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	11/23/2025

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. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the status for 3 of 5 residents (Residents #3, #4, and #22) reviewed for accuracy of assessments in that: The facility staff failed to address Resident #22, Resident #3, Resident #4, and Resident#5's respiratory treatments on the MDS.These failures could place residents at risk of not receiving care and treatments. Findings included:1.Record review of Resident #22 face sheet dated 11/23/2025, reflected the resident was an 80- year-old male that was admitted on [DATE]. The resident was diagnosed with: Vascular Dementia (impaired blood supply to the brain), Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen) and atherosclerotic heart disease of native coronary artery. (artery build-up of fat and plaque). Record review of Resident #22's Annual MDS dated [DATE] reflected the resident had a BIMS score of 00, indicating he was severely impaired cognitively. Resident #22 was dependent on facility staff for total care of ADL task. MDS Sections O for respiratory treatments were not addressed. MDS-P and MDS-G signed that the MDS was completed on 11/08/2025.Record review of Resident #22's care plan dated 11/07/2025 reflected he had impaired cognition, poor safety decision making, and memory loss. Record review of Resident #22's MAR and progress note reflected Albuterol Sulfate Inhalation Nebulization Solution 1application inhale orally via nebulizer every shift for wheezing.During an observation and interview with Resident #22 on 11/21/2025 at 11:30 AM, the resident was sitting in his wheelchair outside his room. Resident #22 stated that the staff were assisting with administration of his oxygen and nebulizer mask. 2. Record review of Resident #3 face sheet dated 11/23/2025, reflected the resident was a 67- years-old male that was admitted on [DATE]. The resident was diagnosed with: Metabolic Encephalopathy (problem in the brain) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record review of Resident #3's Annual MDS dated [DATE] reflected the resident had a BIMS score of 04, indicating he was severely impaired cognitively. Resident #4 was dependent on staff for all ADL task with maximum assistance. Sections O. Respiratory treatments were not addressed. MDS-R and MDS-G signed that the MDS was completed on 09/05/2025. Record review of Resident 3's care plan dated 08/22/2025 reflected Resident #3's had cognitive loss and impaired thought process r/t History of CVA. Resident has a terminal prognosis r/t Senile Degeneration of the Brain (decline in cognitive function) and receive hospice services for palliative care. Record review of Resident #3's MD orders reflected active orders dated 09/11/2025.02: Change H20 bottles on concentrators once a week. every night shifts every Sunday.02: Change 02 tubing and date once a week every night shifts every Sundays.02: Check 02 sat every night shift every Sunday.02: Clean 02 concentrator filters once a week.every night shifts every Sunday. 02: Oxygen (2-51pm) via (NC) as needed 02 sats above 92%. During an observation and interview on 11/23/2025 at 1:45 PM with Resident #3's nebulizer machine and oxygen concentrator was observed, and treatment were not performed. Resident stated that he does use the machines when needed. 3. Record review of Resident #4 face sheet dated 11/23/2025, reflected the resident was an 81- years-old male that was admitted on [DATE]. The resident was diagnosed with: Senile Degenerative of the brain (progressive decline in the brain cognition) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen)Record review of Resident #4's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 00, indicating he was severely impaired cognitively. Resident #4 was dependent on staff for all personal hygiene task, toileting, showers, dressing, and meal support for eating. Sections O special treatments and procedures Resident #4's respiratory treatments were not addressed. MDS-R and MDS-G signed that the MDS was completed on 10/31/2025. Record review of Resident #4's care plan dated 08/08/2025 reflected he had a terminal illness and received hospice palliative care r/t Senile Degenerative of the brain (progressive decline in the brain cognition). Record review of Resident #4's MAR reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (ipratropium-Albuterol) 3 ml inhale orally three times a day for 7 Days. The order was not dated. Albuterol Sulfate HFA Inhalation Aerosol Respiratory Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally as needed for Shortness of breath.Order for Morphine Sulfate (concentrate) solution 20 MG/ML. give 0.25 ML orally every 1 hours as needed for pain.During an observation on 11/23/2025 at 12:00 PM with Resident #4's was located in the facility dining room sitting in his wheelchair. Resident #4 was not interviewable due to confusion and communication deficit.During an interview on 11/23/2025 at 1:10 PM the DON stated the MDS should be coded for the care that the resident was receiving to reflect on the care plan

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included describing the services to be furnished to attain or maintain measurable objectives to meet the resident's highest practicable physical, mental, and psychosocial well-being, for 5 of 5 residents (Residents #10, #22, #3, #4, #5 and #10) reviewed for care plans, in that: Resident #10, #22, Resident #3, Resident #4 and Resident #5's care plan did not address the respiratory treatments. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. Findings included:Resident #10Record Review of Resident #10's face sheet dated 11/23/2025, reflected the resident was a 78 years-old female that was admitted on [DATE]. The resident was diagnosed with: Alzheimer's Disease (progressive disease that impairs memory) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record Review of Resident #10's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 15, indicating she was cognitively intact. Resident #10 was dependent on staff for all personal hygiene task, toileting, showers, and dressing, She required set up for Meals. Sections O special treatments and procedures addressed the resident's oxygen therapy. Record review of Resident #10's Care Plan (CP) dated 05/13/2025 reflected that she has an ADL self-care deficit related to Alzheimer's and required substantial maximum assistance from staff. Resident #10's respiratory treatment was not addressed in her care plan. Record Review of Resident #10's MD active orders dated 02/11/2022 reflected O2: Check O2 sat every shift. Vital sign q shifts every shift Alert provider for temperature >101 or pulse greater than 110. During an observation and interview on 11/23/2025 at 10:00 AM Resident #10 was observed lying in her bed on her back. She stated that the staff administer her nebulizer treatment when needed. She stated the Nebulizer mask had not been cleaned by the staff or bagged.Resident #22Record Review of Resident #22 face sheet dated 11/23/2025, reflected the resident was an 80- years-old male that was admitted on [DATE]. The resident was diagnosed with: Vascular Dementia (impaired blood supply to the brain), Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen) and atherosclerotic heart disease of native coronary artery. (artery build-up of fat and plaque). Record Review of Resident #22's Annual MDS dated [DATE] reflected the resident had a BIMS score of 00, indicating he was severely impaired cognitively. Resident #22 was dependent on staff maximal assistance with personal hygiene task, toileting, showers, and dressing. Resident #22 required staff set up for Meals. Record Review of Resident #22 care plan dated 11/07/2025 reflected impaired cognition, decision making, and memory loss. Resident #22's care plan did not address the use of respiratory treatment. During an observation and interview with Resident #22 on 11/23/2025 at 11:30 AM his nebulizer tubing was located on his nightstand and NC was not found. Resident #22 stated that the staff had removed his NC this morning. Resident #3 Record Review of Resident #3 face sheet dated 11/23/2025, reflected the resident was a 67-years-old male that was admitted on [DATE]. The resident was diagnosed with: Metabolic Encephalopathy (problem in the brain) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record Review of Resident #3's Annual MDS dated [DATE] reflected the resident had a BIMS score of 04, indicating he was severely impaired cognitively. Resident #1 was dependent on staff and required maximum assistance with all personal hygiene task, toileting, showers, and dressing, he required partial assistance with meals. Record Review of Resident #3's care plan dated 08/22/2025 reflected he had a terminal illness and received hospice palliative care r/t Senile Degenerative of the brain (progressive decline in the brain cognition). Resident #3's respiratory treatments were not addressed in the care plan.Record Review of Resident #3's MD orders reflected active orders dated 09/11/2025.02: Change H20 bottles on concentrators once a week. every night shifts every Sunday. 02: Change 02 tubing and date once a week every night shifts every Sundays. 02: Check 02 sat every night shift every Sunday.02: Clean 02 concentrator filters once a week.every night shifts every Sunday. 02: Oxygen (2-51pm) via (NC) as needed 02 sats above 92%.During an observation and interview with Resident #3 on 11/23/2025 at 11:45 AM oxygen tubing and nebulizer equipment was observed. Resident stated that the staff administer the treatments daily. Resident #4Record Review of Resident #4 face sheet dated 11/23/2025, reflected the resident was an 81- years-old male that was admitted on [DATE]. The resident was diagnosed with: Senile Degenerative of the brain (progressive decline in the brain cognition) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record Review of Resident #4's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 00

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	676141	A. Building B. Wing	11/23/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 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, observation, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for one of six residents (Resident #3) reviewed for pressure ulcers The facility failed to ensure LVN A provided Resident #3 her physician ordered wound care on 11/22/25. This failure could place residents at risk of developing infections or worsening of their wounds.Findings included: Record review of Resident #3's Quarterly MDS assessment, dated 10/31/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The staff had assessed the resident to severely cognitively impaired. She was dependent on staff with all ADL care and was always incontinent of urine and bowel. She had a feeding tube and received 51 % of her nutrition through a feeding tube. She was coded to be at risk of pressure ulcers. Her active diagnoses included Alzheimer's disease, malnutrition, abnormal posture and muscle wasting. Record review of Resident #3's care plan with a revision date of 06/25/25 reflected, The resident has a Stage 4 pressure injury on her right lateral (outside) ankle related to history of ulcers.Interventions.Administer treatments as ordered and monitor for effectiveness. Record review of Resident #3's Physician order summary report dated 11/23/25, reflected, Cleanse non-pressure wound to right medial foot with wound. and pressure wound to right lateral ankle with wound cleanser, pat dry. Apply calcium alginate (absorbent dressing made of seaweed) to wound bed. Cover with dry dressing daily and PRN if saturated, soiled or dislodged, with a start date of 11/07/25. Cleanse open areas to left medial and dorsal foot with wound cleanser, pat dry. Apply calcium alginate (absorbent dressing made of seaweed) to wound bed. Cover with dry dressing daily and PRN if saturated, soiled or dislodged, with a start date of 11/04/25. Record review of Resident #3's Wound care administration record for November 2025 reflected no treatment was provided on 11/22/25 for any of the wounds on the resident's left or right foot. In an observation and interview on 11/23/25 at 9:45 a.m. revealed LVN A and CNA F in Resident #3's room repositioning her in preparation to provide wound care to the resident's feet. Resident #1 had a feeding tube, and her legs were drawn up into a fetal position. Resident #1 was positioned on her left side with pillows between her legs to offload them and a pillow under her left ankle. The resident had an alternating pressure mattress in use. The resident was nonverbal. The dressings on residents' right foot and left foot were dated 11/21/25. The resident's right foot was edematous (swollen with excess fluid) and the dressing on her foot was soaked with drainage and had a foul odor. LVN A stated she was working yesterday (11/22/25) and stated she did not do the wound care on Resident #1. She stated it was a crazy shift, and she just did not get around to doing it. She stated she should have asked the oncoming shift to do it but stated she did not ask them. She stated she was getting her supplies together now to change the dressings. In an observation of 11/23/25 at 10:00 a.m. revealed LVN A performed hand hygiene and put on gloves and gowns. LVN A stated the resident had 4 different wounds, two of both feet and all were to be cleansed with wound cleanser, pat dry, and apply calcium alginate and covered with a bordered dressing. LVN A entered the room. She had all the wound care supplies placed on the bedside table on top of a towel. LVN A opened the packages of the boarded dressing and placed today's date (11/23/25) on the dressing. The resident was positioned on her left side. LVN removed all of the dressing from all four wounds, cleansed them with wound cleanser and applied calcium alginate and covered with bordered dressing. In an interview with LVN A on 11/23/25 at 10:20 a.m. she stated she knew the resident had daily wound care orders and felt bad she did not get the wound care done yesterday. She stated the wound on the resident's right foot does not have an odor once it was cleaned. She stated once the dressing becomes saturated with the drainage it will start to have an odor. In an interview with the DON on 11/23/25 at 11:15 a.m. she stated they had a Treatment Nurse who worked Monday through Friday, and the weekend nurses were responsible for their wound care. She stated Resident #3 had chronic wounds with poor prognosis due to her debilitated state. She stated the wound on her right foot had a lot of drainage due to the edema. She stated the wound care physician had told them once the dressing became soaked it would start to have an odor, but the wound itself did not have an odor. She stated they had an order to change the dressing daily or more often if it became soiled or dislodged. She stated since it did not get changed yesterday she understood why it had an odor. She stated she was not aware of the wound care being missed on 11/22/25 until today (11/23/25). She stated the Treatment Nurse had not told her of any wound care not being completed on the weekends but

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of six residents (Resident #1) reviewed for accidents hazards The Facility failed to ensure CNA F provided a safe two-person transfer and instead lifted Resident #1 under her arms when transferring her from her bed to her wheelchair on 11/23/25. These failures could affect the residents by placing the residents at risk for falls, injuries, and skin tears.Findings included: Record Review of Resident #1's quarterly MDS assessment, dated 09/02/25 reflected a [AGE] year-old female with a BIMS score of 2 which indicated she was severely cognitively impaired. She was dependent on all activities of daily living with exception of eating and required the assistance of 2 persons for transfers. She was always incontinent with bladder and bowel. Diagnoses included dementia and multiple sclerosis (chronic disease of the central nervous system) Review of Resident #1s care plan initiated on 03/24/25 reflected, [Resident #1] has an ADL self- care Performance Deficit related to impaired balance.Intervention.Transfer: The resident requires mechanical lift.with 2 staff assistance for transfers. In an observation on 11/23/25 at 07:40 a.m. CNA F entered Resident #1's room to provide incontinent care and get her up for breakfast. Resident #1 was very petite and could follow direction from the staff when asked to turn or reposition during care. After completion of incontinence care CNA F positioned the resident's wheelchair beside the bed, assisted the resident onto the side of the bed and placed both his arms under the resident's arm pits and lifted her up and over into the wheelchair. The resident did not bear weight during the transfer and did not appear to be in pain. CNA F then stated he was going to take her to the dining room. In an interview with CNA F on 11/23/25 at 08:00 a.m. he stated he had been taught that any transfer required a gait belt but stated he did not see a gait belt in her room. He stated he was not that familiar with the resident and should have asked before providing her care or should have looked at the resident's care plan. He stated the risk of lifting someone under the arms was injury to the resident's shoulders. In an interview with PTA D on 11/23/25 at 12:00 p.m. he stated any resident who required assistance with one person for transfers required the use of a gait belt to help prevent injury to the resident and to the staff. He stated staff were never to lift a resident under the arms due to the risk of dislocating their shoulder. He stated when a resident requires two-person maximum assistance they usually recommended a mechanical lift transfer. He stated if therapy had seen a resident they will indicate to nursing what level of assistance a resident needs, or nursing will make the determination for resident who had not been on therapy. In an interview with the DON on 11/23/25 at 01:15 p.m. she stated the staff were to always use a gait belt when transferring a resident if they were a one-person transfer. She stated if resident required two-person transfers they were to use a mechanical lift unless it was contraindicated. She stated they do training on transfers during orientation and annually or when they determine there is an issue. She stated they would be in-servicing staff on proper transfer techniques. She stated Resident #1 was care planned for a mechanical lift transfer. She stated the CNA should have never done a one person transfer on her. She stated he was a PRN staff member but stated he should have asked if he was unsure of her care needs. She stated the risk was injury to the resident and staff member. Record review of the facility's policy titled, Safe Lifting and Movement of Residents, dated July 2017, reflected, In order to protect the safety of and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents.Manual lifting of residents shall be eliminated when feasible.Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts,.) and mechanical lifting devices.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 5 (Residents #10, Resident #22, Resident #3, Resident #4, and Resident #5) of 10 residents reviewed for respiratory care, in that:. Resident #10, Resident #22, Resident #3, and Resident #4's nebulizer mask was not bagged.Resident #4's and Resident #5's NC tubing was not dated.These failures could place residents at risk of receiving inadequate respiratory careFindings: Resident #10 Record Review of Resident #10's face sheet dated 11/23/2025, reflected the resident was a 78 years-old female that was admitted on [DATE]. The resident was diagnosed with: Alzheimer's Disease (progressive disease that impairs memory) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record Review of Resident #10's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 15, indicating she was cognitively intact. Resident #10 was dependent on staff for all personal hygiene task, toileting, showers, and dressing, She required set up for Meals. Sections O special treatments and procedures addressed the resident's oxygen therapy. Record review of Resident #10's Care Plan (CP) dated 05/13/2025 reflected that she has an ADL self-care deficit related to Alzheimer's and required substantial maximum assistance from staff. Resident #10's respiratory treatment was not addressed in her care plan. Record Review of Resident #10's MD active orders dated 02/11/2022 reflected O2: Check O2 sat every shift. Vital sign q shifts every shift Alert provider for temperature >101 or pulse greater than 110. During an observation and interview on 11/23/2025 at 10:00 AM Resident #10 was observed lying in her bed on her back. She stated that the staff administer her nebulizer treatment when needed. She stated the Nebulizer mask had not been cleaned by the staff or bagged. 02/11/202 Resident #22, Record Review of Resident #22 face sheet dated 11/23/2025, reflected the resident was an 80- years-old male that was admitted on [DATE]. The resident was diagnosed with: Vascular Dementia (impaired blood flow to the brain), Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen) and atherosclerotic heart disease of native coronary artery. (artery build-up of fat and plaque). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #22's Annual MDS dated [DATE] reflected the resident had a BIMS score of 00, indicating he was severely impaired cognitively. Resident #22 was dependent on staff maximal assistance with personal hygiene task, toileting, showers, and dressing. Resident #2 required set up for Meals. MDS Sections O for respiratory treatments were not addressed. MDS-P and MDS-G signed that the MDS was completed on 11/08/2025. Record Review of Resident #22's care plan dated 10/12/2025 reflected he had an unwitnessed fall on 10/12/2025 and the care plan was updated. Resident #22's care plan did not address the use of respiratory treatment. During an observation and interview on 11/23/2025 at 11:30 AM. with Resident #22's Nebulizer mask was stored on the nightstand not bagged. Resident stated that the staff had removed his NC this morning. He stated the nebulizer mask was not cleaned, changed, or bagged. Resident #22 does not recall if the staff cleaned the mask. Resident #3 Record Review of Resident #3 face sheet dated 11/23/2025, reflected the resident was a 67- years-old male that was admitted on [DATE]. The resident was diagnosed with: Metabolic Encephalopathy (problem in the brain) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). Record Review of Resident #3's Annual MDS dated [DATE] reflected the resident had a BIMS score of 04, indicating he was severely impaired cognitively. Resident #1 was dependent on staff and required maximum assistance with all personal hygiene task, toileting, showers, and dressing, he required partial assistance with meals. Record Review of Resident #3's care plan dated 08/22/2025 reflected he had a terminal illness and received hospice palliative care r/t Senile Degenerative of the brain (progressive decline in the brain cognition). Resident #3's respiratory treatments were not addressed in the care plan. Record Review of Resident #3's MD orders reflected active orders dated 09/11/2025. reflected 02: Change 02 tubing and date once a week every night shifts every Sundays. 02: Check 02 sat every night shift every Sunday.02: Clean 02 concentrator filters once a week.every night shift every Sunday.02: Oxygen (2-51pm) via (NC) as needed 02 sats above 92%. During an observation and interview on 11/23/2025 at 1:45 AM with Resident #3, his NC tubing was not dated and bagged. His oxygen concentrator machine was observed with white, tan and gray small particles. His nebulizer mask was observed on the nightstand not bagged. Resident #3 stated that the used both the nebulizer machine and mask and oxygen concentrator machine and the staff had not bagged the nebulizer mask. Resident #3 did not remember if the staff cleaned the mask routinely. Resident #4 Record Review of Resident #4 face sheet dated 11/23/2025, reflected the resident was an 81- years-old male that was admitted on [DATE]. The resident was diagnosed with: Senile Degenerative of the brain (progressive decline in the brain cognition) and Acute Respiratory with Hypoxia (inability to maintain blood in the oxygen). (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	11/23/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #4's care plan dated 08/08/2025 reflected he had a terminal illness and received hospice palliative care r/t Senile Degenerative of the brain (progressive decline in the brain cognition). Record Review of Resident #4's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 00, indicating he was severely impaired cognitively. Resident #4 was dependent on staff for all personal hygiene task, toileting, showers, dressing, and meal support for eating. Sections O special treatments and procedures Resident #4's respiratory treatments were not addressed. MDS-R and MDS-G signed that the MDS was completed on 10/31/2025. Record Review of Resident #4's active MD orders dated ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (ipratropium-Albuterol) 3 ml inhale orally three times a day for 7 Days. The order was not dated. Albuterol Sulfate HFA Inhalation Aerosol Respiratory Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally as needed for Shortness of breath. The was no order for NC or respiratory treatments. Record review of Resident #4's progress note dated 11/08/2025 at 10:26 AM by LPN-T reflected ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 1 ml inhale orally three times a day for 7 Days. Upon assessment prior to administering breathing treatment, pt's SpO2 improved to 99% and HR decreased to 89 bpm. Prior SpO2 was 80% and HR 136 bpm. Breathing treatment then given as ordered. Pt. tolerated treatment well. The plan of care is ongoing. Record review of Resident #4's progress note dated 11/08/2025 at 4:55 PM by LPN-T reflected Pt. agitated and restlessness, respirations labored.his 02 reading low 80% and his HR 145 BPS. Morphine given per PRN hospice order for comfort and SOB. The plan of care is ongoing. This progress note was added in relation to his Morphine order and treatment for SOB. During an observation on 11/23/2025 at 12:00 PM, Resident #4's was observed in the dining room with his NC tubing wrapped around the oxygen tank. The tubing was not dated and not bagged. Resident #4 was not interviewable due to confusion and communication deficit. During an interview with LVN-C on 11/23/2025 12:55 PM for Resident's #10 and Resident #22, she stated that she had conducted rounds and failed to observe the tubing undated and masked unbagged. She stated that NC tubing was changed on Sundays during the overnight shift, and as needed. She stated that the nursing staff were responsible for washing the nebulizer mask as needed, then bag and date for sanitation. She stated that expectation was to monitor the respiratory equipment for sanitation and operations during rounds. She stated this was an error that could result in infections for the residents. During an interview with LVN-T on 11/23/2025 at 12:58 PM for Resident's #3 and Resident #4 she stated all respiratory equipment was cleaned and tubing was changed and dated weekly on the night shift every Sunday. She said residents could get infections from cross contamination and when the procedures were not followed. She stated she had not noticed the equipment unbagged during her rounds. (continued on next page)

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	676141	A. Building B. Wing	11/23/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/23/2025 at 1:10 PM the DON stated it was her expectations for the nursing staff to monitor respiratory equipment for sanitation, storage, dates, and labeling during resident rounds. She said failing to bag and dated the nebulizer mask and tubing when not in sue could result in infections to the resident. She stated it was the charge nurse, ADON, and DON's responsibility to monitoring the nursing clinical care task. During an interview on 11/23/2025 at 1:20 PM, the Administrator stated that everything used for the resident should be kept clean to prevent cross contamination and respiratory infection. She stated that all assigned equipment with tubing was to be bagged when not in use for sanitation. She stated that it was the responsibility of the DON to monitor and educate the staff on respiratory protocol. There were no weekend night shift nurses interviewed about respiratory equipment protocol. The quality-of-care respiratory treatments policy was requested on 11/23/2025 at 12:00 PM and was not provided prior to exiting the building.

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	676141	A. Building B. Wing	11/23/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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	676141	A. Building B. Wing	11/23/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 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 3 of 3 Residents (Resident #1 Resident #2 and Resident #3) observed for infection control. 1.The facility failed to ensure CNA F utilized Enhanced Barrier Precautions, performed hand hygiene during incontinence for Resident #1 and performed hand hygiene prior to leaving Resident #1 room on 11/23/25. 2.The facility failed to ensure CNA E utilized Enhanced Barrier Precautions, performed hand hygiene during incontinence care and mechanical lift transfer to Resident #2 and performed hand hygiene prior to leaving Resident #2's room on 11/23/25. 3. The facility failed to ensure CNA G properly removed her Enhanced barrier equipment and performed hand hygiene prior to leaving Resident #2's room on 11/23/25. 4. The facility failed to ensure LVN A performed hand hygiene during wound care and changed her gloves and performed hand hygiene after cleaning each wound on Resident #3's feet on 11/23/25. Findings included: 1. Record Review of Resident #1's quarterly MDS assessment, dated 09/02/25 reflected a [AGE] year-old female with a BIMS score of 2 which indicated she was severely cognitively impaired. She was dependent for all activities of daily living with exception of eating and required the assistance of 2 persons for transfers. She was always incontinent of bladder and bowel. Diagnoses included dementia and multiple sclerosis (chronic disease of the central nervous system) In an observation on 11/23/25 at 07:40 a.m. CNA F entered Resident #1's room to provide incontinence care and get her up for breakfast. A sign was posted over the resident's bed which indicated the resident was on Enhanced Barrier Precautions (a set of infection control measures used to reduce the spread of mulit-drug resistance organisms). CNA F put on gloves without performing hand hygiene and did not put on a gown. CNA F opened the residents brief and wiped down the middle and out to both sides, changing the surface of the wipe with each swipe. He then assisted resident onto her side and wiped her anal area from front to back, changing the surface of the wipe. CNA F then placed the clean brief under the resident while wearing the same soiled gloves and rolled her back onto her back. CNA F removed his gloves and did not perform hand hygiene. He then went to the resident's closet and pulled out a couple of items of clothing and asked the resident what she wanted to wear today. After resident selected her clothing, he placed the remaining items back in the closet. CNA F then put on gloves with no hand hygiene and dressed the resident. CNA F transferred the resident into the wheelchair. CNA F then removed his gloves and left the room without performing hand hygiene and pushed the resident down to the dining room. In an interview with CNA F on 11/23/25 at 08:00 a.m. he stated he was supposed to perform hand hygiene before entering the resident's room and before leaving the resident's room. He stated he had used the hand sanitizer in the hall before coming into the resident's room but acknowledged he had not performed hand hygiene before he left the room. He stated he had worn gloves during incontinence care and did not know he had to change his gloves before placing the clean brief and residents' clothing on her. He stated he had not noticed the sign indicating the resident was on Enhanced Barrier Precautions. He stated the risk of not providing hand hygiene and wearing the proper personal protective equipment was the spread of germs. In an interview with the DON on 11/23/25 at 8:10 a.m. she stated any resident who was on enhanced barrier precautions would have a sign posted over their bed to let the staff know what type of precautions were to be used. She stated Resident #1 was on enhanced barrier precautions due to a chronic eye infection which they were currently treating. She stated the CNAs were required to wear gown and gloves during direct care for her. 2. Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admission date of 09/28/20. Resident had a BIMS of 13 which indicated she was cognitively intact. She required substantial to max assistance with ADLs. She was always incontinent of urine and had colostomy. (an opening in the abdomen to connect the colon to the outside of the body). She had non-pressure wounds to her feet. Diagnoses included diabetes. In an interview and observation on 11/23/25 at 08:05 a.m. Resident #2 resident was observed in her bed. The resident had O2 via nasal cannula in use and an Enhanced Barrier Precaution sign posted over her bed. She stated she had some wounds on her feet, and the staff were dressing them. She stated she also had a colostomy which the nurses change for her. In an observation on 11/23/25 at 08:50 a.m. CNA E entered Resident #2's room and put on gloves without performing hand hygiene and did not put on a gown to provide incontinence care and get the resident up for the day. CNA E