

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  05/20/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and home-like environment for 1 of 5 residents (Resident #73) reviewed for environment.</p> <p>The facility failed to ensure Resident #73 had a home-like environment when she was relocated temporarily to another room leaving her without any of her belongings or entertainment.</p> <p>These failures could place residents at risk of an uncomfortable environment, depression and feeling lonely.</p> <p>Findings included:</p> <p>Record review of Resident #73's face sheet dated 05/20/25 reflected the resident was an [AGE] year-old female admitted on [DATE] and readmitted [DATE].</p> <p>Record review of Resident #73's Quarterly MDS assessment dated [DATE] reflected the resident was usually understood and understood others. The MDS indicated a BIMS score of 09 indicating Resident #73 had a moderate cognitive impairment with diagnoses including Depression (persistent feeling of sadness), paralysis or severe weakness on one side of the bod, hypertension (high blood pressure). The MDS reflected Resident #73 had 2-11 days of feelings down, depressed or hopeless. Resident #73 had limited range of motion with lower extremities and utilized a wheelchair. Resident #73 was dependent on staff for activities of daily living.</p> <p>Record review of Resident #73's care plan reflected Resident #73 had little or no organized involvement in activities related to cognitive memory loss, Will conduct one on ones with resident until next review date. Goal included: Resident will have activity needs met. Intervention included: Provide materials appropriate to Resident's health. Resident #73 used Antidepressant Medication related to depression. Goal: Resident #73 will be free from discomfort or adverse reactions related to antidepressant therapy. Intervention included: Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift.</p> <p>Record review of Resident #73's Medication Administration Record reflected Cymbalta oral capsule delayed release particles 30 mg (Duloxetine HCl) Give 1 capsule by mouth at bedtime for depression start 04/24/25. Duloxetine HCl Oral Capsule Delayed release particles 20 mg. Give 3 capsule by mouth one time a day for depression.</p> <p>(continued on next page)</p>

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  05/20/2025
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #73's progress notes written by LVN K reflected: This resident has been moved temporarily to room on another hall. Responsible Party has been notified and is ok with move.</p> <p>During observation and interview on 05/18/25 at 10:37 AM, Resident #73 was lying in bed. Resident #73 looked like she was saddened and almost in tears when she revealed she was uncomfortable about something. When asked how she was doing, she replied she was not feeling well. Resident #73 further stated I relocated from my room because my roommate was having a lot of family. They have me in here with no television. I asked them to bring my television and they told me I couldn't. The clock is not working, and I have nothing to do. I have nothing but blank walls to look at. Observation revealed the clock on the wall was not working, there was no television in the room, Resident #73's walls and room were bare other than the activities calendar, which she asked for to read prior to surveyor exiting the room. Observation revealed Resident #73 was relocated in her wheelchair, no other belongings were in the room.</p> <p>Interview on 05/18/25 at 10:40 AM with CNA L revealed Resident #73 was relocated to this room on 05/17/25 due to her roommate declining and had lots of family gathering in the room. CNA L stated she made rounds to check on Resident L however did not notice that she may have been bored or with nothing to do. When asked if she could provide Resident #73 with books or something to read, CNA L stated she would speak with the nurse about activities and reading material. According to CNA L, Resident #73 could become depressed or sad with no television and nothing to do. According to CNA L the Activity Director was responsible for ensuring residents had activities.</p> <p>Observation and interview on 05/18/25 at 12:00 PM revealed Resident #73 did not have a television in room, clock was not adjusted to the correct time, and she did not have evidence of reading material or self-pace activities. During interview Resident #73 stated no one had returned to the room to offer any reading material or activities.</p> <p>Interview on 05/20/25 at 11:28 AM with LVN J revealed Resident #73 was relocated due to her roommate declining. LVN J stated she was aware that none of Resident #73's belongings were moved with her, however there was no discussion about having any of her personal items. LVN J stated LVN K remained her nurse and continued care for her, therefore she was responsible to ensure Resident #73's needs were met. According to LVN J when a resident is moved to an alternate room for whatever reason, we should move some of their personal items to make them feel comfortable.</p> <p>Interview on 05/20/25 at 11:32 AM with the LVN K revealed Resident #73 was relocated to another hall because her roommate was declining and had family members in and out of the room. LVN K stated this gave the roommate privacy with family and Resident #73 peace away from the situation. LVN K stated she and Resident #73 discussed the room not having television and that Resident #73 was bored without a television. LVN K stated I spoke with the DON about Resident #73 having a television however all them were mounted to the wall. LVN K stated she was not able to find a television to bring into the room for Resident #73. LVN K stated she did not suggest or think of other forms of entertainment because Resident #73 was only concerned about not having a television. LVN K stated I know she was bored, but I did try to get her a television, check on her and offered snacks and drinks. LVN K stated she and the nurse aide was responsible for checking with Resident #73 so that she would not feel bored, alone or depressed.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/20/25 at 12:16 PM with the ADON revealed he knew Resident #73 was relocated to another room. The ADON stated Resident #73 could not bring all her belongings for this short stay, but staff could have provided her with some of her belongings to make her feel at home and comfortable. According to the ADON, the Activity Director does leave activities, puzzles and books for residents to do for fun, it would be the nursing staff's responsibilities to ensure she was not bored, sad or depressed while being in a room with nothing to do.</p> <p>Interview on 05/20/25 at 2:40 PM with the DON revealed she was aware Resident #73 relocated to another room, we could have picked a different room with a television and moved some of her personal items. The DON stated it would be a team effort to ensure Resident #73 was not feeling sad or depressed about being in the room with nothing to do.</p> <p>Record review of the facility's Transfer, Room to Room policy revised December 2016 reflected: Orient the resident to the transfer in a form and manner that the resident can understand. Reassure the resident that all his or her personal effects will be brought to his or her new room.</p>

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  05/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident 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 2 of 5 (Residents #85 and #58) reviewed for comprehensive care plans.</p> <ol style="list-style-type: none"> <li>The facility failed to develop a care plan for Resident #85's hospice services.</li> <li>The facility failed to develop a care plan for Resident #58's enteral feeding.</li> </ol> <p>These failures placed resident at risk of not receiving appropriate care.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #85's admission Record, dated 05/19/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE].</li> </ol> <p>Record review of Resident #85's Quarterly MDS Assessment, dated 05/02/25, reflected she had a BIMS Score of 08, indicating moderate cognitive impairment. Her active diagnoses included traumatic brain injury (a serious condition caused by a blow or jolt to the head or body), anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, or dread that interferes with daily life), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Her MDS indicated that she received hospice care services while she was a resident.</p> <p>Record review of Resident #85's Order Summary Report, dated 05/19/25, reflected the following:</p> <ul style="list-style-type: none"> <li>- Admit to [Hospice Company H] DX: Protein calorie malnutrition with an active date of 10/04/24.</li> </ul> <p>Record review of Resident #85's care plan, revised on 04/21/25, reflected it did not address her use of hospice services.</p> <p>Observation and interview on 05/18/25 at 10:09 AM with Resident #85 revealed she was laying in bed and had no concerns with her hospice company and the services they provided to her.</p> <p>Interview on 05/19/25 at 3:03 PM with LVN G revealed she cared for Resident #85 and knew she was on hospice services. LVN G said Resident #85 had been on hospice services for about 4-5 months now she thought. LVN G said as the nurse she only completed the baseline care plan for a resident. LVN G said the DON and ADON address the resident's care plan beyond the baseline care plan.</p> <p>Interview on 05/20/25 at 10:03 AM with the ADON revealed Resident #85 had been on hospice services for about 3-4 months now. The ADON said any resident receiving hospice services should have been included on their care plan. The ADON said usually the MDS Coordinator would update the residents care plan, not him.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/20/25 at 11:10 AM with the MDS Coordinator revealed she saw that Resident #85's care plan did not include her use of hospice services. The MDS Coordinator said a significant change MDS assessment was completed back in October, and it was on the resident's care plan, but it was not noticed to include it on their care plan. The MDS Coordinator said the previous MDS Coordinator would have been responsible for ensuring it was included on the resident's care plan. The MDS Coordinator said the corporate company hired a service to go behind the MDS Coordinators to ensure that all the necessary components were included on a resident's care plan. The MDS Coordinator said the purpose of the care plan was to notify all the staff on the floor who physically cared for her of the resident's needs. The MDS Coordinator said if something was missing from the resident's care plan, there can be a miscommunication regarding the resident's care. The MDS Coordinator said she had been an MDS Coordinator for a long time and knew what her role was, so she did not need any training.</p> <p>Interview on 05/20/25 at 2:51 PM with the DON revealed the previous MDS Coordinator would have been responsible for ensuring that the resident's care plan was updated to include all care aspects, including hospice services being provided.</p> <p>2. Record review of Resident #58's face sheet dated 05/18/25 revealed the resident was [AGE] year-old female admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #58's admission MDS dated [DATE] revealed the resident had severe cognitive impairment with a BIMS score of 07. The assessment reflected Resident #58 required total dependence with eating, and the resident received nutrition via a feeding tube. Resident #58 active diagnoses included Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), Hyperlipidemia (high cholesterol),</p> <p>Record review of Resident #58's undated care plan did not reflect Resident #58 required the use of tube feeding.</p> <p>Record review of Resident #58's physician order active 09/14/24 revealed enteral Feed Order every shift for Nutrition Glucerna 1.5 at 60cc/hour for 20 hours a day with water flush at 200 cc every 6 hours. Enteral: Continuous feeding pump: Pump turn off at 8:00 AM. Turn pump back on at 12:00 PM noon every day. The order had an active date of 09/13/24.</p> <p>Observation and interview on 05/18/25 at 11:16 AM with Resident #58 revealed resident was in bed, tube feeding machine was turned off, not administering feeding. Resident #58 stated she was not feeling well and expressed that she was tired. According to Resident #58 she had lived in the facility for some time and had no concerns with the care she was receiving.</p> <p>Observation on 05/19/25 at 8:43 AM of Resident #58 revealed tube feeding machine was running at 60 ml, 200 water flush every 6 hours.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and record review on 05/19/25 at 2:11 PM with LVN N revealed she was the nurse on duty for Resident #58, Resident #58 has no nutrition by mouth and on continuous tube feeding except when she goes down at 8:00 AM and her machine is up and running at 12:00 PM. LVN N stated she had worked with Resident #58 for some time therefore she knew that she required nutrition from a tube feeding machine. LVN N stated she was not aware the care plan did not indicate Resident #58 used a tube feeding machine, LVN N stated she had not reviewed the care plan in a long time. LVN N stated when there was a change in condition or update to resident condition, she will usually receive report from the previous shift. LVN N stated it was the responsibility of the ADON and DON to ensure resident care plans were updated to reflect their plan of care. According to LVN N not having the care plans updated could affect the type of care they receive.</p> <p>Interview on 05/20/25 at 11:12 AM with the MDS Coordinator revealed her team was responsible for creating and updated resident care plans. According to MDS Coordinator they have a quality team that reviews care plans to ensure they were updated and completed with resident care needs. MDS Coordinator stated all disciplines have access to enter on the care plan and update it, as necessary. MDS Coordinator stated the care plan was used to notify all persons working with the resident of their needs and how to provide individualized care. MDS Coordinator stated being on a tube feeding machine is something that should have been updated on the care plan, not doing so placed residents at risk of staff miscommunicating between nurses and aides, being administered the wrong rate of formula.</p> <p>Interview and record review on 05/20/25 at 12:03 PM with the ADON revealed MDS nurses were responsible for entering the information on resident care plans. According to the ADON, not having care plans updated placed residents at risk of not fulfilling resident needs.</p> <p>Interview on 05/20/25 at 2:40 PM with the DON revealed Resident #58 was administered nutrition by tube feeding. The DON stated the interdisciplinary team was responsible for ensuring resident care plans were updated. The DON stated not having the care plans updated placed residents at risk of issues with continuity of care between disciplines and failure to provide proper care and their needs. The DON stated she expected all disciplines to ensure their areas were kept updated.</p> <p>Record review of the facility's Care Plans, Comprehensive Person-Centered policy, dated 2001, reflected: .7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: . (3) which professional services are responsible for each element of care .</p>		

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  05/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and records review, the facility failed to ensure 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 3 (Residents #16, #35, and #198) of 3 residents reviewed for pressure ulcers.</p> <ol style="list-style-type: none"> <li>On 05/19/25, the facility failed to provide PRN wound care to Resident #16's right buttocks wound.</li> <li>On 05/17/25 and 05/18/25, the facility failed to provide wound care to Resident #35's left foot.</li> <li>On 05/09/25, the facility failed to provide wound care to Resident #198's sacrum wound.</li> </ol> <p>These failures placed residents at risk of developing new or worsening pressure ulcers.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #16's admission Record, dated 05/19/25, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE].</li> </ol> <p>Record review of Resident #16's Quarterly MDS Assessment, dated 04/22/25, reflected a BIMS score was not calculated. Record review of her cognitive patterns revealed Resident #16 had a memory problem for both short-term and long-term and was severely impaired for daily decision making. Her active diagnoses included other neurological conditions, malnutrition, and Alzheimer's disease. Her MDS indicated she had other open lesion(s) on the foot which required nutrition or hydration intervention and pressure ulcer/injury care.</p> <p>Record review of Resident #16's Order Summary Report, dated 05/18/25, reflected the following:</p> <ul style="list-style-type: none"> <li>- Cleanse wound to Right [sic] buttock with wound cleanser, pat dry. Apply calcium alginate to wound bed, cover with foam dressing daily and PRN as needed with an active date of 05/14/25.</li> </ul> <p>Record review of Resident #16's Wound Care Administration Record for May 2025 reflected the Wound Care Nurse signed off that care was provided on 05/19/25 for the following order: Cleanse wound to Right [sic] buttock with wound cleanser, pat dry. Apply calcium alginate to wound bed, cover with foam dressing daily and PRN as needed.</p> <p>Record review of Resident #16's care plan, revised on 05/15/25, reflected the following:</p> <p>Focus: [Resident #16] has Stage 3 pressure wound to right buttocks due to poor skin integrity and immobility . 5/14- d/c medihoney, apply calcium alginate to wound bed .</p> <p>Observation on 05/20/25 at 7:34 AM of Resident #16 revealed she was laying in bed and a CNA positioned her to be ready for wound care. Resident #16 did not have a dressing to her right buttocks wound.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #16's Progress Notes for May 2025 reflected there was not any information related to her wound dressing not being there on 05/19/25.</p> <p>Interview on 05/20/25 at 8:00 AM with the Wound Care Nurse revealed the CNA was positioning Resident #16 to receive wound care this morning when she noticed there was not a dressing covering her wound to the right buttocks. The Wound Care Nurse said she expected to be notified if the CNA noticed the dressing was soiled or dislodged somehow. The Wound Care Nurse said the CNA should also notify the nurse so they could replace the dressing. The Wound Care Nurse said the risk to not replacing the dressing to the wound was that it could get infected or slow its healing process. The Wound Care Nurse said the nurses knew that when she was not in the building, they were responsible for their resident's wound care.</p> <p>Interview on the phone on 05/20/25 at 10:02 AM with CNA E revealed she worked with Resident #16 last night (05/19/25) and provided her incontinent care twice during her shift. CNA E said both times she provided incontinent care there was not a dressing to Resident #16's right buttocks. CNA E said the nurse, LVN D, also helped provide Resident #16 incontinent care and never mentioned anything about the missing dressing to the resident's right buttocks. CNA E said from what she saw on Resident #16's buttocks it was black and red but did not look like she needed a dressing because there was not an open wound or any blood. CNA E said if she saw a resident without a dressing on their wound, she knew to let the nurse know.</p> <p>Interview on the phone on 05/20/25 at 1:52 PM with LVN D revealed she worked with Resident #16 last night (05/19/25). LVN D said she helped CNA E provide incontinent care to Resident #16 and she did not know that that the resident had a wound to her right buttocks. LVN D said CNA E did not say anything about the missing dressing to her either. LVN D said she expected the CNA to tell her when a dressing was soiled or fallen off.</p> <p>Interview on 05/20/25 at 2:51 PM with the DON revealed Resident #16 should have had a dressing to all of her wounds, including the one to her right buttocks. The DON said all wound dressing orders have the schedule and PRN orders so that if the dressing was soiled during incontinent care, it could be replaced by the nurse on duty. The DON said the nurse on duty would have been responsible for replacing it in that time frame when they noticed it was missing or soiled. The DON said all nurses had been trained to know to do this but that no one goes behind the nurses to make sure that all dressings were in place for resident's wounds. The DON said if residents did not receive wound care as ordered it could lead to increased risk of infection or hospitalizations.</p> <p>2. Record review of Resident #35's admission Record, dated 05/19/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #35's Quarterly MDS Assessment, dated 04/02/25, reflected she had a BIMS score of 15, indicating no cognitive impairment. Her active diagnoses included renal insufficiency and diabetes. Her MDS assessment indicated that she had diabetic foot ulcers which required the application of ointments/medications and dressings to her feet.</p> <p>Record review of Resident #35's Order Summary Report, dated 05/19/25, reflected the following:</p> <p>- Left foot: Cleanse with wound cleanser, paint wound bed with betadine cover with gauze and secure with kerlix daily everyday shift for wound care with an active date of 05/15/25</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #35's Wound Care Administration Record for May 2025 reflected there were no entries, and the spaces were left blank for 05/17/25 and 05/18/25.</p> <p>Record review of Resident #35's care plan, revised on 02/21/25, reflected the following:</p> <p>Focus: The resident has non pressure wound to left and right plantar foot r/t disease process diabetes and has a Hx of ulcers .5/14 .paint L plantar foot wound with betadine .Interventions/Tasks: Administer treatments as ordered and monitor for effectiveness .</p> <p>Record review of Resident #35's May 2025 Progress Notes did not reflect any information about her wound care on 05/17/25 and 05/18/25.</p> <p>Observation and interview on 05/18/25 at 10:46 AM of Resident #35 revealed she was laying in bed and had bandages to her feet. Resident #35 said she had wounds to both of her feet , and she was worried about them because the staff were supposed to dress them daily and they were not. The bandages on her feet were dated as 5/16.</p> <p>Observation and interview on 05/18/25 at 3:05 PM with Resident #35 revealed she was sitting up in her wheelchair in her room. Resident #35 said no one had come to change her dressings for her and she saw and said, the bandages are dated, and they say '5/16'. Resident #35 said staff were supposed to change them every day and no one had come yet to change her bandages and treat her wounds.</p> <p>Interview on 05/18/25 at 11:48 AM with the Wound Care Nurse revealed Resident #35 had wounds to both of her feet, but only the left foot required daily dressings. The Wound Care Nurse said she provided Resident #35 her wound care this morning and noticed that the left foot dressing had not been changed over the weekend as it was still dated 05/16/25. The Wound Care Nurse said the charge nurse would have been responsible for providing wound care to Resident #35 over the weekend. The Wound Care Nurse said no one communicated with her that Resident #35's wound care was not completed on either Saturday or Sunday. The Wound Care Nurse said the charge nurse would need to go to the wound care administration record in the resident's chart to see what wound care needed to be done for that resident during their shift. The Wound Care Nurse said she just assumed the charge nurse did not see that the resident needed wound care over the weekend. The Wound Care Nurse said she completed the wound care during the week only.</p> <p>Attempted phone interview on 05/19/25 at 1:29 PM with LVN I (who worked with Resident #35 on Saturday 05/17/25) was not successful as she did not answer.</p> <p>Attempted phone interview on 05/19/25 at 1:30 PM with LVN J (who worked with Resident #35 on Sunday 05/18/25) was not successful as she did not answer.</p> <p>Interview on 05/20/25 at 2:51 PM with the DON revealed staff had been trained to check all resident's orders, including wound care orders and ensure they provided the care over the weekend when the Wound Care Nurse was not present. The DON said the charge nurses were responsible for completing a resident's wound care over the weekend. The DON said the charge nurses on Saturday and Sunday should have provided Resident #35 wound care to her left foot as ordered. The DON said the Wound Care Nurse followed up and monitored all wounds in the building. The DON said if residents did not receive wound care as ordered it could lead to increased risk of infection or hospitalizations.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #198's admission Record, dated 05/20/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 05/10/25.</p> <p>Record review of Resident #198's admission MDS Assessment, dated 05/01/25, revealed he had a BIMS score of 00 and that a staff assessment for mental status should not be conducted. His active diagnoses included non-traumatic brain dysfunction (brain injury as the result of a change, damage, or infection internal to the body), muscle weakness, and need for assistance with personal care. His MDS indicated he had 2 stage 2 pressure ulcers upon admission which required pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention, pressure ulcer/injury care, and applications of ointments/medications.</p> <p>Record review of Resident #198's Order Summary Report, dated 05/20/25, reflected the following:</p> <p>-Cleanse sacrum with wound cleanser, pat dry, apply anasep gel and silicone/foam dressing daily and PRN every day shift with an active date of 05/12/25.</p> <p>Record review of Resident #198's Wound Care Administration Record for May 2025 reflected a blank in the space for 05/09/25 for the order of Cleanse sacrum with wound cleanser, pat dry, apply anasep gel and silicone/foam dressing daily and PRN ever day shift.</p> <p>Record review of Resident #198's care plan, revised on 05/13/25, reflected the following:</p> <p>Focus: CANCELLED: The resident has actual impairment to skin integrity of the sacrum r/t end of life processes .</p> <p>Record review of Resident #198's Progress Notes for 05/09/25 did not reflect anything about the missing wound care.</p> <p>Interview on 05/19/25 at 12:02 PM with the Wound Care Nurse revealed Resident #198 had open wounds on his sacrum, that required daily dressings. The Wound Care Nurse said she provided Resident #198 his wound care 05/08/25 before she went off on 05/09/25. The Wound Care Nurse said the charge nurse would have been responsible for providing wound care to Resident #198 on 05/09/25. The Wound Care Nurse said the charge nurse would need to go to the wound care administration record in the resident's chart to see what wound care needed to be done for that resident during their shift after being notified Wound Care Nurse was to be off. The Wound Care Nurse stated it was the responsibility of the management to notify charge nurses on the morning meeting if Wound Care Nurse was absent.</p> <p>Interview on 05/19/25 at 01:05 PM with LVN M revealed Resident #198 had open wounds on his sacrum, that required dressings. The LVN M said she was not aware that Wound Care Nurse was not in the facility on 05/09/25. She stated management notified them in the morning meeting if the Wound Care Nurse was going to be absent, and she did not recall hearing about it. She stated she did not notify the oncoming nurse because she thought the Wound Care Nurse would be taking care of the wound and wounds were taken care of by the morning shift. LVN M said she was the charge nurse, who would have been responsible for providing wound care to Resident #198 on 05/09/25, but she did not. She stated failure to provide wound care could lead to wound getting worse and also getting infected.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/20/25 at 11:33 AM with the DON revealed staff had been trained to check all resident's orders, including wound care orders and ensure they provided the care when the Wound Care Nurse was not present. The DON said the charge nurses were responsible for completing Resident #198 wound care on 05/09/25. The DON said the charge nurses on Friday 05/09/25 should have provided Resident #198 wound care to his sacrum as ordered. She stated the charge nurses were notified in the morning clinical meeting that they Wound Care Nurse was to be absent that day. She stated the morning shift nurses were responsible of wound care. She stated the weekend nurse called her and notified her the family member for Residnet#198 was asking why the dressing was not changed on 05/09/25 and that was how she knew the charge nurse that worked on 05/09/25 did not perform wound care to Residnet#198. The DON said if residents did not receive wound care as ordered it could lead to increased risk of infection or hospitalizations.</p> <p>Record review of the facility's Wound Treatment Management policy, revised 01/01/23, reflected: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change</p>		

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  05/20/2025
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means, received the appropriate treatment and services to prevent complications of enteral feeding, for 2 of 4 resident (Residents #16 and #58) reviewed for enteral nutrition.</p> <p>1. The facility failed to follow physician orders for Resident 16's enteral feeding tube formula when it was not available and required a substitution.</p> <p>2. The facility failed to follow Resident #58's physician orders for enteral feeding by not allowing Resident to have down time between the hours of 8:00 AM-12:00 PM.</p> <p>These failures could place residents who had gastrostomy tube at risk for weight loss, weight gain or stomach and digestion issues.</p> <p>Findings included:</p> <p>1. Record review of Resident #16's admission Record, dated 05/19/25, revealed the resident was an [AGE] year-old who originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #16's Quarterly MDS Assessment, dated 04/22/25, reflected a BIMS score was not calculated. Record review of her cognitive patterns revealed Resident #16 had a memory problem for both short-term and long-term and was severely impaired for daily decision making. Her active diagnoses included other neurological conditions, malnutrition, and Alzheimer's disease. Her MDS indicated she utilized a feeding tube and received 51% or more of her total calories through a feeding tube.</p> <p>Record review of Resident #16's Order Summary Report reflected an order for - Isosource 1.5 @ 50 ml/hr x 20hrs via GT</p> <p>Record review of Resident #16's care plan, revised 03/21/25, reflected the following: Focus: [Resident #16 requires tube feeding d/t inadequate nutritional intake .Interventions/Tasks: 12/07/23 Isosource 1.5 increase to 50cc/hr x20 hrs .</p> <p>Observation on 05/18/25 at 3:11 PM of Resident #16 revealed she was lying in bed with her tube feeding machine running. The formula that was hanging at her bedside providing her nutrition was Jevity 1.5. Resident #16 was not able to be interviewed based on her condition.</p> <p>Observation on 05/19/25 at 8:38 AM of Resident #16 revealed she was lying in bed with her tube feeding machine not running. The formula that was hanging at her bedside was Jevity 1.5. Resident #16 was not able to be interviewed based on her condition.</p> <p>Attempted interview on the phone on 05/19/25 at 1:20 PM with Resident #16's RP was not successful as there was not an answer.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/19/25 at 3:00 PM with LVN G revealed she had been caring for Resident #16 since November 2024. LVN G said the formula Resident #16 normally received was Isosource 1.5 and she was normally the nurse responsible for hanging the resident's formula during her shift. LVN G said she understood that the NP approved the change in formula temporarily because the Isosource was not available at the time and the resident still needed nutrition . LVN G said there should have been an order put in to approve the substitution from Isosource to Jevity for Resident #16. LVN G said the nurse who contacted the NP about the substitution should have added the order to the chart, but she was not sure when this would have occurred or who would have received the order to do so. LVN G said she only worked during the week and the weekend nurse was the one who had hung Resident #16's nutrition the last two days.</p> <p>Interview on 05/20/25 at 2:51 PM with the DON revealed Resident #16's order should have specified that the substitution between Isosource and Jevity should have been included before being administered to her. The DON said she found out yesterday about the substitution and said when the facility's shipment of formulas came, the Isosource ones had curdled so they were thrown out and more was ordered. The DON said staff spoke with the NP and were approved to use Jevity for Resident #16, but they failed to document the order in her chart. The DON said the purpose of making sure the order was specific was because there could be potential weight loss or gain or changes to labs if the substitution was not approved and noted. The DON said the nurse at the time of the administration of the nutrition would have been responsible for communicating and documenting the approval with the NP or Doctor. The DON said there is not a monitoring tool in place to ensure the right formula was being administered to residents who used tube feedings for nutrition. The DON said all staff were trained to make sure they were following the orders for residents.</p> <p>2. Record review of Resident #58's face sheet dated 05/18/25 revealed the resident was [AGE] year-old female admitted on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #58's admission MDS dated [DATE] revealed the resident had severe cognitive impairment with a BIMS score of 07. The assessment reflected Resident #58 required total dependence with eating, and the resident received nutrition via a feeding tube. Resident #58 active diagnoses included Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), Hyperlipidemia (high cholesterol).</p> <p>Record review of Resident #58's undated care plan did not reflect Resident #58 required the use of tube feeding.</p> <p>Record review of Resident #58's physician order active 09/14/24 revealed:</p> <p>Enteral Feed Order every shift for Nutrition Glucerna 1.5 at 60cc/hour for 20 hours a day with water flush at 200 cc every 6 hours. Enteral: Continuous feeding pump: Pump turn off at 8 AM. Turn pump back on at 12 noon every day. Active 09/13/24.</p> <p>Observation and interview on 05/18/25 at 11:16 AM with Resident #58 revealed resident was in bed, tube feeding machine was turned off, not administering feeding. Resident #58 stated she was not feeling well and expressed that she was tired. According to Resident #58 she had lived in the facility for some time and had no concerns with the care she was receiving.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 05/19/25 at 8:43 AM of Resident #58 revealed tube feeding machine was running at 60 ml, 200 water flush every 6 hours.</p> <p>Observation on 05/19/25 at 9:40 AM of Resident #58 revealed tube feeding machine was running at 60 ml, 200 water flush every 6 hours.</p> <p>Observation on 05/19/25 at 10:52 AM of Resident #58 revealed tube feeding machine was turned off.</p> <p>Observation on 05/19/25 at 12:10 PM of Resident #58 revealed tube feeding machine was turned off.</p> <p>Observation on 05/19/25 at 12:50 PM of Resident #58 revealed tube feeding machine was running at 60 ml, 200 water flush every 6 hours.</p> <p>Interview and record review on 05/19/25 at 2:11 PM with LVN N revealed she was the nurse on duty for Resident #58. She stated Resident #58 did not receive any nutrition by mouth. She stated the resident was on continuous tube feeding, except when she went down at 8:00 AM, and her machine was up and running at 12:00 PM. LVN N stated she had morning duty in the dining room, and she turned Resident #58's feeding machine off at 9:00 AM and continued her feeding at 1:00 PM. LVN N was told about the observations of Resident #58's tube feeding continuing at least until after 9:40 AM and machine had resumed prior to 12:50 PM leaving Resident #58 with less than 4 hours of down time. According to LVN N she was responsible for contacting the physician and documenting when physician orders were not followed, she further stated she would need to follow any new orders or recommendations from the physician. LVN N stated she had not had a chance to contact the doctor or document. LVN N stated Resident #58 was placed at risk of having too much formula in her stomach and not having proper downtime to allow formula to digest.</p> <p>Interview and record review on 05/20/25 at 12:03 PM with The ADON revealed nurses on the floor were responsible for following physician orders. The ADON stated nurses were responsible for making rounds on residents with tube feeding nutrition to ensure they were getting proper nutrition rate and water flushes according to the physician orders, if they had a break from feeding the nurses should go by the time perimeters set by the physician's order. The ADON stated the ADON and DON were responsible for ensuring staff were following physician orders, not doing so would place residents at risk of not getting enough nutrition, getting too full, not allowing their stomach enough time to rest between feedings.</p> <p>Interview on 05/20/25 at 2:40 PM with the DON revealed Resident #58 was administered nutrition by tube feeding. The DON stated nurses were responsible to ensure they were following physician orders at all times. The DON stated she expected the nursing staff working with her to allow Resident #58 to have her full 4-hour break from feeding, if not, she should have contacted the physician to alert him and document on the situation and any new instructions to follow from the physician. The DON stated not allowing Resident #58 to have a break from feeding according to the physician orders placed her at risk of fluid overload and weight gain, along with possible stomach issues.</p> <p>Record review of the facility's Care and Treatment of Feeding Tubes policy, dated 2021, reflected: .9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: . e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Care and Treatment of Feeding Tubes policy, dated November 2017, reflected:</p> <p>.Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and it's caloric value, volume, duration, mechanism of administration, and frequency of flush.</p> <p>.ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders</p>

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  05/20/2025
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)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Residents #23 and #33) reviewed for dialysis.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure dialysis communication forms were completed for Resident #23 after returning from dialysis treatment.</li> <li>The facility failed to ensure Resident #33 had an order to complete dialysis treatment.</li> </ol> <p>This failure could place residents at risk of inadequate monitoring after returning to facility.</p> <p>Findings included:</p> <p>Record review of Resident #23's admission MDS assessment, dated 05/07/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #23 had a diagnosis of end-stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively). She had a BIMS score of 15, which indicated her cognition was intact. The MDS reflected Resident #23 received dialysis.</p> <p>Record review of Resident #23's care plan, dated 04/24/25, reflected Focus: Resident #23 needed hemodialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly). Goals: The resident will have no signs or symptoms of complications from dialysis through the review date. Interventions: Monitor vital signs. notify MD of significant abnormalities.</p> <p>Record review of Resident #23's May 2025 physician's order reflected orders to obtain and document vital signs prior to Resident #23 left for dialysis and upon return from dialysis.</p> <p>Record review of Resident #23's EHR reflected there was no nursing documentation regarding Resident #23's post-dialysis vital signs monitoring.</p> <p>Review of Resident #23's renal dialysis communication forms for the month of April 2025 dated: -04/09/25, 04/14/25,4/16/25,4/18/25,4/21/25,4/23/25,4/25/25,4/30/25, Post dialysis reflected dialysis communication forms with no information on the resident's assessment and observation post dialysis section completed. For the month of May 2025, pre dialysis and post dialysis for 5/2/25,5/5/25,5/7/25,5/9/25,5/12/25,5/16/25 communications forms were provided and had no post dialysis vitals completed. Facility was unable to provide dialysis communications forms for the days of 04/11/25, 4/28/25 and 05/14/25 that were requested from DON on 05/19/25.</p> <p>Interview on 05/18/25 at 10:43 AM with Resident #23 revealed she went for dialysis on Monday, Wednesday, and Friday. She stated she got a form that she took to dialysis and brought back to facility.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/19/25 at 03:52 PM with RN A revealed he was the nurse that worked Monday, Wednesday, and Friday when resident came back from dialysis. He stated he was aware he was supposed collect the communication form from Resident#23 when the resident returned from dialysis. RN A stated he knew he was supposed to monitor the dialysis access site for the bruit thrill (a vibration caused by blood flowing through the fistula and can be felt by placing fingers just above incision line), dressing for bleeding and vital signs when Resident #23 was back from dialysis. He stated he was checking the vitals but could not provide where he was documenting. He checked the file and there were no Resident #23 communication forms that were completed with post dialysis vital signs. He stated the importance of the post dialysis vitals was to ensure the resident was received stable from dialysis. He stated failure to follow-up on the communication form after dialysis was, they could miss orders and recommendations from the dialysis center. He stated had done training on the dialysis communication form.</p> <p>Interview on 05/20/25 at 11:11 AM with the DON revealed her expectation was for the nurses to send Resident #23 with a communication form and get it when back from dialysis and put it in the dialysis binder. She stated she also expected staff to perform post-dialysis assessments when residents returned from dialysis, and document on the dialysis communication forms on dialysis days and in the electronic health records. The DON stated failure to collect the forms back from dialysis could result in them missing important orders from the dialysis center and delay in action if there were noted changes at the dialysis. She stated ADON was responsible of following up with nurse to ensure the nurse are completing the forms, but she had terminated her due to failure to perform her task. She stated the facility had done training with staff, documentation of the training was provided dated 03/29/24 on dialysis sheet and RN A was in attendance.</p> <p>2. Record review of Resident #33's admission MDS assessment, dated 02/15/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33 had a diagnosis of end-stage renal disease (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively). He had a BIMS score of 15, which indicated his cognition was intact. The MDS reflected Resident #33 received dialysis.</p> <p>Record review of Resident #33's care plan, dated 04/09/23, reflected Focus: Resident #33 required hemodialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly) for renal failure. Goals: The resident will have immediate intervention should any signs or symptoms of complications from dialysis occur. Resident will have no signs or symptoms of complications from dialysis. Interventions: Check and change dressing daily at access site. Document. Do not draw blood or take blood pressure in left arm. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis three times per week. Monitor for dry skin and apply lotion as needed. Monitor intake and output. Monitor labs and report to doctor as needed. Monitor labs and report to doctor as needed. Monitor vital signs as ordered and indicated. Dialysis shunt site monitoring and vital signs before and after dialysis as ordered. Monitor document and report any signs of infection to access site. Monitor document and report for signs of renal insufficiency, changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.</p> <p>Record review of Resident #33's EHR reflected there were communication forms regarding Resident #33's pre- and post-dialysis vital signs monitoring.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on 05/18/25 at 11:43 AM with Resident #33 revealed he went for dialysis on Tuesday, Thursday, and Saturdays. He stated the facility provided him with a binder for communication logs that he returned. Resident #33 further revealed his site was dry, clean and without complications.</p> <p>Record review of Resident #33's May 2025 physician's order reflected there were no orders for completing dialysis on Tuesday, Thursday, or Saturdays or to obtain and document vital signs prior to Resident #33 leaving for dialysis and upon return from dialysis.</p> <p>Interview on 05/19/25 at 04:16 PM with LVN O revealed she worked with Resident #33, he did attend dialysis on Tuesday, Thursday and Saturdays. LVN O stated she worked 2:00 - 10:00 PM shift, Resident #33 had an early chair time therefore he came back on the first shift (6:00- 2:00 PM). LVN O stated she had never gotten reports of concern with Resident #33 concerning his dialysis or any effects afterwards. When LVN O was asked to review his orders, LVN O revealed he did not have an order for dialysis. LVN O stated the admitting nurse was responsible for entering orders for dialysis and ADON and the DON reviewed charts to ensure orders were correct. According to LVN O there should had been an ordered created for Resident #33's need for dialysis and it should include the location, dates, and chair times. LVN O stated not having an order placed Resident #33 at risk of possibly missing his dialysis treatment, swelling, overload of fluids and furthering his kidney issue or toxicity of his blood.</p> <p>Interview on 05/20/25 at 8:18 AM with LVN N revealed she worked with Resident #33 for some time and knew about his dialysis. LVN N stated she assessed him prior to exiting the building and sent him with his dialysis communication form. Upon review of Resident #33's orders, LVN N stated he did not have an order referenced for his requirement of dialysis. According to LVN N the admitting nurse, ADON and the DON were responsible for ensuring ordered were entered for each resident's needs. LVN N stated not having orders could create miscommunication among staff and could result Resident #33 in not receiving dialysis.</p> <p>Interview on 05/20/25 at 2:40 PM with the DON revealed her expectation was for the nurses to ensure orders were entered to provide care. The DON stated charge nurses, ADON and herself were responsible for entering orders for each resident. The DON stated not doing so placed Resident #33 at risk of possibility of missing his chair time for dialysis. According to the DON Resident #33 had been on dialysis since she started a year ago, the DON stated Resident #33 must have had an order, and it was deleted by mistake.</p> <p>Record review of the facility's current, Hemodialysis policy, dated 06/01/24, reflected the following:</p> <p>.7. The nurse will monitor and document the status of the resident's access site upon return from dialysis treatment to observe for bleeding or other complications</p> <p>.6. Treatment Orders - when recording treatment orders, specify the treatment, frequency and duration of the treatment.</p>		

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  05/20/2025
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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 medication carts (600,700 and 800 Halls cart) and 3 of 3 residents (Residents #68,#91 and #98) reviewed for pharmacy services.</p> <p>The facility failed to ensure the 600,700 and 800 Halls nurses' medication cart had accurate narcotic counts for Residents #68, #91 and #98.</p> <p>This failure could place residents at risk for medication errors, drug diversion, and delay in medication administration.</p> <p>Findings included:</p> <p>1. Record review of Resident #68's comprehensive MDS Assessment, dated 05/07/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #68 had diagnoses which included chronic obstructive pulmonary disease (a long-term lung disease that makes it difficult to breathe) and difficulty in walking. The resident BIMS score was 15 indicating his cognition was intact.</p> <p>Record review of Resident #68's physician's orders, dated 5/02/25, reflected an order for the resident to receive Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (narcotic pain medication), 1 tablet by mouth every 4 hours as needed for pain.</p> <p>Record review of Resident #68's physician's orders, dated 5/16/25, reflected an order for the resident to receive Lorazepam Oral Tablet 0.5 MG. Give one tablet every 8 hours as need for anxiety.</p> <p>Record review of Resident 68's May 2025 MAR reflected Hydrocodone-Acetaminophen Oral Tablet 5-325 mg was last administered on 05/19/25 at 08:47 AM and Lorazepam Oral Tablet 0.5 MG was last administered on 05/19/25 at 08:46 AM.</p> <p>2. Record review of Resident #91's Entry MDS Assessment, dated 04/28/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #91 had diagnoses which included acute and chronic respiratory failure with hypoxia (a sudden, life-threatening condition requiring immediate treatment, while chronic respiratory failure is an ongoing condition that can be managed at home or in a long-term care center). The resident BIMS score was 15 indicating her cognition was intact.</p> <p>Record review of Resident #91's physician's orders, dated 04/23/25, reflected an order for the resident to receive oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl). Give 1 tablet by mouth every 8 hours as needed for pain.</p> <p>Record review of Resident #91's May 2025 MAR reflected oxycodone- HCl Oral Tablet 5 MG was last administered on 05/19/25 at 8:49 AM.</p> <p>(continued on next page)</p>

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  05/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #98's Entry MDS Assessment, dated 05/08/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #98 had diagnoses which included cellulitis of left lower limb (a bacterial skin infection, frequently affects the lower limb, particularly the lower leg). The resident BIMS score was not documented she was newly admitted .</p> <p>Record review of Resident #98's physician's orders, dated 05/08/25, reflected an order for the resident to receive Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (narcotic pain medication), 1 tablet by mouth every 6 hours as needed for pain.</p> <p>Record review of Resident 98's May 2025 MAR reflected Hydrocodone-Acetaminophen Oral Tablet 5-325 mg was last administered on 05/19/25 at 7:05 AM.</p> <p>Observation and record review on 05/19/25 beginning at 11:29 AM of the 600,700 and 800 Hall nurses' medication cart and the Narcotic Administration Record with LVN M revealed Resident #68's Narcotic Administration Record for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg reflected a total of 46 pills remaining, while the blister pack count was 45 pills. It had last been administered on 05/18/25. Administration Record for Lorazepam Oral Tablet 0.5 MG reflected a total of 28 pills remaining, while the blister pack count was 27. It had last been administered on 05/18/25.</p> <p>Record review of Resident #91's Narcotic Administration Record for oxycodone 5 mg reflected a total of 45 pills remaining, while the blister pack count was 44 pills. It had last been administered on 05/17/25.</p> <p>Record review Resident #98's Narcotic Administration Record for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg reflected a total of 53 pills remaining, while the blister pack count was 52 pills. It had last been administered on 05/18/25.</p> <p>Interview with LVN M on 05/19/25 11:50 AM revealed she administered Resident #61's Hydrocodone-Acetaminophen Oral Tablet 5-325 mg 1 tablet every 6 hours as needed and Lorazepam 0.5 mg 1 tablet every 8 hours and oxycodone 5 mg 1 tablet to Resident #91 as needed every 8 hours and Hydrocodone-Acetaminophen Oral Tablet 5-325 mg 1 tablet every 6 hours as needed to Resident#98, and she had not signed off on the Narcotic Administration Record log. She said she gave the residents the medication, but she forgot to sign off on the Narcotic Administration Record. She stated she knew she was supposed to sign-out on the narcotic count sheet log after administration and on the Medication Administration Record, but she did not. LVN M stated failure to sign off narcotics could lead to overdose since the person who came after her would not be able to tell when the narcotic was administered. She said she had done in-service on medication administration.</p> <p>Interview on 05/20/25 11:29 AM with the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the MAR and to sign on the narcotic log. The DON said failure to document could lead to overdose and missing pills. She said it was her responsibility to audit the medication carts since she does not have the ADON for that station. She said the facility had completed in services on medication administration and narcotic sign out.</p> <p>Record review of the training records on narcotic administration was requested on 05/20/25 and none was provided.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Controlled Substances Administration and Accountability policy, dated 01/01/23, reflected the following:</p> <p>.All controlled substance (Scheduled ii iii iv, v) are accounted for in one of the following ways:</p> <p>.ii. All controlled substance obtained from non- automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided</p>		

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  05/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure the medication error rate was not five percent (5%) or greater for 1 of 3 staff (LVN B) which resulted in a 43.9 % medication error rate after 41 opportunities with 18 errors for 1 of 4 residents (Resident #16) reviewed medication administration.</p> <p>LVN B failed to follow the physician orders for flushing Resident #16's gastrostomy tube with 5-10 mL (or prescribed amount) of water between medications, when she administered 13 medications to Resident #16.</p> <p>LVN B also failed to administer all the medications in medicatoin cups leading to 5 cups being left with residual medication.</p> <p>These failures could place residents at risk of physical and chemical incompatibilities leading to an altered therapeutic response and put residents who received medications via gastrostomy tube at risk for gastronomy tube blockage and medication interaction.</p> <p>Findings included:</p> <p>1. Record review of Resident #16's quarterly MDS assessment, dated 04/22/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The assessment reflected the resident cognition was not documented. The resident had diagnoses which included Hypertension, (high blood pressure), anemia (condition characterized by a lower-than-normal number of red blood cells, or a deficiency of hemoglobin, which carries oxygen in the blood)). The nutritional approaches revealed feeding tube.</p> <p>Review of Resident #16's May 2025 Physician Orders reflected there were orders for flushing gastrostomy tube with 5-10 ml of tap water between medication administration. Do not cocktail (mix) multiple medications to be administered via G tube. Each med must be administered individually.</p> <p>Observation on 05/19/25 08:19 AM revealed LVN B prepared medications outside resident's room. She sanitized and prepared the following medications:</p> <p>Arginaid 4.5 gm 1 packet mix with 6-8 ounces water via g-tube.</p> <p>ASA 81 mg 1 table via g-tube</p> <p>Losartan 50 mg 1 tablet daily via g-tube</p> <p>[NAME] at 30 ml via g-tube bid mix with</p> <p>Senna 86 1 tablet daily via g-tube</p> <p>Vitamin B 12 500 mcg 1 tablet via g-tube daily</p> <p>Vitamin D 25 mcg 1000 units 1 tablet daily</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Docusate 100 mg 1 tablet daily via g-tube.</p> <p>Ferrous sulfate 7.5 ml bid via g-tube.</p> <p>Lasix 20 mg 1 tablet daily via g-tube.</p> <p>Sodium chloride 1 gram 2 times a day via g-tube</p> <p>Spirolactone 25 mg 1 tablet daily via g-tube</p> <p>Tylenol 325 mg 2 tablets tid via g-tube,</p> <p>She put the medications in different cups. LVN B crushed the medication and put in separate cups, mixed with 5 ml water. She washed hands and put on gloves and gown and went to Resident #16's room. LVN B positioned Resident #23 in an upright position. LVN B checked for the gastrostomy tube placement and checked for residual. She flushed the gastrostomy tube with 30 ml of water administered medication one at a time, she did not flush the gastrostomy tube with water between each medication. LVN B flushed the gastrostomy tube with 30 ml of water after medications and she left the resident comfortable. Observation of the cups it was noted there were 5 cups with residuals. She removed the gloves and gown, and she washed hands.</p> <p>Interview with LVN B on 05/19/25 10:18 AM, revealed she was aware of the order to flush gastrostomy tube with 5-10 ml of water before, between, and after medication administration through gastrostomy tube for Resident #23. She said she forgot to flush the gastrostomy tube between medication administration. LVN B stated failure to check orders and flush in between the medication could lead to gastrostomy tube blockage and medication interactions. She stated she was also supposed to administer all the medication without leaving residuals in cups. She stated she realized she had residual after she had completed administering medication. She stated failure to administer the full dose as orders would risk resident not getting the intended therapy. She stated she had received training on medication administration via gastrostomy tube.</p> <p>Interview with DON on 05/20/25 11:22 AM revealed her expectation was nurses are supposed to crush medication for gastrostomy tube in different cups mix with water and flush the tube before, between administration and after medication administration. She stated she was responsible of monitoring the nurses and the MA. She stated the risk of not flushing before between and after medication administration would be gastrostomy tube being clogged and medication interactions.</p> <p>Record review of the g-tube medication administration training dated 10/13/24 revealed LVN B was not in attendance.</p> <p>Record review of the facility's current Medication Administration policy revised 01/01/23, reflected the following:</p> <p>.Do not crush medication:</p> <p>Crushed medication is not to be combined and given all at once if via feeding tube</p> <p>(continued on next page)</p>		

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  05/20/2025
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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's current, undated Administering Medication Through Enteral Tube policy reflected the following:</p> <p>.13 If administering more than one medication flush with 15 ml warm purified water or prescribed amount between medications</p>

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  05/20/2025
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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observations and interviews, the facility failed to ensure the menus were followed for 1 (the lunch meal on 05/20/25) of 2 meals reviewed for menus.</p> <p>The facility did not serve the correct portions of pureed broccoli and cauliflower, pureed pizza pasta bake, and pureed garlic bread for the lunch meal on 05/20/25.</p> <p>This failure could affect residents in the facility, who eat from the kitchen, by placing them at risk of being hungry or losing weight.</p> <p>Findings included:</p> <p>Observation on 05/20/25 at 11:45 AM of the kitchen revealed the steam table included the prepared pureed foods, including pureed broccoli and cauliflower, pureed garlic bread, and pureed pizza pasta bake.</p> <p>Interview and observation on 05/20/25 at 11:50 AM revealed the DM and [NAME] F were reviewing the recipe for the foods to be served and calling out the scoops required for each of the meal items. [NAME] F said she was using a 3-ounce scoop for the pureed broccoli and cauliflower, a 3-ounce scoop for the pureed pizza pasta bake, and a 2-ounce scoop for the pureed garlic bread. The DM provided [NAME] F with the scoop sizes and [NAME] F began to start serving and plating the foods using the scoops.</p> <p>A sample tray was requested and tasted on 05/20/25 at 12:55 PM with three surveyors and the DM. The tray that was tasted included pureed pizza pasta bake, pureed garlic bread, and pureed broccoli and cauliflower. The portions did not appear to be accurate based on the sizes of what was provided on the plate, they were significantly smaller than what they should have been.</p> <p>Interview on 05/20/25 at 1:00 PM with the DM revealed after looking at the plate that included the pureed foods, the portions did appear smaller than what they should have been. The DM said she handed [NAME] F the scoops to use during meal service today (05/20/25) during lunch and had checked the recipe to make sure they were correct. The DM said she got confused because the garlic bread weight before being pureed was 2 ounces, so she thought that was the correct scoop size for the pureed garlic bread to be served. The DM said she thought she handed [NAME] F the right scoop sizes for the pureed meat and pureed vegetables. The DM said both her and [NAME] F did not realize the wrong scoop sizes were used. The DM said if the residents on a pureed diet were getting smaller amounts of food, they could not be full and need to ask for extra food. The DM said she and [NAME] F were responsible for making sure the right scoop sizes were used. The DM said she monitors to make sure the right scoop sizes were used. The DM said she and her staff had been trained to review the recipe and ensure the right scoop sizes were used. The DM said she and her staff got nervous and that was why the mistake happened.</p> <p>Record review of an undated and untitled list provided by the DON identified as the list of residents who were ordered a pureed diet revealed eight total residents.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of a menu dated 04/18/25 and titled Weekly Menu For [Corporate Name] 2025- Week 1- Diet: Regular/Regular reflected for Tuesday: Pizza Pasta Bake, Tossed Salad, Breadstick, Dressing of Choice, Applesauce, Beverage.</p> <p>Record review of a recipe card, dated 04/18/25, and titled Tuesday [Corporate Name] 2025- Week 1 reflected: Regular/Puree: 1 #6 Sc P Pizza Pasta Bake, 1 #10 Sc P Soft Cooked Vegetable, 1 #10 Sc P Breadstick, 1 Ea Dressing of Choice, &amp;frac12; C Applesauce .Scoop Sizes: No.6 =2/3 cup= 5.3 oz, No. 10= 3/8 cup= 3.75 oz .</p> <p>Record review of the facility's Portion Control policy, dated 2013, reflected: .2. The menu should list the specific portion size for each food item. Menus should be posted at the tray line for staff to refer to for proper portions for each diet. 3. Serve the food with ladles, scoops, spoodles, and spoons of standard sizes . Portions that are too small result in the individual not receiving the nutrients needed.</p>

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  05/20/2025
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility provided food that was palatable, for one (the lunch meal on 05/20/25) of three observed meals reviewed for dietary services.</p> <p>The facility failed to serve food that had a smooth, pudding like texture during the lunch meal on 05/20/25.</p> <p>This failure could affect residents by placing them at risk of weight loss, altered nutritional status, and a diminished quality of life.</p> <p>Findings included:</p> <p>Observation on 05/20/25 at 10:30 AM of the kitchen revealed the DM had taken a tray out of the oven that had prepared pizza pasta bake that included ground meat, pasta, and a sauce. The DM added several scoops of the prepared food to the machine to puree the food. The DM pureed the prepared food, but it still had bits of pasta in it and was not smooth or pudding like.</p> <p>A sample tray was requested and tasted on 05/20/25 at 12:55 PM with three surveyors and the DM. The tray that was tasted included pureed pizza pasta bake, pureed garlic bread, and pureed broccoli and cauliflower. The pureed pizza pasta bake was chunky with pieces of cooked pasta chunks in it; it did not have a smooth or pudding like texture.</p> <p>Interview on 05/20/25 at 1:00 PM with the DM revealed the pizza pasta bake still had pasta chunks in it and was not smooth or pudding like consistency. The DM said she made the pureed foods today and usually the cook did that. The DM said she usually made sure the texture was right and realized now that she should have mixed the pizza pasta bake more. The DM said if the texture was not smooth and pudding like, residents may not be able to swallow the food. The DM said she had been trained to make sure the pureed foods a smooth and pudding like texture.</p> <p>The DM said she and the cook were responsible for ensuring the pureed foods were a smooth and pudding like texture.</p> <p>Record review of an undated and untitled list provided by the DON identified as the list of residents who were ordered a pureed diet revealed eight total residents.</p> <p>Record review of a menu dated 04/18/25 and titled Weekly Menu For [Corporate Name] 2025- Week 1- Diet: Regular/Regular reflected for Tuesday: Pizza Pasta Bake, Tossed Salad, Breadstick, Dressing of Choice, Applesauce, Beverage.</p> <p>Record review of the facility's Dysphagia Diets policy, dated 2013, reflected: .5. The food service department will be responsible for preparing and serving the diet and fluid consistency as ordered.</p>		

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  05/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 20 residents (Resident #36) reviewed for clinical records.</p> <p>The facility failed to have complete records for Resident #36's wound care for April and May 2025</p> <p>This failure could place residents at risk for incomplete and inaccurately documented medical records that included their progress treatment, services, and interventions.</p> <p>Findings include:</p> <p>Review of Resident #36's MDS dated [DATE] reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included heart disease and Alzheimer's disease. The resident had a BIMS of 1, indicating her cognition was severely impaired. The MDS reflected the resident had a chronic disease that may result in a life expectancy of less than 6 months and was on hospice care. The MDS further reflected the resident had a stage 4 pressure ulcer.</p> <p>Review of Resident #36's care plan updated on 03/10/25 reflected the resident had the potential for pressure ulcer development related to decreased mobility and urinary incontinence. Resident #36 had a wound to her sacrum. Interventions included to follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Review of Resident #36's physician orders for May 2025 reflected the following:</p> <p>.Cleanse area to sacrum with wound cleanser, pat dry, apply TAO to wound be lightly pack wound with DAKIN'S-SOAKED GAUZE, apply skin prep to peri-wound and cover with bordered foam dressing daily and PRN if saturated, soiled, or dislodged everyday shift</p> <p>Review of Resident #36's wound care report for April 2025 and May 2025 reflected wound care was not completed on 04/06/25, 04/10/25, 04/12/25, 04/26/25, 05/05/25, 05/09/25, 05/11/25.</p> <p>Review of the Resident #36's wound care report by the wound care doctor for April 2025 and May 2025 reflected the resident was being seen and treated weekly and there was no evidence the wound deteriorated.</p> <p>Interview on 05/19/25 at 1:42 PM with the Wound Care Nurse revealed she was responsible for Resident #36's wound care Monday through Friday and on the weekends, it was done by the Weekend Supervisor or the charge nurses. The Wound Care Nurse said Resident #36's wound care was done on 04/10/25, 05/05/25 and 05/09/25 and the wound record did not reflect that because if the wound care doctor was there and/or orders were changed, the computer system would not let her go back and mark that the wound care had been complete. The Wound Care Nurse acknowledged the wound care report not being completed would indicate the wound care was not done.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/20/24 at 11:00 AM with LVN K revealed she provided wound care to the residents on the weekends including Resident #36. LVN K said there were days that the Weekend Supervisor would do the resident's wound care and if there were dates that were blank (04/06/25, 04/26/25, 04/27/25, 05/11/25) that probably meant the Weekend Supervisor did resident wound care and probably forgot to check the box because she (LVN K) always made sure to document when she (LVN K) did it.</p> <p>Attempts to contact the Weekend Supervisor on 05/20/25 were unsuccessful.</p> <p>Interview on 05/20/25 at 11:59 AM with the DON revealed the expectation was that the charge nurses provided wound care on the weekends and if the Weekend Supervisor was doing it, it was because she was being nice. If the wound report was being left blank that could indicate that wound care was not given to the residents including Resident #36.</p> <p>Review of the facility's policy titled Wound Treatment Management revised on 01/2023 reflected the following:</p> <p>Policy</p> <p>To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.</p> <p>.7. Treatments will be documented on the Treatment Administration Record or in the electronic health record</p>		

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  05/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of 2 residents (Residents #2 and #16) observed for infection control.</p> <ol style="list-style-type: none"> <li>1. CNA P and C N A Q failed to perform hand hygiene while providing incontinence care to Resident #16.</li> <li>2. The facility failed to ensure Wound Care Nurse performed hand hygiene and change gloves during the wound care for Residents #2 and #16.</li> </ol> <p>This failure could affect the residents, by placing them at risk for worsening conditions and cross contamination.</p> <p>Findings included:</p> <p>Record review of Resident #2's quarterly MDS assessment, dated 02/12/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis of Respiratory Failure (a serious condition that makes it difficult to breathe on your own). She had a BIMS score of 02, which indicated her cognition was severely impaired. The MDS reflected the resident had pressure ulcers/injuries, and she was at risk of developing pressure ulcers.</p> <p>Record review of Resident #2 's care plan revised on 04/14/25 reflected Focus; - Resident has been placed on Enhanced Barrier Precautions R/T Wound(s). Goal: Resident will not have a decline in psychosocial wellbeing related to being place on enhanced barrier precaution, resident will not have out-of-room activities restricted. Intervention: Wound care: any skin opening requiring a dressing.</p> <p>Record review of Resident #2's physician orders dated 05/14/25 reflected the following order: Sacrum: Cleanse with wound cleanser, pat dry. Apply calcium alginate to wound bed secure with silicone adhesive foam dressing. Change QD and PRN.</p> <p>Observation on 05/20/25 at 7:00 AM revealed the Wound Care Nurse got all supplies ready outside Resident #2's room. She washed hands and done gown and gloves. She entered Resident #2's room and explained the procedure. Removed the old dressing on the sacrum. she did not change the gloves or perform hand hygiene. She cleansed Resident #2's, pressure ulcer on the sacrum with wound cleanser. She pat dried the wound, without performing hand hygiene or changing the gloves. She removed gloves sanitized and put new gloves. She applied the skin prep on the edges let to dry and then applied the calcium alginate and dry dressing dated 05/20/25. She then removed the gloves washed hands put on gloves disinfected the table remove gloves and gown and wash hands.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #16's Quarterly MDS Assessment, dated 04/22/25, reflected Resident#16 was an [AGE] year-old female. She was admitted to the facility on [DATE] and readmitted on [DATE]. BIMS score was not calculated. Record review of her cognitive patterns revealed Resident #16 had a memory problem for both short-term and long-term and was severely impaired for daily decision making. Her active diagnoses included other neurological conditions, malnutrition, and Alzheimer's disease. Her MDS indicated she had other open lesion(s) on the foot which required nutrition or hydration intervention and pressure ulcer/injury care.</p> <p>Record review of Resident #16's physician orders dated 05/14/25 reflected the following order: Right buttocks: Cleanse with wound cleanser, pat dry. Apply calcium alginate to wound bed cover with foam dressing daily and as needed.</p> <p>Observation on 05/20/25 7:22 AM revealed CNA P and CNA Q providing incontinent care to Resident #16. CNA P and CNA Q were observed completing hand hygiene and putting on gloves before care. CNA P explained procedure to Resident#16. CNA Q positioned the resident and unfastened the brief and CNA P proceeded to clean Resident#16's abdominal folds and perineal area inside out. He was observed putting soiled wipes on a trash can without a plastic lining. They positioned the resident on her side and cleansed her bottom area. The open area on the sacrum was observed with no dressing. Resident #16 was observed soiled with urine and feces. CNA P was observed changing soiled gloves and not performing hand hygiene and putting on new gloves. After cleaning the resident CNA Q did complete hand hygiene after changing gloves then she applied the clean brief and left the Resident clean for the wound to be dressed. CNA P was observed leaving the room to doff gloves without washing hands, went to the wound care nurse cart, got some spatulas and gave them to the Wound Care Nurse who put them together with wound supplies .He went and brought the barrel to empty the soiled wipes and briefs from the trash can and notified the house keeping about disinfecting the trash can. After care CNA P and CNA Q completed hand hygiene and left the room with trash.</p> <p>Observation on 05/20/25 at 7:34 AM revealed Wound Care Nurse after getting all the wound care supplies ready, she entered the Resident #16's room and explained the procedure. She removed the old dressing on Resident #16 right lateral ankle which was soiled with drainage. She did not change the gloves or perform hand hygiene. She cleansed Resident #16's, pressure ulcer with wound cleanser. She pat dried the wound, without performing hand hygiene or changing the gloves. She then with same gloves she cleansed the Right medial foot with wound cleanser and pat dried. She removed gloves sanitized and put new gloves. She applied med honey with the spatula and then calcium alginate on the right lateral ankle and then applied triple antibiotic ointment then calcium alginate on the medial foot and covered with a rolled gauze. The dressing was dated 05/20/25. She then doffed the gloves and personal protective equipment. She washed hands put on gloves disinfected the table remove gloves and gown and wash hands.</p> <p>Interview on 05/230/25 7:56 AM with CNA P revealed he forgot to perform hand hygiene during perineal care. CNA P stated he was expected to clean hands before in between the care if gloves were soiled and after care, but he forgot he was only changing the gloves. CNA P stated he was supposed to complete hand hygiene and change gloves during incontinent care to prevent cross contamination. CNA P stated he realized the trash can was not lined with a plastic bag when he had started cleansing Resident #16. He stated failure to have plastic lining on trash and not washing hands after removing gloves could lead to cross contamination. He stated he has done training on Handwashing.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Wound Care Nurse on 05/20/25 8:00 AM revealed she was supposed to change gloves and wash hands after removal of the old dressing. She stated she also supposed to repeat the same after cleaning of the wound. She stated she was nervous, and she thought the old dressing and the wound were dirty and she was only supposed to change gloves and sanitize while applying treatment and new dressing. She stated failure to perform hand hygiene and change of gloves would cause cross contamination and spread of infection. She stated she had done training on infection control, handwashing, and wound care.</p> <p>Interview on 05/20/25 at 11:40 AM with the DON revealed her expectation was the Wound Care Nurse was supposed to change gloves from dirty to clean and wash hands. She stated she expected the Wound Care Nurse to wash hand after removing the old dressing and also between care in case of contamination. She stated failure to change gloves and perform hand hygiene after removal of the old dressing could risk infection and wound getting worse. She stated she had done training with staffs on infection control hand washing and wound care.</p> <p>Interview on 05/20/25 at 11:52 AM with the DON revealed her expectation during incontinent care was staff to complete hand hygiene before and after care. The DON also stated in between care CNA P was supposed to complete hand hygiene and change gloves because her hands were considered dirty after cleaning the resident. The DON stated CNA P was to complete hand hygiene during care to prevent the spread on infection. The DON stated the nursing staff had been offered the in-service on hand hygiene/infection.</p> <p>Record review of the facility training records revealed the facility had done training on infection control and handwashing on 01/09/25 and on 02/19/25. CNA P and CNA Q were in attendance.</p> <p>Record review of the facility Perineal Care policy, dated February 2018, reflected, .The purpose of this procedure is to provide cleanliness and comfort to resident, to prevent infections and skin irritation and to observe the resident's skin condition</p> <p>Record review of the facility's Wound Treatment Management Care policy dated 01/01/23, reflected:</p> <p>.1. Wound treatments will be provided in accordance with physician orders, including the cleansing method type of dressing, and frequency of dressing change .</p>		

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  05/20/2025
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)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on interview and record review, the facility failed to ensure nurse aides received required training which included dementia management training for 1 of 16 (CNA V) staff reviewed for in-service training requirements.</p> <p>The facility failed to ensure CNA V received dementia management training.</p> <p>This failure could place residents at risk of being cared for by staff who have been insufficiently trained.</p> <p>Findings included:</p> <p>Record review of personnel records provided by the HR Manager revealed CNA V with hire date of 04/17/23 did not have any documented evidence in the facility for annual trainings taken on Residents with Dementia which was consistent with her expected role.</p> <p>During an interview and record review on 05/20/25 at 10:12 AM with Human Resource Specialist revealed she was responsible for new hire orientation. Human Resource Specialist stated that new hires did not have dementia training during orientation with her. Human Resource Specialist stated she did not review job description responsibilities with newly hired staff. Human Resource Specialist stated the DON was over all training and if there were any dementia training, she would have them. Human Resource Specialist stated not having completed trainings placed residents at risk of injury, neglect and abuse. Human Resource Specialist stated the facility will be converting to online training where she will be responsible for ensuring all trainings were completed based on what the online training required.</p> <p>Interview on 05/20/25 at 11:55 AM with ADON revealed the DON was over all trainings. The ADON stated inservices were done throughout the year however in-services or trainings on Dementia did not sound familiar. The ADON revealed the facility will be using a computer-based training in the near future. The ADON stated not providing staff with trainings that were consistent with their expected roles placed residents at risk of abuse and neglect.</p> <p>Interview on 05/20/25 at 2:40 PM with The DON revealed she completed group inservices on a monthly basis however could not provide documentation that Dementia training had been provided to staff. The DON stated she could not say what trainings were done upon orientation because Human Resource Specialist was responsible for those trainings. According to the DON she was currently responsible for annual trainings and not covering all required topics placed residents at risk in many areas like abuse and neglect.</p> <p>Interview on 05/20/25 at 4:11 PM with the Administrator revealed the facility was not able to provide evidence of annual trainings. According to the Administrator he arrived to the facility in April 2025. The Administrator stated he was surprised to hear the facility did not have anything with annual trainings in place. He expected employee files to include annual trainings and have up to date information. The Administrator stated it was the responsibility of the Human Resources Specialist to ensure trainings were completed. The Administrator stated when staff are not up to date on trainings it puts residents at risks of not receiving proper care.</p> <p>(continued on next page)</p>		

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  05/20/2025
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)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Request of the facility's policy on training was requested the Human Resouces Specialist and the DON however was not presented prior to exit.</p>		