Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676407	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Purehealth Transitional Care at Thr Arlington	800 W. Randol Mill Road, 6th Floor Arlington, TX 76012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Patient #1) of 6 patients reviewed for ADLs. -The facility failed to provide showers or bed baths and oral care consistently for Patient #1 according to the facility's ADL schedule. This failure could place all patients who require assistance with ADL care at risk for poor personal hygiene, odors and a decline in their quality of life. Findings included: Record review of Patient #1's Face Sheet, dated 11/21/24, revealed the resident was a [AGE] year old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included: morbid (severe) obesity, reduced mobility, heart failure, peripheral vascular disease (circulation disorder), and urogenital implants (implanted medical device used to treat urinary incontinence). Record review of Patient #1's Nursing Home PPS MDS Assessment, dated 11/11/24, reflected the resident had a BIMS score of 15 which indicated cognition was intact. The MDS Assessment also reflected Patient #1 required set-up assistance for most ADLs and refused shower/bath task. Further review reflected the patient was dependent on staff for all mobility. Record review of Patient #1's care plan, dated 11/08/24, reflected the resident had a focus in personalized care and activity with interventions that included providing favorite items and preferences and having family and close friends involved in discussions about care. Record review of Patient #1's ADL tasks in the electronic health record, dated 11/08/24-11/16/24, reflected the following: Oral hygiene: -11/08/24- dependent-required all effort by helper (staff) to complete activity -11/09/24- no documentation (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Purehealth Transitional Care at Thr Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W. Randol Mill Road, 6th Floor Arlington, TX 76012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/10/24- no documentation -11/11/24- setup/clean-up assistance to complete activity -11/12/24- setup/clean-up assistance to complete activity -11/13/24- oral hygiene not applicable -11/15/24- independent-pt completed activity by themselves -11/16/24- no documentation Shower/bathe self: -11/08/24- shower not applicable -11/11/24- shower not applicable -11/12/24- shower not applicable -11/13/24- shower not applicable -11/15/24- dependent- required all effort by helper (staff) to complete activity In an interview on 11/21/24 at 1:55 PM, Patient #1 stated he admitted to the nursing facility for rehabilitation to regain his strength after a hospital stay. He stated he resided at the nursing facility for about 10 days and did not receive the best care. Patient #1 stated a staff wiped his lower legs and abdomen off with a wet wipe on one occasion; however, he never received a full shower or bed bath during his entire stay. He stated staff informed him that he would have to be transferred using a mechanical lift due to his large size for all care/treatment. Patient #1 stated he was very anxious about getting on the mechanical lift and may have refused it once. However, he later informed staff that he would get on it. Patient #1 stated even after agreeing to get on the mechanical lift, staff never attempted to transfer him for a shower or provide a bed bath. He stated not being bathed made him more concerned about the wounds on his body, although he was receiving wound care. Patient #1 stated he also was not provided toiletries or a setup for him to brush his teeth daily as he would have liked. Patient #1 stated that made him feel ashamed and unclean. He stated his friends would help as much as they could when they visited. (continued on next page)

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER: Purehealth Transitional Care at Thr Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 W. Randol Mill Road, 6th Floor Arlington, TX 76012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/21/24 at 03:02 PM, CNA A stated she worked at the facility for about one month. She stated she sometimes worked with Patient #1 and his shower days were every Monday, Wednesday, and Friday. CNA A stated she worked with Patient #1 on 11/15/24 and she initially stated she took the patient to the shower room to shower him. When asked if she used a mechanical lift to transfer the patient, she stated No, then said she must have given him a bed bath. CNA A stated she marked Patient #1's ADL task sheet in the electronic health record as not applicable for his shower and stated it was a mistake. CNA A stated Patient #1 was able to complete oral care independently, so she never assisted him with it. CNA A stated she recalled seeing a toothbrush, toothpaste, and basin in his room. CNA A stated staff would have to provide water for the basin if a patient was unable to get out of bed and she could not recall if she did so. CNA A stated Patient #1 never complained to her about not receiving a shower/bed bath or oral care. CNA A stated most day there were enough staff to accommodate all patients and denied concerns that any patients were being neglected. In an interview on 11/21/24 at 03:15 PM, the Interim DON stated staff were expected to provide all patients' showers or baths on scheduled days. The DON stated if a patient refused, the aides were supposed to notify the nurse so they could offer alternatives and ask about concerns. The Interim DON stated they would involve the family if refusals were persistent. The Interim DON stated staff were expected to document all encounters, whether the task was completed or refused. In an interview on 11/22/24 at 10:58 AM, CNA B stated she worked at the facility for about 5 months. She stated she sometimes worked with Patient #1. CNA B stated Patient #1 required a 2-person assist with most care, but he was able to help some. CNA B stated she recalled giving the patient a bed bath one day but could not remember the date. She stated there was another day Patient #1 was due for a shower or bath, but the facility was short-staffed, and he was unable to get it during the morning shift. CNA B stated if they were unable to provide a shower due to being short-staffed, they would inform the oncoming staff so they could provide it. CNA B stated she could not recall if she informed the oncoming staff that Patient #1 did not receive a shower or bath on that day. CNA B stated it was important for patients to receive their showers or baths as scheduled to keep the body clean from bacteria and prevent odor. In an interview on 11/22/24 at 11:39 AM, the Administrator stated the expectation was for the staff to document each time a patient received a shower/bath. The Administrator stated a patient had the right to refuse showers or baths, but it also needed to be documented. She stated the facility did not use paper shower sheets and documented all ADL tasks in the electronic health record. The Administrator stated not providing hygiene care to patients could place them at risk for infections and further skin breakdown. In a further interview on 11/22/24 at 1:35 PM, the Interim DON stated the risk of not providing patients with proper ADL care could place them at risk of skin breakdown, dignity issues, and infection. Record review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, revised 8/2024, reflected in part the following: Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Purehealth Transitional Care at Thr Arlington		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W. Randol Mill Road, 6th Floor Arlington, TX 76012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. .