Date- 07/10/24 -D/C Date-12/06/24 - Neurontin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth two times a day for :anticonvulsants -Start Date- 07/10/24 -D/C Date- 12/06/24 - Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for pain -Start Date- 09/14/24 -D/C Date-12/06/24 - Ziprasidone HCl Capsule Give 20 mg by mouth two times a day for Schizophrenia. Start Date- 07/11/24 -D/C Date- 12/06/24 - Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for severe pain 7-10 hold for SBP <100 and or HR <60 -D/C Date- 12/06/24 - Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for Moderate pain Can be given with Tylenol 325, 1 tab -D/C Date- 12/06/24 - Pregabalin Oral Capsule 50 MG (Pregabalin) Give 1capsule by mouth at bedtime for neuropathy. Start Date- 12/08/24 -D/C Date-12/20/24 - Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 1 tablet by mouth every 6 hours as needed for moderate or severe pain, Start Date- 12/08/24 -D/C Date-12/20/24 - Geodon Oral Capsule 20 MG (Ziprasidone HCl) Give 1 capsule by mouth two times a day for Schizophrenia. Start Date- 12/08/24 -D/C Date-12/20/24 - Eliquis Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day. Start Date- 12/08/24 -D/C Date-12/20/24 - Doxycycline Hyclate Oral Capsule (Doxycycline Hyclate) Give 100 mg by mouth two times a day for PNA for 10 Days. Start Date- 12/11/24 -D/C Date-12/20/24 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Acetaminophen-Codeine Oral Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 6 hours as needed for moderate pain. Start Date- 12/08/24 -D/C Date-12/20/24 Record review of Resident #1's November and December 2024 MARs reflected the resident medications were administered according to physician orders and PRN medications (Norco and Tramadol) were administered to Resident #1 on 11/05/24, 11/07/24, 11/12/24, 12/05/24, and 12/10/24. In an interview on 01/09/25 at 4:50 p.m., the MDS Coordinator stated she had been the facility's MDS Coordinator for roughly 3 years. She stated she was unaware Resident #1's medication were not recorded accurately on his Annual and quarterly MDS. She stated she and another staff member were responsible for the completion of all MDS assessment, but she completed Resident #1's. She stated after establishing the appropriate look-back period, medical documentation (like hospital discharge orders, skilled nursing notes current physician orders, and medication administration) to complete the MDS assessment. She stated section N of the assessment was where medications were reported according their classification and Section J asked for the use of the medication. She stated the MDS assessment was utilized to develop a plan of care for a resident. She stated care planning was completed by the interdisciplinary team and any missed medications and interventions were in place but any missed information could lead to a lack of needed care, monitoring or services for the resident. She stated she would develop a process to check assessments for accuracy. In an interview on 01/08/25 at 5:37 p.m., the DON stated the MDS Coordinator notified her of the inaccuracies of Resident #1's MDS assessments prior to her interview with the state surveyor. The DON stated it was expected for all resident assessments to be accurate to show the entire picture of the resident's condition. The DON stated not doing so could potentially lead to misinformation/understanding of a resident condition, which could affect the care residents received. The DON stated she and the MDS Coordinator were responsible for the accuracy of the MDS assessments, as the MDS Coordinator completed the assessment, and she finalized the assessment. The DON stated she would audit all MDS assessments, in-service staff and monitor assessment to ensure their accuracy. In an interview on 01/08/25 at 5:53 p.m., the Administrator stated the DON notified him of the inaccuracies of Resident #1's MDS assessments. The Administrator stated he expected for assessments to be accurate, as not doing so could lead to the resident receiving a lower level of care. The Administrator stated the MDS Coordinator, DON and ADONs were responsible for all facility assessments, which included the MDS. The Administrator stated he planned to Inservice staff over accurate assessments and would get with the MDS Coordinator and the DON to develop a process to monitor and review assessments for their accuracy before they were finalized. A related policy was requested from the DON on 01/08/25 at 5:37 p.m. but was not provided prior to exit.