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	08/28/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of six residents (Resident #1 and Resident #2) reviewed for abuse. The facility failed to ensure Resident #2, who had prior behaviors towards others, did not physically abuse Resident #1. On 08/26/25, Resident #2 had her hands around Resident #1's neck and had to be separated by facility staff. An Immediate Jeopardy (IJ) situation was identified on 08/27/25. While the IJ was removed on 08/28/25, the facility remained out of compliance at a scope of pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for abuse. Findings included: Review of Resident #1's Quarterly MDS Assessment, dated 05/02/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS score was 05, which indicated severe cognitive impairment. Resident #1 did not have any physical or verbal behaviors towards others. Her active diagnoses included Alzheimer's Disease (a brain condition that gradually destroys memory and cognitive skills, interfering with daily life) and Depression (a mood disorder that causes persistent sadness and changes in how you think, sleep, eat, and act). Review of Resident #1's care plan, revised 11/17/24, reflected: Focus: The resident is/has potential to be physically/verbally aggressive and resistive to care r/t Dementia.Interventions/Tasks: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Review of Resident #1's skin assessment, dated 08/27/25 at 4:43 AM, reflected the resident had redness and an open spot on the right side of her neck and redness/spot on her right cheek. Review of Resident #1's Progress Notes reflected the following: LVN A wrote on 08/26/25 at 7:48 PM: The resident was attacked by an aggressive resident in the dining room. The aggressive resident was seen by the CNA putting her hand around the resident's neck [Resident #1] in the dining room. Nurse and CNA immediately ran towards them and intervened. Upon assessment, no injury noted. resident [sic] denies pain. Resident was redirected and taken to another seat away from the aggressive resident. NP and DON notified. Observation and interview on 08/27/25 at 10:40 AM with Resident #1 revealed she was sitting in a chair in the dining room. Resident #1 said she was doing great today. Resident #1 was observed to have redness to the right side of her neck that appeared to be a bruise that was about two inches long and an inch wide with a small open area. Resident #1 also appeared to have a small scratch to the right side of her cheek on her jawline that was also reddened. Resident #1 said she did not know what happened to her cheek or neck but it did not bother her. Review of Resident #2's admission MDS Assessment, dated 07/29/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS score could not be conducted, but it was noted she had both short-term and long-term memory problems and could not make her own daily decisions. She was noted to not have any physical or verbal behaviors towards others but wandered daily that intruded on the privacy or activity of others. Her active diagnoses included Alzheimer's Disease (a brain condition that gradually destroys memory and cognitive skills, interfering with daily life) and Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). Review of Resident #2's Physician's Orders, dated 08/27/25, reflected the following:- Ativan Gel 0.5mg q 12 hours prn apply topically every 12 hours as needed for agitation for 14 days- Seroquel Oral Tablet 25 MG Give 1 Tablet by mouth two times a day for agitation Review of Resident #2's Treatment Administration Record reflected the following: - Resident #2 was administered the Ativan Gel (which had an order start date of 08/13/25) on the following dates: 08/14/25, 08/16/25, 08/17/25, 08/18/25, 08/19/25, 08/20/25, 08/24/25, 08/25/25, and 08/26/25. - Resident #2 was noted to have behaviors on the following dates as monitored for psychoactive behaviors: 08/02/25, 08/03/25, 08/08/25, 08/09/25, 08/14/25, 08/16/25, 08/17/25, 08/20/25, 08/21/25, 08/23/25, 08/24/25, 08/25/25, and 08/26/25. - Resident #2 was administered the Seroquel (which had a start date of 08/25/25) on the following dates: 08/25/25, 08/26/25, and 08/27/25. Review of Resident #2's Progress Notes reflected the following entries: - LVN B wrote on 07/25/25 at 2:57 PM: Resident follow up on new admit, resident continue pacing down the hallway, attempt to push fire alarm during this shift, resident continue to monitor [sic] - LVN C wrote on 07/27/25 at 1:39 AM: The resident woke up, and was very agitated, throwing around everything she could come across in her room. She was yelling out at the staff when they were offering incontinent care to her. She was calmed down and laid back to bed

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #2) reviewed for care plan accuracy. The facility failed to develop and implement a care plan revised on 08/14/25 for Resident #2, which addressed her physically aggressive behaviors towards others between 08/02/25 to 08/26/25. LVN A and CNA E were able to pull Resident #2's hand away from Resident #1's neck on 08/26/2025. An IJ was identified on 08/27/25. The IJ template was provided to the facility on [DATE] at 5:18 PM. While the IJ was removed on 08/28/25, the facility remained out of compliance at a scope of pattern and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. This failure placed residents at risk of not receiving needed services due to inaccurate comprehensive care plans. Findings included: Review of Resident #2's admission MDS Assessment, dated 07/29/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS score could not be conducted, but it was noted she had both short-term and long-term memory problems and could not make her own daily decisions. She was noted to not have any physical or verbal behaviors towards others, but did wander daily that intruded on the privacy or activity of others. Her active diagnoses included Alzheimer's Disease (a brain condition that gradually destroys memory and cognitive skills, interfering with daily life) and Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). Review of Resident #2's care plan, revised on 08/14/25, revealed it did not reflect anything regarding her aggressive behaviors. Review of Resident #2's Physician's Orders reflected the following:- Ativan Gel 0.5mg q 12 hours prn apply topically every 12 hours as needed for agitation for 14 days- Seroquel Oral Tablet 25 MG Give 1 Tablet by mouth two times a day for agitation Review of Resident #2's Treatment Administration Record reflected the following:- She was administered the Ativan Gel on the following dates: 08/14/25, 08/16/25, 08/17/25, 08/18/25, 08/19/25, 08/20/25, 08/24/25, 08/25/25, and 08/26/25. - She was noted to have behaviors on the following dates as monitored for psychoactive behaviors: 08/02/25, 08/03/25, 08/08/25, 08/09/25, 08/14/25, 08/16/25, 08/17/25, 08/20/25, 08/21/25, 08/23/25, 08/24/25, 08/25/25, and 08/26/25.- She was administered the Seroquel on the following dates: 08/25/25, 08/26/25, and 08/27/25. Review of Resident #2's Progress Notes reflected the following:- LVN B wrote on 07/25/25 at 2:57 PM: Resident follow up on new admit, resident continue pacing down the hallway, attempt to push fire alarm during this shift, resident continue to monitor [sic]- LVN C wrote on 07/27/25 at 1:39 AM: The resident woke up, and was very agitated, throwing around everything she could come across in her room. She was yelling out at the staff when they were offering incontinent care to her. She was calmed down and laid back to bed but still kept on waking up and coming out of her room, and re-direction was done appropriately.- LVN D wrote on 07/27/25 at 8:49 PM: Resident combative with incontinent care. She came out from the room and started pushing dining table and chairs. Resident able to redirect, sleeping in bed at this time. No s/s of acute distress noted. Bed in low position, call light within reach.- LVN C wrote on 07/28/25 at 2:14 AM: The resident woke up and was banging stuff in her room and bathroom. Staff redirected her back to bed, but she was combative, and yelling. She was brought to the dining room via wheelchair but kept standing up and pushing the tables and chairs around. She wandered through the hallway back and forth. She was redirected back to her room and agreed to lay back in bed. Right now, she is resting in bed eyes closed.- LVN B wrote on 08/07/25 at 8:47 AM: Resident going all other [sic] resident room [sic] attempting to pull them from the bed staffs [sic] continue redirecting the resident.- LVN A wrote on 08/08/25 at 1:01 AM: Resident is combative, non-compliant to care, yelling and destroying anything within her reach. Resident refused to sleep, attempting to pull roommate from the bed. All efforts to redirect resident is ineffective. NP and DON notified.- LVN C wrote on 08/10/25 at 6:29 AM: The resident pacing [sic] in the hallway entering into other patients' rooms and banging doors and throwing everything she comes across. At the dining room at the moment, throwing chairs all over and moving tables around.- LVN A wrote on 08/26/25 at 9:40 PM: Resident noted with aggressive behavior. She was seen by the CNA putting her hand around another resident's neck (Resident #1) in the dining room. Nurse and CNA immediately ran

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for one of five residents (Resident #2) reviewed for unnecessary medications.The facility failed when ADON J did not ensure Resident #2, who had a diagnosis of Alzheimer's disease (dementia), was not prescribed an antipsychotic medication, Seroquel, without a diagnosis for the use of the antipsychotic and that was not approved for treatment of patients with dementia-related psychosis. The Psych NP said he had ordered the Seroquel for Resident #2's unspecified psychosis which he diagnosed her with after meeting Resident #2 a few times. Resident was administered Seroquel on 08/25/25, 08/26/25, and 08/27/25. This failure could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate indication. Findings included: Review of Resident #2's admission MDS Assessment, dated 07/29/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS score could not be conducted, but it was noted she had both short-term and long-term memory problems and could not make her own daily decisions. She was noted to not have any physical or verbal behaviors towards others but did wander daily that intruded on the privacy or activity of others. Her active diagnoses included Alzheimer's Disease (a brain condition that gradually destroys memory and cognitive skills, interfering with daily life) and Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). Review of Resident #2's Physician's Orders reflected the following:- Seroquel Oral Tablet 25 MG Give 1 Tablet by mouth two times a day for agitation with an active order date of 08/25/25 Review of Resident #2's Treatment Administration Record reflected the following:- Resident #2 was administered the Seroquel on the following dates: 08/25/25, 08/26/25, and 08/27/25. Observation and attempted interview on 08/27/25 at 10:35 AM with Resident #2 revealed she was sitting in a chair in the dining room mumbling to herself. Resident #2 did not look the surveyor's way or at the surveyor until the surveyor continued trying to talk to her. Resident #2 appeared calm but was not able to answer any questions. Phone interview on 08/28/25 at 9:32 AM with the Psych NP revealed Resident #2 was physically aggressive during moments of agitation and was difficult to redirect. The Psych NP said staff had been communicating with him about the increase in her behaviors and he had added orders for a PRN Ativan gel and Seroquel more recently. The Psych NP said he had ordered the Seroquel for Resident #2's unspecified psychosis which he diagnosed her with after meeting with her a few times. The Psych NP said he provides the facility with his notes and any additional new diagnoses as well as any new medication orders. The Psych NP said the order should have specified Resident #2's diagnosis for the medication. Interview on 08/28/25 at 3:51 PM with ADON J revealed he added Resident #2's order to her chart for Seroquel. ADON J said the indication for use of the medication was agitation but that was not the associating diagnosis. ADON J said he should have added the associating diagnosis to the order. ADON J said the purpose of this was to ensure the resident has appropriate medications for appropriate things. ADON J said if the diagnosis was not with the order, the wrong medication could be used for the resident. ADON J said he had been trained to make sure the diagnosis was included with the medication order. Interview on 08/28/25 at 4:21 PM with the DON revealed Resident #2's Seroquel order should have had an associating diagnosis instead of just the indication for use on it. The DON said normally the MDS Coordinator, the ADON's, and herself check resident's orders to ensure they are correct. The DON said ADON J would have been responsible for making sure the diagnosis was listed with the medication order since he was the one to add the order to her chart. The DON said the purpose of this was so that the medication was given for the right reason. The DON said if this was not done, the medication may be given for an inappropriate reason. The DON said all staff had been trained to ensure the diagnosis was always included with a medication order. Review of the facility's Psychotropic Medication Use policy, dated 2001, reflected it did not address having a diagnosis for a medication order. Review of the manufacturer's information, dated January 2025, for Seroquel (quetiapine fumarate) reflected the following black box warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis; and Suicidal Thoughts and Behaviors Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death.Seroquel (quetiapine) is not approved for the treatment of patients with Dementia-Related Psychosis.