

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 03/22/2024
NAME OF PROVIDER OR SUPPLIER Pure Health 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made. If the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 8 residents (Resident #193) reviewed for neglect reporting.</p> <p>The facility failed to report an unwitnessed fall with injury to the head by unknown source for Resident #193 on 03/16/24.</p> <p>This failure could place residents at risk of not receiving timely investigations and reporting of injuries of unknown source.</p> <p>Findings included:</p> <p>Review of Resident #193's admission record dated 03/20/24, revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral ischemia (a brain injury caused by a lack of blood flow to the brain aka stroke), dehydration, unspecified dementia without behaviors (a brain disorder of cognitive confusion and forgetfulness), muscle wasting and atopy, fall from bed, other reduced mobility, altered mental status (a brain condition of confusion, disorientation, and disorder), and weakness.</p> <p>Review of Resident #193's admission MDS section C dated 03/11/24, revealed a BIMS score of 3, indicating severe cognitive impairment.</p> <p>Record review of progress notes dated 03/19/24 at 12:10 pm by Care Manager reflected BIMS Evaluation completed.</p> <p>BIMS summary score: 7.0, BIMS of 7 indicated severe cognitive impairment.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #193's care plan dated 03/07/24 reflected Focus: The resident had an actual fall 3/16/24; unwitnessed fall with injury. Date initiated 03/17/24. Goal: The resident will resume usual activities without further incidents through the review date. Date initiated 3/17/24. Interventions: Monitor/document /report as needed (PRN) x 72h(hour) to Medical Doctor (MD) for signs/symptoms: Pain, bruises, Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation o Neuro-checks o Re-educate guest on use of call light o Staff to perform frequent visual safety checks o TRANSFER GUEST TO ED [emergency department] TO EVAL AND TREAT FOR LACERATION due to FALL Date Initiated: 03/17/2024. Focus: wound management post-surgical general (stapled laceration to rear of head. Initiated 03/20/24. Goal: wound will be free of signs or symptoms of infection. Intervention: notify provider if no signs of improvement on current wound regime, provide wound care per treatment order, weekly documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate [discharge], and any other notable changes or observations. Date initiated 03/20/24.</p> <p>Record review of progress note for Resident #193's entry by RN C on 03/16/24 at 09:20 pm reflected At 2120hr [09:20 PM], this nurse had heard a shout for help. Upon entering the room, guest was seen lying on the floor. Upon assessment, with GCS 14/15, with PERRLA, able to move all extremities, with a large swelling and a laceration on occipital area [back of head], with skin tear and swelling on left leg, with complaints of dizziness when sitting up and generalized pain. Guest was transferred to bed, cleansed wound on left leg and applied steri-strip [tape used to hold torn skin together], applied ice pack on occipital area.</p> <p>Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Hold Eliquis for 3 days, Neurocheck monitoring [checking if the resident is alert, can they follow commands], send to ER.</p> <p>Interview with Resident #193 and family on 03/20/24 at 12:51 pm revealed Resident#193 could not remember what happened when he fell . His family said the facility called her around 9 pm on 03/16/24 stating that Resident #193 had a fall. Family said she was told that Resident #193 got out of bed and was walking towards the walker when he fell and hit his head and sustained a cut on his head and leg. The family said the facility told her that they could not stop the bleeding due to the blood thinners and he was sent to the emergency room .</p> <p>Interview with RN C on 03/20/24 at 01:05 pm could not be completed voicemail was left for RN C to return phone call. The facility schedule indicated that RN C worked night shift from 6 PM to 6 AM.</p> <p>Interview with RN H on 03/17/24 at 10:31 AM revealed that she did not work with Resident #193 the day he fell . She was aware that Resident 193 was a fall risk, and she maked sure his bed was in low position, his call light was within reach, she rounded more frequently on him and those residents with high fall risks. She said that she was in-serviced about falls and reporting timely. She said that she is expected to notify the DON, Administrator, the physician, and family immediately. She said that she is expected to report any incidents as soon as they happen. She said Failure to report can cause delay in resident getting medical attention.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on 03/20/24 at 12:19 pm revealed that she was notified on Monday morning 3/18/24 about Resident #193's fall. She said that she was waiting for the IDT meeting to figure out the next step. She said the administrator did the reporting of incidents. She said she expected nursing staff to report all falls to either the ADON and/or to herself immediately. She said, she started to in-service on timely reporting falls with injury, and abuse and neglect was always an ongoing in-service for the facility. She said CNA's and nurses check on fall risk residents every 15 minutes. She said the facility has interventions in place including floor mats however if a resident has a history of shuffling gait, then a floor mat can be a fall risk. She said both CNA's and nurses have been in serviced about offering bathroom needs more frequently and or making sure a urinal is within reach or in other cases the use of a bedside commode. She did not say what the failure in delayed reporting to State Agency may have affected the resident.</p> <p>Interview with the administrator on 3/19/24 at 12:30 pm revealed that he was aware of Resident #193's unwitnessed fall with injury of unknown origin. He said that he was responsible for reporting incidents to State Agency. He said that he was waiting for the BIMS score to determine if the unwitnessed fall with injury for Resident #193 was a reportable incident. He did not see risk to the resident because the facility followed interventions put in place. The administrator reported a self-report incident to State Agency after the State surveyor interview on 3/19/24. The administrator did not say the failure this delay may have affected the resident because he said they did everything they were supposed to do for the resident post fall.</p> <p>Review of in service dated 03/19/24 by DON titled Abuse & Neglect, Fall Prevention, reporting falls w/injury was completed in the following departments: Nursing, administration, MDS, Rehabilitation, and therapy.</p> <p>Review of the facility policy, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 09/22, reflected: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to the local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Finding of all investigations are documented and reported .All allegations are thoroughly investigated. The administrator initiates the investigation .</p> <p>The facility Reportable Incident Protocol, dated November 2017, reflected: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <ol style="list-style-type: none"> 1. Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property, are reported immediately, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the Facility to other officials (including State Survey Agency .)in accordance with state law through established procedures. 2. Have evidence that all alleged violations are thoroughly investigated. 3. Prevent further potential abuse, neglect, exploitation, or mistreatment while investigation is in progress. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Report the results of all investigations to the executive director or his or her designee and to other officials in accordance with state law, including state survey agency within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Injuries of unknown source: Any injury should be classified as an injury of unknown source when both of the following conditions are met:</p> <p>The source of the injury was not observed by any person, or the source of the injury could not be explained by the patient and the injury is suspicious because of the extent of the injury or location of the injury .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48329</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for</p> <p>one (Resident #139) of five residents reviewed for quality of care.</p> <p>The facility failed to identify a significant change of condition in Resident #139 between 03/14/24 to 03/19/24.</p> <p>This failure could place residents at risk for diminished quality of care and worsening conditions.</p> <p>Findings included:</p> <p>Review of Resident #139's admission record, dated 03/21/24, revealed Resident #139 was a [AGE] year-old male who was admitted into the facility on [DATE] with a diagnosis of Encephalopathy (disease of the brain), muscle wasting, hypertension (high-blood pressure), and Dysphagia (difficulty swallowing).</p> <p>Review of Resident #139's nursing notes dated, 03/19/2022 revealed on 02/22/24 Resident #139 experienced a fall. The resident was assessed and at the time, there were no concerns at the time. Resident was not sent out to the hospital and x-rays were not ordered. The physician was notified.</p> <p>Review of Resident #139's Quarterly MDS Assessment, dated 02/13/24, revealed that resident active diagnoses included Encephalopathy, muscle wasting, cognitive communication deficit, sleep apnea, acute myocardial infraction, heart disease, and hearing loss.</p> <p>Review of Resident #139's Care Plan, dated 02/12/24, revealed the resident had impaired cognitive function as evidenced by his BIMs score of 8.</p> <p>Observation and interview on 3/19/2024 at 11:15 am with Resident #139 revealed that the resident had to be assisted with drinking. The resident was unable to hold a cup of water up to his mouth to take a sip of water.</p> <p>Interview on 03/19/24 at 10:15 AM with Resident #139's family member revealed 2-3 days (02/24/24 - 02/25/24) after Resident #139's 02/22/24 fall, family noticed cognitive decline. Resident #139 used to be able to do 500-piece puzzles prior to fall. However, after the fall, he couldn't match 2 pieces of a puzzle together.</p> <p>Observation on 03/21/24 at 11:10am revealed Resident #139 could not support his upper body and a gait belt was used to help keep him upright on the wheelchair. Resident was unable to speak to the state surveyor.</p> <p>Observation on 03/21/24 at 2:33 revealed Resident #139's family member holding the resident upright to cut his hair. Resident #139 was unable to support himself.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/21/24 at 12:09 PM with Physician D revealed he was not concerned with Resident #139's decline, stated it was age-related and his nutrition was not the best. Physician D stated Resident #139 was at his baseline. Primary physician had not seen Resident #139 . He stated he would see Resident #139 on Sunday, 03/25/24.</p> <p>Interview on 03/21/24 at 12:45 PM with the DON revealed Resident #139 had been gradually declining since he was first admitted .</p> <p>Interview on 03/21/24 at 7:00 AM with RN G revealed she had been providing care to Resident #139 since he had admitted to the unit. She stated when Resident #139 first arrived, he was able to move around on his own she could recall a time when he was able to walk to the bathroom on his on with the assistance of the walker or cane. She stated that she even recalled when Resident #139 first admitted , and he was able to walk to and from the bathroom back to bed on his own. She stated that his decline happened around two weeks from today (around 03/07/24). RN G stated she noticed that Resident #139 had been weaker than normal in that he's had a total decline. She stated she thought it was due to him being nervous due to the fall, but his decline was more than what she would consider to be from nerves. RN G stated the protocol for change in condition was to inform the physician immediately and then to follow the updated orders.</p> <p>Review of Resident #139's progress notes from 03/02/24, RN G charted change in condition altered mental status in progress notes. Resident disoriented with things around him, unable to stand on his own. Family concerned with abrupt change. Wants further evaluation. Physician notified. Blood work done, given saline.</p> <p>Review of Resident #139's PT notes from 03/06/24 to 03/14/24 revealed the following:</p> <p>03/06/24 - Resident #139 was able to do leg strength training.</p> <p>03/07/24 - Resident #139 noted with fatigue, requiring extra time with energy conservation techniques. O2 SAT monitored.</p> <p>03/08/24 - Resident #139 wearing O2 during therapy.</p> <p>03/14/24 - Resident #139 followed all instructions but was confused and impulsive. PT focused on energy conserving techniques.</p> <p>Review of Resident #139's Appeal Determination Letter, dated 03/14/24, revealed Resident #139 was able to walk 75 feet with minimal assistance, was able to perform ADLs independently with some assistance, and was able to sit/stand with minimal assistance.</p> <p>Interview on 03/22/24 at 11:38 AM with PT F revealed Resident #139 a week ago (approximately 03/14/24) was able to walk 75 feet but shortly after was only able to walk 10 feet sometime last week (date unknown). He stated he notified the nurse and DOR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/22/24 at 1:01 PM with RN E revealed the only change of condition she was aware of was on 03/02/24, in which she reported to the physician. From 03/03/24 to 03/21/24, RN R revealed the resident had not had any changes to his condition and that it was Resident #139's baseline to have good days and bad days (worsening/improving function .) RN E stated she was not aware of any changes to Resident #139 from therapy. She stated she noticed a change in condition in Resident #139 on 03/21/24 and notified the physician. The physician saw Resident #139 and assessed the resident.</p> <p>Review of Resident #139's progress notes from 03/03/24 - 03/19/24 revealed no issues or indication of Resident #139's decline or improvement.</p> <p>Review of Resident #139's progress notes dated 03/21/24 revealed a change of condition related to hypertension and symptoms of increased confusion, increased weakness, and increased need for assistance. Physician D recommended Clonidine 0.1 mg 6hrs PRN.</p>		