STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675034	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Lake Nursing & Rehabilitation LLC	901 Pennsylvania Ave Fort Worth, TX 76104

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure the residents had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 30 residents (Resident #71) reviewed for resident rights. The facility failed to obtain a signed informed psychotropic consent based on information of the benefits, risks, and options available from Resident #71's responsible party/representative prior to administering Zoloft 50 mg, Buspirone Hcl 10 mg, Seroquel 25 mg, Valproic Acid Oral Solution 250 mg/5 ml (Valproate Sodium), and Seroquel 50 mg. These failures could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party. Findings included: Record review of Resident #71's face sheet dated 03/10/24 revealed Resident #71 was a [AGE] year-old male admitted on [DATE] with diagnoses including dementia, anxiety disorder, psychosis, and psychotic disorder with delusions (a serious mental illness that affects how a person thinks, feels, and behaves such as hallucinations involving sensing things such as visions, sounds, or smells that seem real but are not). The face sheet indicated Resident #71's responsible party and emergency contact was Family Member A. Record review of Resident #71's quarterly MDS assessment dated [DATE] revealed indicated Resident #71 had severe cognitive impairment with a BIMS score of 7. The MDS revealed the resident usually was understood when making his wants and needs known. Record review of Resident #71 baseline care plan dated 04/26/24 indicated Resident #71 was a new admission to the nursing facility for long term care. The care plan did not have interventions stating nursing staff will educate resident and/or responsible agent and have responsible agent sign consents related to antipsychotic, antidepressant, and anxiolytic medications ordered. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #71's care plan dated 04/26/24 indicated Resident #71 was at risk for adverse consequence related to receiving antipsychotic medication Seroquel, Valproic Acid, and Zoloft for treatment of psychosis, psychotic disorder, and adjustment disorder. Intervention/Tasks reflected: Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Intervention included assess/record effectiveness of drug treatment. Record review of Resident #71's care plan dated 04/26/24 indicated Resident #71 was at risk for adverse consequence and impaired decision making related to receiving antianxiety medication Buspirone, related to anxiety disorder. The care plan reflected: Intervention/Tasks reflected: Monitor/document side effects and effectiveness. ANTIANXIETY SIDE EFFECTS: Drowsiness, lack of energy, Clumsiness, slow reflexes, Slurred speech, Confusion and disorientation, Depression, Dizziness, lightheadedness, Impaired thinking and judgment, Memory loss, forgetfulness, Nausea, stomach upset, Blurred or double vision. PARADOXICAL SIDE EFFECTS: Mania, Hostility, and rage, Aggressive or impulsive behavior, Hallucinations. to make decision(s). Record review of Resident #71's care plan dated 04/26/24 indicated Resident #71 was risk for adverse consequence and impaired decision making related to receiving antidepressant medication, Quetiapine Fumarate, related to diagnosis of depression. The care plan reflected: Intervention/Tasks reflected: Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. ANTIDEPRESSANT SIDE EFFECTS: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Record review of Resident #71's Physician Order Report dated 04/26/24 revealed an order for Zoloft oral tablet 50 mg (Sertraline Hcl) Give 1 tablet by mouth at bedtime for behavior, DX: Depression, start date 04/27/24. Record review of Resident #71's Physician Order Report dated 04/26/24 indicated Valproic Acid Oral Solution 250 mg/5ml (Valproate Sodium) Give 10ml by mouth two times a day for psychosis, DX: Psychosis, psychotic disorder, and adjustment disorder, start date 04/27/24. Record review of Resident #71's Physician Order Report dated 04/26/24 indicated Seroquel oral tablet 25 mg (Quetiapine Fumarate) Give 1 tablet by mouth one time a day for unspecified psychosis start date 04/27/24. Record review of Resident #71's Physician Order Report dated 04/26/24 indicated Seroquel oral tablet 50 mg (Quetiapine Fumarate) Give 1 tablet by mouth one time a day in the evening for unspecified dementia start date 4/27/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/24 at 12:49 PM with the ADON revealed it was the admitting nurse's responsibility to obtain consents from the responsible party or the resident when a resident is admitted to the facility with orders for antipsychotic, antidepressants, and anti-anxiolytic medications. She also stated that the consents were supposed to be obtained before these medications were administered. The ADON stated that consents were audited by the ADON's in the facility to ensure that they were completed and in residents' charts upon admission. The ADON revealed Resident #71's EHR had been missed during her chart audit which would have caught the missing consents. The ADON stated that when consents were not obtained from residents, they were not informed about the medications they were taking including the risks/benefits as well as the possible side-affects. She stated that consents were used to educate the resident on their medications. Interview on 05/09/24 at 4:05 PM with the DON revealed consents should be received before medications were given. The DON stated the resident or family may not want the resident to have the medication due to an allergy that staff was unaware of. The DON stated the representative or the resident also may not want to risk possible side effects related to the medication. The DON acknowledged missing consents for Zoloft 50 mg, Buspirone Hcl 10 mg, Seroquel 25 mg, Valproic Acid Oral Solution 250 mg/5 ml (Valproate Sodium), and Seroquel 50 mg. The consents were not provided prior to exit. Record review of the facility's Psychotherapeutic Drug Management policy revised 10/24/22 reflected the following: .The licensed nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the Attending Physician from the resident and/or surrogate decision maker, unless it is an emergency situation. Record review of the facility's Resident Rights policy revised August 2020 reflected the following: .federal and state laws guarantee certain basic rights to all residents of this facility .these rights include the resident's right to .be informed of, and participate in, his or her care planning and treatment .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44140 Based on observation, interview, and record review, the facility failed to ensure the resident had the right to a safe, clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safely for 5 of 15 residents (confidential residents) reviewed for safe, clean, comfortable, and homelike environment. The facility failed to maintain resident's wheelchairs in a sanitary and safe operating condition according to 5 residents who attended the confidential group interview. These failures could affect residents and place them at risk for not having a safe and sanitary homelike environment. Findings included: During the confidential resident group interview and observation, 5 of the 10 residents revealed their wheelchairs were not being cleaned. Seven residents were sitting in their wheelchairs. The wheelchairs had dust build-up on the wheel spokes, footrest, breaks, and frame. The residents stated they had not seen anyone clean the wheelchair. The residents stated they did not like the wheelchairs being dirty. Interview on 05/09/24 at 1:06 PM with LVN B revealed residents' wheelchairs were cleaned during the 10:00 PM-6:00 AM shift. She stated she had noticed residents' wheelchairs were dirty. She stated when she noticed a wheelchair dirty, she would clean it. She stated she had not cleaned any wheelchairs lately. She stated she was not sure what system was in place. However, the nurses should notify the 10:00 PM-6:00 AM shift regarding which wheelchairs needed to be cleaned. She stated the potential risk of wheelchair being dirty could lead to infections. Interview on 05/09/24 at 1:24 PM with CNA E revealed resident's wheelchairs were cleaned during the 10:00 PM-6:00 AM shift. She stated she had noticed residents' wheelchairs were dirty. She stated she would notify the nurses on the hall. She stated night shift were responsible for cleaning the wheelchairs, but they don't. She stated she had not had any residents complain about the wheelchairs, but she had noticed them being dirty. She stated the risk of not cleaning the wheelchairs could lead to infections. Interview on 05/09/24 at 3:17 PM with the ADON revealed night shift staff were responsible for cleaning the wheelchairs. She stated she and central supply staff were supposed to ensure wheelchairs were being cleaned. She stated she had noticed night shift staff had been lacking on cleaning wheelchairs. She stated she had noticed some wheelchairs being dirty. She stated the dirt on the wheelchairs posed an infection control and sanitation concern. Interview on 05/09/24 at 3:26 PM with the DON revealed wheelchairs were cleaned by the 10:00 PM-6:00 AM staff. She stated it was the responsibility of the ADON to ensure that wheelchairs were being cleaned. She stated on occasions she had noticed residents' wheelchairs were dirty, and she would ask her staff to cleaned them. She stated the potential risk would be dignity issues. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/09/24 at 4:04 PM with the Administrator revealed the 10:00 PM-6:00 AM shift were responsible for cleaning residents' wheelchairs. She stated nursing management was responsible for ensuring wheelchairs were being cleaned. She stated her expectation was for residents' wheelchairs to be cleaned. She stated the potential risk of wheelchairs being dirty would be a dignity concern. Review of facility Resident Rights policy, revised dated August 2020, reflected the following: To promote and protect the rights of all residents at the Facility. All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 12 residents (Resident #56) reviewed for MDS assessment accuracy. The facility failed to ensure Resident #56's quarterly MDS assessment, dated 04/17/24, was coded correctly for gastrostomy tube status. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Review of Resident #56's face sheet dated 05/09/24 revealed Resident #56 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #56 had diagnoses of unspecified sequelae of unspecified cerebrovascular disease (conditions that affect blood flow to your brain), hypokalemia (low potassium), encephalopathy (disturbance of brain function), dysphagia (difficulty swallowing foods or liquids), encounter for attention to gastrostomy (opening into the stomach). Review of Resident #56's quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15 which indicated cognition was intact. The MDS Assessment further revealed Section K - Swallowing/Nutritional Status indicated mechanically altered diet was checked. No indication of feeding tube was checked. Review of Resident #56's care plan, revised date 04/12/24, revealed Focus: Resident requires tube feeding r/t dysphagia, swallowing problem Has Puree diet during day hours 12-28-23 Had MBSS continue Puree diet resident may request Mechanical soft diet. Continuous feeding at night - Osmolyte 1.5 at 30 ml / HR x 12 hours 1-18 continued weight gain and eating oral diet, DC nightly feeding, Flush PEG with 150 ml water q shift. Review of Resident #56's physician orders dated 07/16/2023, revealed, Peg Tube: Cleanse with NS; Pat Dry; Apply Dry Dressing Q NIGHT every day shift for PEG TUBE CARE Review of Resident #56's physician orders dated 07/16/2023, revealed, Enteral Feed Order every day shift Cleanse G-Tube site Qday Review of Resident #56's physician orders dated 01/17/24, revealed, Enteral Feed Order every shift 150 ml water flush per PEG tube Interview and observation on 05/09/24 at 3:28 PM with Resident #56 revealed she was doing well. Resident #56 stated she had a feeding tube, which she had it for a while, and recently she had been able to eat by mouth. Resident #56 could not recall when her feedings were stopped. Resident #56 stated the nurses provided care daily and received water flushes via g-tube. Observed g-tube to be intact, and dressing was on. Resident #56 denied any pain or discomfort. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/24 at 9:45 AM with LVN B revealed she was the nurse for Resident #56. She stated Resident #56 had a g-tube. She stated Resident #56 no longer received her feeding through her g-tube; however, resident received her flushes. LVN B stated resident was able to eat by mouth, she stated she could not recall when the g-tube feedings were discontinued. She stated Resident #56 received care/treatment for her g-tube. Interview on 05/09/24 at 9:58 AM with the MDS Coordinator revealed she was responsible for creating, completing, and transmitting all MDSs in the facility. She stated she gathers the MDS information from care plans, progress notes and documents. She stated Resident #56 had a g-tube but no longer received her feedings through the g-tube. The MDS Coordinator reviewed Resident #56's completed quarterly MDS assessment dated [DATE] and stated she coded the assessment incorrectly. She stated she was responsible for completing the assessments and corporate would review. The MDS Coordinator stated there was no risk to the resident if the MDS was not completed correctly because she was still getting treatment. Interview on 05/09/24 at 3:01 PM with the DON revealed Resident #56 had a g-tube; however, resident no longer received her feedings through the g-tube. She stated Resident #56's nutrition by mouth. She stated Resident #56 only received her flushes and treatment via g-tube. She stated her expectation was for residents' MDS' to be completed timely and accurately. She stated it was the MDS Coordinator's responsibility to complete the residents MDS assessments and corporate would review. The DON stated there was no risk for the residents. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, October 2023 reflected the following: an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44140 Based on observation, interview, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 2 of 8 residents (Resident #33) reviewed for quality of life. The facility failed to ensure Resident #33's fingernails were cleaned and cut. This failure could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: Review of Resident #33's Face Sheet, dated 05/09/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included heart failure, contracture of muscle, reduce mobility, rheumatoid arthritis (chronic inflammatory disorder effects joints), essential hypertension (high blood pressure). Review of Resident #33's MDS assessment, dated 03/21/24, reflected a BIMS score of 11 indicating moderate cognitive impairment. The MDS further revealed Section G: Activities of Daily Living Assistance revealed Resident #33 required extensive assistance for ADLs. Review of Resident #33's Care Plan, dated 04/05/24, reflected Focus: Resident has an ADL Self Care Performance Deficit r/t Impaired balance, Limited Mobility. Goal: Resident will demonstrate the appropriate use of adaptive device(s) to increase ability in ADLs such as Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Interventions: Bed mobility the resident requires moderate assist of one staff member for mobility in bed. Bathing The resident requires moderate to maximum assist of one staff member for bathing/showering. Personal Hygiene/oral care the resident the moderate assist of one staff member for personal hygiene/oral care, she requires someone to set it up and clean it up. Observation and interview on 05/07/24 at 1:08 PM revealed Resident #33 lying in bed and eating lunch. Resident #33 stated she was doing well. Observed Resident #33's fingernails to be long on both hands. Resident stated she would like her fingernails to be short, she stated no one has ever cut her fingernails since being admitted . She stated she could not recall if she had asked the staff to cut her fingernails. Interview and observation on 05/09/24 at 1:06 PM with LVN B revealed residents' fingernails were cleaned and cut by the CNA's and if the resident was a diabetic it was the nurse's responsibility to cut them. LVN B stated she had not had any residents complain about fingernails not being cut and she had not noticed any that residents' fingernails that need to be cut. LVN B entered Resident #33's room and observed resident fingernails. LVN B stated Resident #33's fingernails needed to be cut. LVN B asked Resident #33 if she wanted her fingernails cut, Resident #33 responded, yes please. LVN B then cut Resident #33's fingernails. LVN B stated the risk of not keeping the nails cut was that it could lead to bacteria building up and infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/24 at 1:24 PM with CNA E revealed she had been employed since February 2024. She stated fingernails were cut by the CNAs or nurses depending on the resident's diagnosis. She stated she had provided Resident #33 with ADLs. She stated she had noticed Resident #33's fingernails being long and they needed to be cut. She stated she had not cut them because she was unsure if Resident #33 was a diabetic. She stated she had notified the nurse on duty; however, she could not recall when she notified the nurse. CNA E stated the risk of not cutting residents' fingernails was that it could lead to residents cutting themselves or bacteria build-up. Interview on 05/09/24 at 3:01 PM with the DON revealed her expectation was for the CNAs and nurses to clean and trim residents' fingernails. She stated the risk of not cleaning or trimming residents' fingernails was that it could cause residents to scratch themselves. Interview on 05/09/24 at 3:17 PM with the ADON revealed CNAs were responsible for cleaning and file/cutting fingernails unless the resident was diabetic it would be the nurses responsibility. She stated fingernails should be cut when showers/bed baths were provided to residents. She stated her expectation was for the nurses to ensure residents fingernails were being clean and cut. The ADON stated the risk of not cutting fingernails was that it could lead residents to injuring themselves or infections. Review of the facility's current, undated Grooming Care of the Fingernails and Toenails policy reflected the following: Nail care is given to clean and keep the nails trimmed. Fingernails are trimmed by Certified Nursing Assistants except for residents with the following conditions: A. Diabetes or circulatory impairment of the hands B. Ingrown, infected, or painful nails C. Nails that are too hard, thick, or difficult to cut easily. (Note: a Licensed Nurse will trim those residents).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 1 of 2 residents (Resident #34) reviewed for peripheral intravenous care. The facility failed to ensure Residents #34's PICC line dressings were changed per the physician's order. This failure placed residents at risk of developing an infection. Findings included: Review of Resident #34's Face Sheet, dated 05/09/24, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included osteomyelitis of vertebra (spinal infection), paraplegia (leg paralysis), muscle weakness, chronic kidney disease, essential hypertension (high blood pressure) and urinary tract infection. Review of Resident #34's MDS assessment, dated 03/21/24, reflected a BIMS score of 13 indicating no cognitive impairment. The MDS further revealed Section O: Special Treatments, Procedures and Programs resident was receiving IV Medications. Review of Resident #34's Care Plan, dated 03/28/24, reflected Focus: Resident has an infection of the sacral wound with Osteomyelitis takes: ceftriaxone IV via PICC line x 36 days, metronidazole x 37 days. Goal: Resident will be free from complications related to infection through the review date. Interventions/Tasks: Administer antibiotic as per MD orders. Follow facility policy and procedures for line listing, summarizing, and reporting infections. Focus: Resident has a PICC line for IV administration of Antibiotics. Osteomyelitis. Goal: Resident will have no issues with PICC line use through the review period. Review of Resident #34's physician orders as of 04/10/24 reflected an order of Change dressing to PICC line every 7 days on Wednesday 6-2 shift every evening shift every Wed for PICC line usage Order start date was 04/10/24. Review of Resident #34's April 2024 MAR/TAR revealed the dressing was changed on 04/24/24 by RN C. Review of Resident #34's May 2024 MAR/TAR revealed the dressing was changed on 05/01/24 by RN C. Observation and interview on 05/07/24 at 1:27 PM with Resident #34 revealed he was lying in bed, and he stated he was doing well. Resident #34 had a PICC line in his right upper arm covered with a transparent dressing. The transparent dressing was dated 04/26/24. There was no redness, drainage, or swelling to the resident's right arm. Resident #34 stated his dressing had not been changed in the last week. He stated the date on the dressing was the last time it was changed, and he did not remember which staff had changed it. Resident #34 denied any pain or discomfort. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 05/07/24 at 1:54 PM with LVN B revealed she was the nurse assigned to Resident #34. LVN B stated Resident #34 was on antibiotics, she stated the nurse from 2-10 PM shift was responsible for changing Resident #34's PICC line dressing. However, all the nurses were responsible to ensure they were being completed. LVN B entered Resident #34 room and observed Resident #34's PICC line and stated the dressing date was 04/26/24. She stated PICC line dressing should be changed every 7 days. She stated she had not noticed Resident #34's PICC line dressing had not been changed. She stated the risk of not changing the dressing could lead to infection. Interview on 05/07/24 at 3:49 PM with RN C revealed she was the 2:00 PM-10:00 PM nurse for 100 Hall. She stated she was the nurse assigned to Resident #34. RN C stated she was the one who changed Resident #34's PICC line dressing on 04/26/24. RN C stated she changed Resident #34's dressing on 04/24/24 and 04/26/24. She stated Resident #34's dressing needed to be changed every 7 days. She stated Resident #34's PICC line dressing should had been changed on 05/03/24. RN C stated she made a mistake and documented on the resident's MAR that his PICC line dressing was changed on 05/01/24. She stated the nurses were responsible for changing the PICC line dressings. She stated the risk of not changing the PICC line dressing could lead to infection. Interview on 05/09/24 at 11:03 AM with the ADON revealed her expectations were for the nurses to follow physician orders regarding the PICC lines, nurses should evaluate the site, ensure no pain and no signs of infections. She stated PICC line dressing should be changed every 7 days. She stated every nurse who was assigned to Resident #34 was responsible for ensure medications were being provided and dressing were being changed. She stated it was the DON and herself responsible for overseeing PICC line dressing were being completed. The ADON revealed if the PICC line dressings were not being changed a resident was at risk of infection. Interview on 05/09/24 at 3:01 PM with the DON revealed her expectation was for nurses to be checking the PICC lines every shift, flush before and after medication and to change the dressing every 7 days and as needed if soiled. The DON stated the PICC line dressing should be dated. She stated the nurses were responsible for changing and dating the dressings. The DON stated it was the ADON and her responsibility to ensure PICC line dressings were being changed and dated. The DON stated the potential risk of not following physician orders was that it could lead to an infection. Review of the facility Central Venous Catheter policy, dated February 2009, reflected the following: .To provide a general procedure regarding central venous catheters. .15. Apply transparent occlusive dressing. .18. Label dressing with nurse and your initials.

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	675034	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Lake Nursing & Rehabilitation LLC	901 Pennsylvania Ave Fort Worth, TX 76104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 1 of 1 resident (Resident #31) reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #31 after return from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Record review of Resident #31's face sheet dated 05/09/24 revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included end stage renal failure (when kidneys suddenly become unable to filter waste products from blood), chronic kidney disease (longstanding disease of the kidneys), Type 2 diabetes (increased blood sugar), and essential hypertension (increased blood pressure). Record review of Resident #31's quarterly MDS assessment dated [DATE], revealed Resident #31 had a BIMS score of 12, reflecting the resident's cognition was mildly impaired. The MDS section O, related to special treatments, procedures, and programs, reflected Resident #31 received dialysis. Record review of Resident #31's care plan, revised date 01/24/24, revealed Focus: Resident #31 has Stage 3 Renal Failure relating to Kidneys. Goals: will have no signs/symptoms of complications relating to fluid deficit through the review date. Interventions included assist resident with ADL'S and ambulation as needed. Fluids as ordered. Restrict or give as ordered. Give medications as ordered by physician. Record review of Resident 31's physician's order, dated 04/11/24, reflected Hemodialysis treatments to be performed via AV shunt, . as indicated on the following days of the week: T-TH-S. Record review of Resident #31's dialysis communication forms on facility's EHR from 04/11/24-05/09/24 reflected either no pre-dialysis weight or post dialysis weight. There were no dialysis communication forms with completed vitals, pre-dialysis weights, and post-dialysis weights for the time reviewed. Observation and interview on 05/09/24 at 10:12 AM revealed Resident #31 sitting in his wheelchair. Resident #31 stated he was doing well. Resident denied any pain. Resident #31 stated he was a dialysis patient, and his dialysis days were Tuesdays, Thursdays, and Saturdays. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/09/24 at 10:31 AM with RN A revealed dialysis residents were supposed to obtain pre and post dialysis weights and vitals on the communication form when they arrive to the dialysis center and before they leave the dialysis center. RN A stated the importance of viewing pre and post dialysis weights was to ensure the dialysis was working. RN A revealed if the dialysis does not pull enough water off the resident, then edema and shortness of breath can occur along with pain and confusion. RN A stated the responsibility of ensuring that pre- and post-dialysis weights were completed on the communication form and returned with the resident along with pre and post dialysis vitals is the receiving nurse. Interview on 05/09/24 at 10:50 AM with the ADON revealed the dialysis center was supposed to send back the completed pre and post dialysis weights and vitals on the communication form. The ADON also stated it was the responsibility of the charge nurse to receive the before and after weights of dialysis and vitals from the dialysis center. The ADON revealed that she recently in-serviced the nursing staff on 04/02/24 because her nursing staff were not obtaining pre and post vitals and weights from the dialysis center when residents returned. The ADON stated that pre and post dialysis weights were important because weight change can signal a change in condition. For example, large water retention can signal a decline in health and the resident would need to be seen by the doctor or be sent out to the emergency room . Interview on 05/09/24 at 4:03 PM with the DON about the missing information on the dialysis communication forms revealed that the protocol for dialysis patients was that the dialysis center was supposed to weigh the resident before and after dialysis to prevent using two different scales and therefore being a variance in weights. The DON was not aware of the missing information. The DON also stated that the receiving nurse should check to make sure that weights were completed on the communication sheet and returned with the resident upon return from dialysis. She also revealed the ADON audits charts and calls dialysis centers to follow up and obtain weights as needed. The DON revealed that the risk of not obtaining pre and post dialysis weights was that the facility does not know the amount of water pulled from the resident during dialysis. This can lead the resident to weakness, syncope, and other health condition without the facility having accurate information. Record Review of the facility's current Dialysis Care policy, dated June 2020, reflected the following: .The dialysis provider will communicate in writing to the facility: a. The resident's current vital signs. b. Pre and post dialysis weight. c. Any problems encountered while the resident was at the dialysis provider. iii. Nursing Staff will keep the Attending Physician, the resident and the resident's family informed of any change in .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview and record review, the facility failed to maintain medical records that were complete and accurately documented for 2 of 5 residents (Resident #45 and Resident #34) reviewed for resident records. 1. The facility failed to ensure Resident #45's Medication Administration Record accurately reflected the medications administered to the resident. 2. The facility failed to accurately document Residents #34's PICC line dressing change. This failure could place the resident at risk of missed or extra doses of her medications. Findings included: 1. Review of Resident #45's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, history of coronavirus disease, emphysema, and reduced mobility. Review of Resident #45's quarterly MDS, dated [DATE], revealed a BIMS score of 15 indicating she was cognitively intact. In the section Skin Conditions, there were no skin conditions documented for the resident. Review of Resident #45's care plan, dated [DATE], revealed she had a rash to her lower legs that was being treated with hydrocortisone cream. Review of Resident #45's physician orders revealed an order written [DATE] for hydrocortisone 1% cream to be applied to her legs every 4 hours as needed for itching times 14 days. Interview on [DATE] at 10:48 AM Resident #45 stated the hydrocortisone cream was the only thing that helped with the itching, but the order expired on [DATE] and staff had not renewed it. Resident #45 stated she was using the cream twice a day, every day. Resident #45 stated she had asked the nurses for a dermatology consult since her physician had no idea what the rash was. Observation on [DATE] at 10:48 AM revealed Resident #45 had red splotches to both lower legs from the knee to her ankle. Splotches appeared to have a scaly layer on top of them. Splotches were of various sizes, and randomly present. There were no white centers that would indicate a bug bite. Splotches were isolated to her lower legs, indicating it was not a systemic problem. Interview on [DATE] at 9:45 AM with RN A revealed staff had been applying the hydrocortisone cream to Resident #45's rash twice a day. RN A stated she was not aware the order for the cream had expired and would contact the physician. Review of Resident #45's [DATE] MAR revealed only two doses of hydrocortisone cream had been documented as being administered, [DATE] and [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow-up interview on [DATE] at 10:00 AM with Resident #45 revealed she confirmed she had used the hydrocortisone cream twice a day, morning and evening, every day because of the itching. Interview and record review on [DATE] at 10:10 AM with the DON revealed after reviewing the April MAR, she concluded the staff had not documented the hydrocortisone cream after each administration. The DON stated her expectation was for nursing staff to document all medications given. She stated failing to do so could result in missed or duplicate medication administration. Regarding the hydrocortisone cream, she stated the physician could conclude the resident did not use it and discontinue it. 2. Review of Resident #34's Face Sheet, dated [DATE], reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included osteomyelitis of vertebra (spinal infection), paraplegia (leg paralysis), muscle weakness, chronic kidney disease, essential hypertension (high blood pressure) and urinary tract infection. Review of Resident #34's MDS assessment, dated [DATE], reflected a BIMS score of 13 indicating no cognitive impairment. The MDS further revealed Section O: Special Treatments, Procedures and Programs resident was receiving IV Medications. Review of Resident #34's Care Plan, dated [DATE], reflected Focus: Resident has an infection of the sacral wound with Osteomyelitis takes: ceftriaxone IV via PICC line x 36 days, metronidazole x 37 days. Goal: Resident will be free from complications related to infection through the review date. Interventions/Tasks: Administer antibiotic as per MD orders. Follow facility policy and procedures for line listing, summarizing, and reporting infections. Focus: Resident has a PICC line for IV administration of Antibiotics. Osteomyelitis. Goal: Resident will have no issues with PICC line use through the review period. Review of Resident #34's physician orders as of [DATE] reflected an order of Change dressing to PICC line every 7 days on Wednesday ,d+[DATE] [6:00 AM-2:00 PM] shift every evening shift every Wed for PICC line usage Order start date was [DATE]. Review of Resident #34's [DATE] MAR/TAR revealed the dressing was changed on [DATE] by RN C. Review of Resident #34's [DATE] MAR/TAR revealed the dressing was changed on [DATE] by RN C. Observation and interview on [DATE] at 1:27 PM with Resident #34 revealed he was lying in bed, and he stated he was doing well. Resident #34 had a PICC line in his right upper arm covered with a transparent dressing. The transparent dressing was dated [DATE]. There was no redness, drainage, or swelling to the resident's right arm. Resident #34 stated his dressing had not been changed in the last week. He stated the date on the dressing was the last time it was changed, and he did not remember which staff had changed it. Resident #34 denied any pain or discomfort. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 1:54 PM with LVN B revealed she was the nurse assigned to Resident #34. LVN B stated Resident #34 was on antibiotics. She stated the 2:00 PM-10:00 PM shift nurse was responsible for changing Resident #34's PICC line dressing. However, all the nurses were responsible to ensure they were being completed. LVN B entered Resident #34 room and observed Resident #34's PICC line. She stated the dressing date was [DATE]. She stated PICC line dressing should be changed every 7 days. She stated she had not noticed Resident #34's PICC line dressing had not been changed. LVN B stated she reviewed Resident #34 documentation, and it stated Resident #34's PICC line dressing was last changed on [DATE]. LVN B stated by documenting incorrectly the risk was there could be a miscommunication between the nurses due to not knowing if something was done or not. Interview on [DATE] at 3:49 PM with RN C revealed she was the 2:00 PM-10:00 PM nurse for 100 Hall. She stated she was the nurse assigned to Resident #34. RN C stated she was the one who changed Resident #34's PICC line dressing on [DATE]. She stated Resident #34's dressing needed to be changed every 7 days. She stated Resident #34's PICC line dressing should had been changed on [DATE]. RN C stated she made a mistake and documented on the resident's MAR that his PICC line dressing was changed on [DATE]. RN C stated she documented something that was not done. She she stated she should have documented when the dressing was changed on [DATE]. RN C stated the potential risk of not documenting accurately was that it could cause a misunderstanding between the nurses and treatment not being provided accurately. Interview on [DATE] at 11:03 AM with the ADON revealed her expectation was for the nurses to chart: any abnormalities, PICC line measurements, and any treatment provided. She stated failure to document accurately could cause incoming staff to be unaware of any care or treatment that was completed. She stated it was the responsibility of both herself and the DON to ensure documentation was accurate. Interview on [DATE] at 3:01 PM with the DON revealed her expectation was for nurses to document accurately and to not document something that was not completed. She stated the risk of not documenting accurately was that it could lead to incoming staff not knowing what had and had not been completed. Review of the facility's current, undated Medication Administration policy reflected the following: .XVI. The Licensed Nurse will chart the drug; time administered and initial his/her name with each medication administration. Review of the facility's Documentation - Nursing policy, revised [DATE], reflected the following: To provide documentation of resident status and care given by nursing staff. Nursing documentation will be concise, clear, pertinent, accurate and evidence based . Nursing staff will not falsify or improperly correct nursing documentation. .H. Medication administration records and treatment administration records are completed with each medication or treatment completed. J. Treatments completed and documented as per physician's order. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. Documentation will be completed by the end of the assigned shift 44140

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44140 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests for 1 of 3 Halls (100 Hall), dining room and 1 of 1 conference room reviewed for pests. The facility failed to ensure an effective pest control program was implemented to prevent the presence of gnats throughout the facility. This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life. Findings included: Observations between 05/07/24 at 9:15 AM through 05/09/24 at 5:00 PM revealed 2-3 gnats in the facility's conference room. Observations between 05/07/24 at 10:05 AM through 05/09/24 at 3:30 PM revealed gnats flying in 100 Hall and in the dining room. Observation and interview on 05/07/24 at 10:13 AM revealed Resident #11 sitting on his bed. Resident #11's room was in the 100 Hall. Resident #11 stated he was doing well. He stated his room was cleaned every day; however, he had been having issues with gnats in his room. Two to three gnats were observed in Resident #11's room. The gnats were around Resident #11's bedside table, wall, and privacy curtain. He stated staff were aware. He stated he made his own house remedies to get rid of them. Observation and interview on 05/07/24 at 12:05 PM revealed Resident #70 lying in his bed, and his roommate Resident #57 was seated in his wheelchair. Their room was in the 100 Hall. Three to four gnats were observed in Resident #70's room. The gnats were on the privacy curtain and wall. Resident #70 shared the room with Resident #57. Three to four gnats were observed on Resident #57's side of the room. The gnats were on the privacy curtain and wall. Resident #57 stated he had not seen pest control company in the building. Resident #57 stated he made his own home remedies to get rid of them. He stated nursing staff and maintenance staff were aware of the issue. He stated he did not like the gnats, and pests had been a big issue in the building. Observation and interview on 05/07/24 at 12:15 PM revealed Resident #23 lying in her bed. Resident #23's room was in the 100 Hall. Three to four gnats were observed in Resident #23's room. The gnats were observed on the wall next to Resident #23's bedside table and privacy curtain. Resident #23 stated from time-to-time gnats would appear. She stated they had less gnats than before. Observation and interview on 05/07/24 at 1:09 PM revealed Resident #33 lying in her bed. Resident #33's room was in the 100 Hall. Three to four gnats were observed in Resident #33's room. The gnats were observed on the wall and privacy curtains. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/07/24 at 3:31 PM revealed Resident #63 sitting in his wheelchair, and his roommate Resident #77 ws lying in bed. Their room was on the 100 Hall. Four to five gnats were observed in Resident #63's room. The gnats were around the resident's wheelchair, privacy curtain, and walls. Resident #63 stated it had been a lot worse that it was now, and he did not like the gnats. He stated he had not observed staff spray anything in a while. Three to four gnats were observed on Resident #77's side of the room. The gnats were around the resident's privacy curtain and bedside table. Resident #77 stated gnats had been an issue, but it had gotten better. During the confidential resident group interview, 8 out of the 10 residents revealed gnats and flies had been a big problem. Residents stated 100 Hall was the worst. Five residents stated they had seen pest control company in the building. Residents stated staff were aware of the issue. Interview on 05/09/24 at 1:00 PM with CNA D revealed gnats had been an issue, but she had not seen them as much. CNA D stated she reported seeing the gnats to the nurse, and the nurse would notify the maintenance staff. She stated she could not recall when pest control had been in the building. Interview on 05/09/24 at 1:06 PM with LVN B revealed she was the nurse assigned to 100 Hall. She stated gnats had been an issue, but she could not recall when pest control had last been in the building. She stated gnats kept appearing due to residents keeping food in their rooms. She stated they had a maintenance logbook where they documented any building concerns. She stated she had reported the issue to the maintenance staff. Interview on 05/09/24 at 1:24 PM with CNA E revealed she has had residents complain about gnats. She stated she reported the complaints to the nurse on the hall. She stated it was maintenance staffs' responsibility to ensure there were no pests in the building. She stated she had not seen pest control in the building to treat the gnats. Interview on 05/09/24 at 2:52 PM with the Housekeeper Supervisor revealed he had been notified of the gnats in the 100 Hall. He stated he reported to the Maintenance Supervisor, and he would treat the area. He stated Pest Control had been to the facility more frequently to treat the gnats. Interview on 05/09/24 at 3:17 PM with the ADON revealed she had not witnessed any gnats in the building. She stated today (05/09/24) Resident #63 complained about gnats in his room. She stated she had observed the pest control company in the building in the past 30 days. She stated if they had any concerns, they would report it to the Administrator and Maintenance Supervisor. Interview on 05/09/24 at 3:56 PM with the Maintenance Supervisor revealed he had been employed at the faciltiy since April 2024. He stated pest control visited once a month and upon request. He stated pest control had been in the building today (05/09/24) and a couple of days ago. He stated he had observed gnats in the building but not an infestation. He stated he had not had any residents or staff complained about gnats. Interview on 05/09/24 at 4:06 PM with the Administrator revealed no one had brought the concerns to her regarding gnats in the building. She stated she had not had any recent complaints regarding pest control from residents. She stated when they had concerns regarding pest the Maintenance Supervisor was notified. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 100 Hall Maintenance Logbook from January 2024 through May 2024 revealed no pest control concerns had been reported. Review of the facility's Pest Control binder for the months of March 2024 through May 2024 revealed pest control visited on 03/11/24 for bed bugs, 03/22/24 for gnats, 04/23/24 for flies, and 05/08/24 for gnats. Record review of facility's Pest Control policy, dated August 2020, reflected the following: To ensure the Facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, Facility Staff, and visitors. The Facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects, rodents, and other pests.