STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675930	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbrook Plaza	401 W Arbrook Blvd Arlington, TX 76014

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 48520 Based on interviews and record review the facility failed to ensure residents had the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States for 8 (Residents #6, #21, #31, #39, #50, #57, #65, and #78) of 10 residents, and 1 of 1 residents reviewed for dignity in the dining room (Resident #9). 1. Residents #6, #21, #31, #39, #50, and #57 were not asked by staff if they were interested in voting. 2. Residents # 65 and #78, interviewed in their room, reported not being asked by staff if they were interested in voting. 3.The facility failed to ensure Residents #9 had the right to a dignified existence when the staff stood over the resident while feeding the resident. This deficient practice could affect all residents and could result in residents not being able to exercise their rights as United Stated citizens. Findings included: 1. Record review of Resident #6's face sheet, dated 11/01/2024, revealed he was readmitted on [DATE] with an initial admission on 02/18/2017. Admitting diagnoses included unspecified diastolic (congestive) heart failure (heart unable to pump blood the way it should); type 2 diabetes mellitus without complications (body unable to use insulin properly); and unspecified convulsions (seizure when exact cause is unknown). In an interview on 10/30/2024 at 10:30 a.m., Resident #6 said the staff had not asked him if he wanted to vote. Resident #6 stated he was interested in voting for the November Presidential election. Record review of Resident #21's face sheet, dated 11/01/2024, revealed she was admitted on [DATE] with diagnoses that included cardiomegaly (enlarged heart); chronic pain syndrome (pain that may be caused by inflammation or dysfunctional nerves); and essential (primary) hypertension (high blood that is multi-factorial and doesn't have one distinct cause). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 10:30 a.m., Resident #21 stated she wanted to vote in the November election, but no staff had asked her about voting. Record review of Resident #31's face sheet, dated 11/01/2024, revealed she was admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe); chronic atrial fibrillation (type of heart arrhythmia that causes the upper chambers if the heart to bear irregularly and quickly); and essential (primary) hypertension (high blood that is multi-factorial and doesn't have one distinct cause). In an interview on 10/30/24 at 10:30 a.m., Resident #31 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. Record review of Resident #39's face sheet, dated 11/01/2024, revealed he was readmitted on [DATE] with an initial admission on 10/27/2018. Admitting diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (conditions that occur after a cerebral infarction, a type of stroke that happens when blood flow to the brain is reduced or blocked); non-traumatic intracerebral hemorrhage, unspecified (type of stroke that occurs when there's bleeding within the brain without trauma or surgery); and cerebral infarction, unspecified (serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die). In an interview on 10/30/24 at 10:30 a.m., Resident #39 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. Record review of Resident #50's face sheet, dated 11/01/2024, revealed she was readmitted on [DATE] with diagnoses included hypopituitarism (decreased secretion of one or more of the eight hormones normally produced by the pituitary gland at the base of the brain); essential (primary) hypertension (high blood that is multi-factorial and doesn't have one distinct cause); and unspecified osteoarthritis, unspecified site (a progressive, degenerative joint disease). In an interview on 10/30/24 at 10:30 a.m., Resident #50 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. Record review of Resident #57's face sheet, dated 11/01/2024, revealed she was readmitted on [DATE] with an initial admission on 02/01/2021. Admitting diagnoses included Alzheimer's Disease, unspecified (causes the brain to shrink and brain cells to eventually die); essential (primary) hypertension (high blood that is multi-factorial and doesn't have one distinct cause); and chronic kidney disease, stage 3 unspecified (a condition where the kidneys are mild to moderately damaged and are less able to filter wastes from the blood). In an interview on 10/30/24 at 10:30 a.m., Resident #57 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. 2. Record review of Resident #65's face sheet, dated 11/01/2024, revealed she was readmitted on [DATE] with an initial admission on 05/09/2024. Admitting diagnoses included diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified (a common complication of type 1 and type 2 diabetes); chronic obstructive pulmonary disorder with (acute) exacerbation (a sudden worsening of COPD symptoms); and essential (primary) hypertension (high blood that is multi-factorial and doesn't have one distinct cause). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/24 at 10:30 a.m., Resident #65 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. Record review of Resident #78's face sheet, dated 11/01/2024, revealed she was admitted on [DATE] with diagnoses that included acute on chronic systolic (congestive) heart failure (occurs when the heart muscle weakens or stiffens, making it difficult to pump blood efficiently; unspecified diastolic (congestive) heart failure; essential (primary) hypertension high blood that is multi-factorial and doesn't have one distinct cause). In an interview on 10/30/24 at 10:30 a.m., Resident #78 stated she was interested in voting in the upcoming election, but no staff had asked her about voting. Residents #6, #21, #31, #39, #50, #57, #65, and #78 felt that their rights were ignored by not being able to vote, In an interview on 10/31/24 at 12:15 p.m., the AD stated he did ask the residents if they wanted to vote. The residents were offered absentee voting or the option to be taken out to the polls to vote. The AD revealed that the resident's family members assisted with this voting. The AD could not provide documentation regarding residents requesting assistance with exercising their right to vote in the election. In an interview on 10/31/24 at 02:45 p.m., the Adm revealed that residents at the facility have never been offered the opportunity to vote. The Adm stated that most of the residents do not have a current ID and the resident was not from the local area. The ADM revealed the Activity Director spoke with the residents related to voting. There was no documentation r/t offering voting in the Presidential Election. The ADM states the facility did not have a policy related to exercising resident rights to vote as united states citizens. 3. Record review of Resident #9's Face sheet, dated 10/30/2024, revealed a [AGE] year-old-female who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, stroke affecting left non-dominant side, dysphagia (difficulty swallowing) oropharyngeal phase (this is a swallowing difficulty of food and liquids), glaucoma and cataract in both eyes (eye diseases that causes vision loss), and generalized weakness. Record review of Resident #9's quarterly MDS, dated [DATE], revealed a BIMS score of 3, indicating severe cognitive impairment. Record review of Resident #9's care plan initiated on 04/09/2024 and revised on 04/09/2024 with a target date of 01/01/2025, revealed Resident #9 had a risk for weight fluctuations related to changes in appetite. Interventions included monitoring weights as per facility protocol, to provide prescribed diet and to observe closely during mealtime. Observation in the main dining room on 10/10/24 at 12:33 PM, revealed Resident #9 in a Geri chair tilted at a 45-degree angle being fed lunch. Resident #9 ate well. CNA G stood over her while feeding her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA G on 10/30/2024 at 12:44 PM, she stated she helped feed Resident #9 sometimes, the resident needed assistance eating. She stated that she had training on feeding the resident. She stated she had to explain to the resident what she was going to do, ask her to drink water, explain, make sure she swallowed small bites. She stated Resident#9 was a good eater and the resident eats everything. She stated Resident #9 was supposed to sit at a 45-degree angle while eating. She stated, I'm supposed to be sitting to feed her. CNA G stated it was important to position the resident because of aspiration. She stated she was supposed to sit down while feeding so that she can hear the residents when talking. CNA G stated the risk was it could cause the resident to feel like they were neglected, and they were not treated like a person. In an interview with the Administrator on 10/30/2024 at 2:56 PM, she stated that she expected all direct care staff to sit down at eye level with residents while feeding them. She said it was important to take the time while feeding residents to communicate, to be kind, not heaping food on spoon, and talk with them. She said the risk to residents was concern of her dignity. Record review of the facility policy titled, Resident Rights, revised 09/2009, reflected, read in part . Employees shall treat all residents with kindness, respect, and dignity . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1.Be informed about what rights and responsibilities he or she has, 2. Voice grievances and have the facility respond to those grievances 3. Residents are entitled to exercise their rights and privileges to the fullest extent possible .4. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity .

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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** 45507 Based on observations, interviews, 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 2 of 2 residents (Resident #9 and Resident #298) reviewed for ADL care. The facility failed to ensure Resident #9, and Resident #298 were provided nail care as needed. These failures could place residents at risk of not receiving services and a decreased quality of life. Findings included: Record review of Resident #9's Admission Record, dated 10/30/2024, revealed a [AGE] year-old-female who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, and other paralytic syndrome (paralysis or weakness) following nontraumatic subarachnoid hemorrhage (brain bleed) affecting left non-dominant side . Record review of Resident #9's quarterly MDS, dated [DATE], revealed a BIMS score of 3, indicating severe cognitive impairment. Record review of Resident #9's care plan initiated on 07/28/2021, and revised on 10/30/2024 revealed Resident #9 had inappropriate behavior; Resistive to treatment/care related to: Cognitive impairment Dx: Dementia, depression: Refused labs and refused to have nails trimmed. Interventions included document care being resisted, if resident refuses care, leave resident and return in 5-10 minutes. Record review of Resident #298's Admission Record, dated 11/01/2024, revealed an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included sepsis, muscle weakness, and malignant neoplasm of rectum (rectal cancer). Record review of Resident #298's Admission MDS, dated [DATE], revealed a BIMS score of 99, indicating the resident was not able to complete the interview. Record review of Resident #298's care plan, initiated on 09/20/2024 revealed Resident #298 exhibited ADL Self Care Performance Deficit, required assistance: limited mobility. Interventions included provide assistance with eating, dressing, bathing, toileting and grooming as needed. Observation on 10/30/24 at 12:40 PM, revealed Resident #9 was seated in a Geri chair in the dining room eating lunch. Resident #9's left arm was covered. All of Resident #9's nails on the left hand appeared long, thick, yellowish-brown, and sharp. Resident #9 was not interviewable. (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 10/30/24 at 02:57 PM, the Administrator stated charge nurses were responsible to make sure the aides were taking care of resident nails. She stated if a patient refused, the aides should tell their charge nurse, the charge nurses should tell their ADONs, and the refusal should be care planned. She said if nails were too long it would not allow a person to do everything they want and inhibited them to be able to use the ends of their fingers. Observation on 10/31/2024 at 1:42 PM, revealed Resident #9 was in her room lying in bed. Resident #9's nails on her left hand appeared the same as 10/30/24. The nails were long, thick, yellowish-brown, curled, and sharp. ADON B held a disposable ruler next to Resident #9's nails while the state surveyors observed. Resident #9's thumb nail measured approximately 1.75 cm past the nail bed, the index fingernail measured approximately 1.0 cm past the nail bed, the middle fingernail measured approximately 2.0 cm past the nail bed, the ring fingernail measured approximately 3.0 cm past the nail bed, and the pinky fingernail measured 1.5 cm past the nail bed. Interview on 10/31/2024 at 1:42 PM, ADON B stated last week she asked the Social Worker to call the podiatrist. ADON B stated the podiatrist came last Friday (10/25/2024) and he was going to cut her nails and toenails. She stated she did not look at Resident #9's nails when he was done. ADON B said the Podiatrist told the SW the resident was resistant and pulling back her hand. ADON B stated she forgot to follow up and staff were doing nail care on everyone. She said the Weekend Supervisor was responsible to make sure resident nails were cut. ADON B stated normally the CNA's cut nails, but the nurse would do it because Resident #9 was diabetic. She said the risk would be the resident could cut their skin, and infection if she scratches. Interview on 11/01/2024 at 9:53 AM, Resident #298 was lying in bed. Resident #298 stated he received a shower the day before yesterday, and they washed his hair, but he wanted his nails cut. Resident #298's fingernails appeared to have a yellow substance underneath and some appeared to have jagged edges. Interview on 11/01/2024 at 1:55 PM CNA P stated resident nail care was done after showers, were supposed to be checked that they were clean, and if nails needed to be cut, they would just cut them. Interview on 11/01/24 at 02:26 PM the SW stated she contacted the podiatrist for Resident #9 on 10/24/24 by text and asked for Resident #9 to be seen. Interview on 11/01/24 at 11:11 AM the Podiatrist stated the facility had called him about Resident #9 and he had seen the resident 6 weeks ago to do her toenails. He stated that when he got a call to come back due to family request, he stated that he took more off her toes. He stated that the facility might have been confused because had they told him to cut her fingernails, he would have said No sorry, I can't do fingernails. He stated his scope of practice was feet, not fingernails. Interview on 11/01/2024 at 4:41 PM, CNA L stated she did not do nail care. She stated when giving showers she would use a towel to wash hands and nails. CNA L stated she would tell her nurse if a resident's nails were long. She said if a resident's nails were left long, they could hurt themselves or have germs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/01/2024 at 4:45 PM, LVN I used a disposable ruler to measure Resident #298's fingernails. Resident #298's nails on both hands measured between 0.5 to 0.75 cm past the nail bed. LVN I removed Resident #298's socks from both feet and the toenails appeared to be yellow, and some appeared to be curling downwards. The fourth toenail on Resident's right foot appeared to have a dried red/black substance underneath the nail and surrounding skin, and the nail was sticking straight up at a 90-degree angle. LVN I measured Resident #298's toenails on both feet which measured between 0.5 to 1.0 cm past the nail bed. LVN I stated he cuts nails upon request, especially ones for diabetes. He stated Resident #298 was not diabetic. LVN I stated he did not notice any issues with Resident #298's nails and the resident had not verbalized any complaints. LVN I stated the fourth toenail was infected and he would ask with the wound nurse about it. He said he would have to clarify with ADON A if Resident #298 should be referred to podiatry. LVN I stated he would raise concerns with the family if they wanted treatment and he stated he does not know how to follow up on the podiatry list. He stated the risk to the resident would be skin integrity, scratches that lead to other skin issues, could be infection control, and could be pain especially if they rub on the fabric. Interview on 11/01/2024 at 3:29 PM, the DON stated the CNA's can clean and file resident nails and the nurses were to trim if the resident was diabetic. She stated all ADL care should be documented. The DON stated nurses were to monitor that nail care was done. She said the risk was residents could get sick. Review of the facility's policy titled Care of Fingernails/Toenails, dated April 2007, reflected in part: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin . 48520

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #5) of five residents reviewed for limited range of motion or therapy services. The facility failed to complete a quarterly Physical Therapy Reevaluation screening for Resident # 5 after completion of his physical therapy 4/27/2024. This failure could place residents at risk for a decline in range of motion, decreased mobility, and a decline in physical capabilities. Findings included: Review of Resident # 5's Admission Record dated 11/01/2024, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included gastrointestinal stromal tumor of other sites (rare cancer that develops in the digestive tract walls), muscle wasting and atrophy, lack of coordination, and generalized muscle weakness. The residents were a full code, and the family was the responsible party (RP). Review of Resident # 5's MDS assessment dated [DATE], revealed the resident admitted to the facility from the hospital. Resident # 5 had intact cognition with a BIMS score of 7. The MDS further reflected the resident needed extensive assistance for bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. The MDS further reflected Resident # 5 had upper and lower extremity functional limitation in range of motion and was dependent of staff. Review of Resident #5 evaluation orders on 11/01/2024 reflected PT to evaluate and tx as indicated verbal order active 11/01/2023. PT to evaluate and tx as indicated verbal order active 03/29/2024. The orders did not reflect a PT evaluation in August, September, or October 2024. Review of Resident # 5's care plan revealed Resident # 5 had ADL self-care performance deficit related to intolerance. Interventions reflected PT, OT were to evaluate and treat as ordered. Date initiated 11/30/2023. Review of Resident # 5's care plan conference plan dated 02/07/2024 revealed Resident #5 was referred for physical therapy (PT), Occupational therapy (OT), and Speech therapy (SLP). NO care conference completed after 02/07/2024. Review of Physical Therapy Evaluation and Plan of Treatments reflected the following: Certification period 10/19/2023 -11/17/2023- Date of service 10/30/2023, Completed 10/31/2023 Response to Tx-Response to session interventions: Patient needed encouragement for OOB activity today. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certification period 11/01/2023-11/30/2023- Date of service 11/05/2023, Completed 11/5/2023 Response to Tx- Response to session interventions: Needs encouragement to work with therapy. Certification period 03/29/2024-04/27/2024 - Date of service 03/29/2024, completed 03/29/24 Response to session interventions: Actively participates with skilled interventions. None of the certification periods reflected Resident #5 refused PT. In an interview on 10/30/2024 at 10:23 AM Resident # 5 and his family stated he had not done any therapy in a long time. Family stated she had talked to the facility, and she was told that the facility had no physical therapist on site earlier this year. The family stated on several occasions the facility stated they were short staffed and could not do physical therapy for Resident #5. Family stated she did not file a grievance because she was expecting the facility to follow up with physical therapy. Resident #5 stated he had not refused to do therapy, and he would like to walk if possible. Resident #5 stated he is getting weaker. In an interview with the Administrator on 10/30/2024 at 02:59 PM, She stated she did not know much about Resident #5's Physical Therapy, that she was unaware of any issues, and family had not said anything to her. She referred any concerns for rehabilitation to the DOR. The Administrator stated the DOR was responsible for following up on the therapy screens. She stated the risk for not getting rehabilitation services was they could lose range of motion and have a negative outcome. She stated she would reach out to the family and DOR to follow up. In an interview on 10/31/2024 at 02:12 PM the DOR stated he had been employed since March 2024. He stated Resident #5 had just been discharged from PT services at that time. He stated reevaluations were done quarterly and he was responsible for the follow up from the therapy screen to ensure the evaluations were completed. The DOR stated he was fully staffed to complete services. The DOR stated Resident # 5 had not been re-evaluated for PT because he was refusing to do PT. When asked why so much time had elapsed from the date of the multidisciplinary care plan meeting without the evaluations being completed, the DOR stated I don't waste my time reevaluating them knowing that they refuse PT. The DOR stated Resident #5 was already bedridden when he was admitted to the facility. The DOR stated OT had just picked up Resident #5 in September. The DOR stated that Resident #5 was reevaluated for PT services after talking to the Administrator yesterday. The DOR did not state the risk for Resident #5 not being reevaluated to PT services quarterly. Review of the facility's Specialized Rehabilitative Services H5MAPL0836 dated December 2009, reflected the following: Our facility will provide Rehabilitative Services to residents as indicated by the MDS.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interviews and record review the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 1 resident (Resident #85) whose records were reviewed for behavioral health services. The facility failed to follow up to ensure Resident #85 received psychiatric services after a referral was made. This failure could place residents at risk of not receiving needed mental health services and a decrease in quality of life. Findings included: Record review of Resident #85's Admission record, dated 11/01/2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, muscle weakness, morbid obesity, and cognitive communication deficit. Record review of Resident #85's 48-hour care plan progress notes, dated 09/06/24, reflected a BIMS score of 6, indicating severe cognitive impairment. Record review of Resident #85's physician orders dated 10/21/2024 reflected need psychiatric evaluation. Record review of Resident #85's progress note dated 10/16/24, written by LVN F, reflected resident yelling, threatening to physically hit roommate and staff in face, confusion, aggression, agitation, unable to be redirected notified physician Dr. [Name] received new order Ativan 1 mg 1x dose administered from E-kit received consent from R.P labs -CBC, BMP, UA labs ordered in PCP. Record review of Resident #85's progress note dated 10/17/24, written by LVN K, revealed Resident refused his meds, appears to be agitated, confused and in an unpleasant mood. Upon asked the reason for refusal, resident stated that 'I'm not happy with the life I'm living, and I would like to die. Record review of Resident #85's progress note, dated 10/21/24, written by LVN O, revealed Resident refused to eat his dinner, asked why he is not eating; responds leave me alone. Offered snack, nutritional shake declines. Res is blood glucose 66 now, offered orange juice refused. Patient teaching completed on dangers of low BS, non-compliant. Lunch tray was in the res room, untouched. RP [Name] didn't pick up the phone, unable to leave voicemail. Daughter [Name] reached, said she is not sure if she will make it to the facility because she is preparing stuff for her schooling children. Res refused writer to assess VS. Dr. [Name] notified with new orders for psych evaluation. DON made aware. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #85's progress note, dated 11/01/24, revealed SSD went to visit patient to conduct PHQ-9 assessment. When asked directly, the patient kept stating no, ma'am to feels of depression, feeling poorly about himself, and thoughts of wanting to harm himself or others. When asked about his experience with his previous roommate, patient stated that he didn't remember. Review of Resident #85's EHR did not reflect a psychiatric evaluation or progress note. Interview on 11/01/2024 at 2:01 PM with LVN F revealed Resident #85 was a little confused, easy to redirect, and did not seem depressed. She said the resident was not on any medication for dementia and when he was really confused, they contacted the Dr. who wanted to try a low dose of Aricept. LVN F stated she thought the resident had a psychiatric evaluation. She said the SW does the referral. Interview on 11/01/2024 at 2:33 PM with the Social Worker revealed she did not know about Resident #85's incident with the roommate and she had only been working at the facility for a month. She stated there had been instances where a patient had needed a psych eval and she would go in and see it had been done and processed. The SW said she did not know if it was the hall nurse who got the order and if the nurse went into [EHR name] and added the provider. She said she had not submitted a referral for anyone since she had been there. She stated the doctors would stop by before they see patients and ask if anyone was outstanding and verify if they were on their list to be seen. She said the risk to residents of not following up on the referral was that it increased harm to themselves or others depending on what was going on mentally. The SW called the Dr. from [provider name] who stated Resident #85 was not on her list, and it would depend on insurance, but she did not see that the resident was ever referred. Interview on 11/01/2024 at 4:03 PM with LVN K was unsuccessful. Interview on 11/01/24 at 3:29 PM the acting DON stated if a psych evaluation was not completed timely, the resident could harm himself, or a functional decline could happen if he was depressed. She stated at every facility, it was different but usually the SW put the order in and followed up on the referral, She stated the SW was responsible and it should be discussed in morning meetings and in the IDT meeting to make sure it did not get dropped. Review of the facility's policy titled Referrals revised September 2005 reflected in part: social services personnel shall coordinate most resident referrals with outside agencies.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (Resident#301) of seven residents reviewed for pharmaceutical services. The facility failed to obtain heart rate and or pulse parameters for heart medication Digoxin 125 MCG before administering it to Resident #301 since 10/29/2024. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings Included: Review of Resident #301's face sheet, dated 10/31/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were metabolic encephalopathy (this is a brain disorder caused by a chemical imbalance in the blood that affects brain function, paroxysmal atrial fibrillation (this is a heart condition that cause an irregular, often rapid heart rate that can cause poor blood flow), heart diseases, fluid overload, and high blood pressure. Review of Resident #301's orders dated 10/31/2024, reflected Digoxin oral tablet 125 MCG. Give 1 tablet by mouth one time a day. Order active. Start date 10/29/2024 at 12:00. Order did not reflect parameter for administering medication. Review of Resident #301's MAR reflected Resident #301 was administered Digoxin 125 MCG on 10/29/2024, 10/30/2024, and 10/31/2024. MAR did not reflect parameter for administering medication. Review of Resident #301's transfer orders dated 10/25/2024 reflected Digoxin Oral tablet 125 MCG (digoxin). Give 1 tablet by mouth one time a day for chf hold if pulse less than 60. Review of Resident #301 care plan on 10/31/2024 did not reflect heart medication digoxin and it did not reflect interventions or monitoring for digoxin toxicity. During medication observation on 10/31/2024 at 11:54 AM with LVN C revealed Resident #301 lying in bed. LVN C checked her pulse on her left finger with a pulse oximeter and the reading was 108. LVN C took medication bubble pack Digoxin tablet 0.125 MG, sub for Lanoxin. Give 1 tablet by mouth 1 time daily. She took 1 pill and administered it to Resident #301. Interview with Resident #301 on 10/31/2024 at 12:00 PM, she stated she had been taking Digoxin heart medication for a while now, but she did not know how many milligrams and she did not know the parameters for the medication. Resident #301 did not appear to have any medication related complications since being at the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN C on 10/31/2024 at 12:02 PM, she stated the medication had no parameters, but she would have used her nursing judgement not to administer the medication if Resident #301's heart rate was below 60. She stated if Resident #301's heart rate was lower than 60, and if it was, she would hold the medication and reach out to the doctor. LVN C stated it was the nurse's responsibility to make sure they obtained order clarification for medication. She stated the ADON was good at auditing new admissions and catching what might have been missed. She stated that all blood pressure and heart medications required parameters before administering. LVN C stated she does not know why she did not reach out to the doctor for parameters, or to the ADON or admission nurse for order clarification. She stated not having parameters could cause adverse effects to residents if given with low vitals. She stated she would check Resident #301's vitals including her blood pressure as the resident was daily full vitals check anyways [temperature, blood pressure, and pulse/heart rate]. Phone interview attempted with LVN N on 10/31/2024 at 03:20 PM, voice mail not available to leave a message. In an interview with LVN M on 10/31/2024 at 03:32 PM she stated she was the admitting nurse however she did not admit resident #301. She stated LVN N notified her that she had called 4-5 times for orders from the sister facility that Resident #301 came from, and they had not gotten back to them. She stated Resident #301 just came to the facility with no admission/discharge paperwork. When asked what could happen to the resident if no parameters or orders were not correct? She stated it would not be a good thing. She stated we must check the heart rate, and it must be at least 60 or greater. If there was nothing to stop the nurse, she would use nursing judgement, however there should be a parameter. LVN M stated only nurses give digoxin medication. She stated to ensure accuracy, checks and balances need to be used. She stated after she finished entering orders, the ADONs came in the next day and they were supposed to lay eyes on it also. In an interview with ADON A on 10/31/2024 at 04:14 PM, she stated LVN C notified her about the digoxin missing parameters after the medication observation, and she was able to fix the order. She stated she was out on leave and just returned and had not been able to look at the new admissions. ADON A stated it was the responsibility of the nurse doing the admission to verify orders and to ask questions if they did not understand something and even to clarify if they see the mistake. The ADON stated medications that require parameters must always have them so that they know when to hold medications and to notify the doctor. She stated not having order parameters can cause confusion and could lead to adverse medication effects. In a phone Interview with LVN N on 11/01/2024 at 04:53 PM she stated that she was PRN at the facility, she worked on 10/28/2024 and did Resident #301's admission. She stated the facility that Resident #301 came from was having a hard time faxing over paperwork and she was unable to complete the orders. She stated she passed it on to the oncoming admission nurse LVN M to follow up. She stated she did not know why she did not document that she had issues completing the orders, but she just verbalized it to the oncoming admission nurse. LVN N stated the transport company that transported Resident #301 did not bring any paperwork and they were gone by the time she discovered the missing orders. LVN N stated she followed protocol and notified the IDT team about missing orders. She stated missing orders could delay residents from getting their medicines. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the acting DON on 11/01/2024 at 03:30 PM, she stated she expected nursing, when they received orders that required parameters, to verify them. She stated she also expected the med aide to ask nursing if medication was missing parameters. She stated she expected nursing managers to follow up on new admission to make sure orders were not missing anything. She stated a resident on digoxin should have orders for blood draw to check digoxin toxicity, they should have parameters for heart rate or pulse, and their vitals should be checked before medication administration. Phone interview attempted with prescribing physician on 11/01/2024 at 09:28 AM, voice mail message left. Record review of the facility's Medication Orders, revision date November 2014, read in part The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. 1. Each resident must be under the care of a Licensed Physician authorized to practice medicine in this state and must be seen by the Physician at least every sixty (60) days. 2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order. 4. Physician Orders/Progress Notes must be signed and dated every thirty (30) days. (Note: This may be changed to every sixty (60) days after the first ninety (90) days of the resident's admission, provided it is approved by the Attending Physician and the Utilization Review Committee.) Recording Orders When recording orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered. A placebo is considered a medication and must also have specific orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 45507 48520 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 4 Residents (Resident's #33, #67, #23, and #48) observed for infection control and 1 of 4 quarters reviewed for water management. 1. The facility failed to ensure LVN E followed facility protocol while administering medication via G-tube entering for a resident on enhanced barrier precautions-EBP, Resident #33. 2. The facility failed to implement infection control and prevention, including wound care procedures and cross contamination for Resident #67 during wound care by LVN D and CNA H. 3. The facility failed to perform a water system flush quarterly. 4. The facility failed to ensure Hospice CNA Q followed facility protocol in maintaining infection control while providing a safe, sanitary environment, while preventing the development and transmission of disease and infection during provision of care for Resident #23 and Resident #48. These failures could place residents at risk of cross contamination and infections. Findings included: 1.Record review of Resident #33's Admission Record dated 10/30/2024, revealed a [AGE] year-old female initial admission to facility on 06/24/2021 and readmitted on [DATE] with diagnoses that included unspecified sequelae of cerebral infarction (a condition that affects blood flow to your brain), left side weakness, colostomy status, (an opening into the colon from the outside of the body), and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individual who have a difficulty swallowing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Resident #33's care plan initiated on 09/09/2024 and revised on 09/09/2024, revealed Resident #33 was on Enhanced Barrier Precaution at risk for infection related to medical device. The goal was to reduce the risk of infection for Resident #33. Interventions included wearing gloves and gowns during high contact activities for residents with indwelling medical devices, wounds, and colonized or infection with CDC targeted MDRO. The care plan further revealed Resident #33 had a feeding tube. Interventions included monitor, document, report to doctor as needed Infection at tube site, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. Date Initiated: 06/25/2021 Revision on: 03/08/2023. The care plan initiated 12/30/2022 with revision date 10/04/2024, revealed Resident #33 had an unavoidable pressure sore stage 4. Goal was for Resident #33 to remain free of infection through review date 01/24/2025. Interventions were to assess, record, and to monitor wound healing weekly. During medication observation on 10/30/2024 at 08:24 AM, it was revealed that LVN E crushed medications belonging to Resident #33. Hand hygiene completed and bedside table cleaned. After putting on gloves, LVN E closed the privacy curtain, stopped Resident #33's feeding and exposed g-tube area by removing some of the covers. She started to administer medication via g-tube. LVN E did not change her gloves before starting to administer medication and she did not wear a gown. In an interview with LVN E on 10/30/2024 at 08:50 AM, she stated that Resident #33 was on EBP, and she was supposed to wear her gown. She stated that she forgot to wear one. She stated she had been trained on EBP which was to protect residents that had medical devices from infection and to prevent carrying infection to other residents. 2. Record review of Resident #67's Admission Record dated 10/30/2024, revealed a [AGE] year-old female initial admission to facility on 09/30/2024 and readmitted on [DATE] with diagnoses that included infection following surgical site procedure, right below the knee amputation, and chronic kidney diseases. Record review of Resident #67 admission MDS dated [DATE] reflected a BIMS score of 9 out of 15 indicating moderate cognitive impairment. MDS reflected Resident #67 had a surgical wound and that she had a wound infection. Review of Resident #67 orders dated 11/01/2024 reflected Wound Vacuum: Change wound vac dressing using green foam on Monday, Wednesday, and Friday. Location of wound: right BKA. Order active 10/24/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During wound care observation and interview on 11/01/24 at 10:07 AM for by LVN D and CNA H, revealed Resident #67 in bed in her room. LVN D prepared items for wound care outside Resident #67's room on the treatment cart. LVN D cleaned bed side table and took it inside Resident #67's room. She handed CNA H a clear trash bag which CNA H filled with some blue gloves and then CNA H placed the bag on top of a COVID isolation cart as he put on his PPE. After collecting her wound care and wound vac supplies, LVN D then placed wax paper on the clean table and placed all the wound supplies on the wax paper. LVN D went to wash her hands and put on PPE. While she was completing those tasks, CNA H entered Resident #67's room and placed the contaminated trash bag on top of clean field with wound care items on the table. LVN D noticed the trash bag on top of the wound care supplies, and she took the bag off and handed it to CNA H. CNA H came around bed to the left side and placed the contaminated trash bag again on top of the wound care items. LVN D took the bag again and gave it to CNA H as he walked back to the right side of Resident #67's bed. CNA H assisted holding Resident #67's leg as LVN H removed the old wound vac and the old dressing from the wound. After removal of the dirty wound vac material, hand hygiene was completed. LVN H then opened sterile wound vac green foam and then she left the bedside and went to get a sessors to cut the form. She placed cut green foam new and dressing from the solid field. Closed it and attached wound vac plastic. LVN H with clean gloves took off soiled wound vac canister with soiled tubing and placed it in the trash bag. Without changing her gloves, LVN H touched the new canister connection and attached tubing from wound to tubing to wound vac machine. All biohazard was bagged and discarded accordingly. Bed side table cleaned, and pain reassessed. LVN D stated that she should have started over after noticing the contamination of her clean field. She stated the risk to Resident #67 was infection and contamination. CNA H stated he was not paying attention to where he had placed the bag. He stated the risk to resident #67 was cross contamination and spread of infection. In an Interview on 11/01/24 at 04:14 PM with ADON A, she stated she was the Infection Control Preventionist. She stated that she had in-services done on hand washing, PPE, and EBP for all staff including rehab, housekeeping, nursing. She stated the expectation was that staff would take all the precautions that were posted outside the residents' doors and if they do not know to come and ask her. ADON A stated she was responsible overall, and the charge nurses were responsible for monitoring infection control on their shifts. She stated they made rounds, making sure doors were closed to rooms during patient care. She stated she went in the hallways to make sure that they had set up isolation carts and that they were following whatever precautions. She stated the wound vac was sterile and contaminating the sterile field can cause the infection to get worse. The treatment nurse would have done the in-services on wound vacs. 3. Interview on 10/31/24 05:11 PM, the VP of Facilities Management and Development stated the former Maintenance Director was here transferred to another property and the current Maintenance Director was in the position for 3 days. He stated they have a policy and procedure for Legionnaires, and they perform a water flush quarterly. He stated they set aside a 3-4-hour time frame and notify the staff of the increase temperature to hot water tanks to above 150 degrees F. He said once the temperature was reached, they release the faucet fixtures on the ends of corridors, utility, and soiled utility to allow that temp to run through it. After that process, they flushed all the pipes with temp water and reduced it back to 110 degrees, closed the faucets back up and tested the temperatures again to ensure they were in normal range. He stated housekeeping and laundry services clean under the faucets and faucet spray heads with high concentrated bleach. He said he wanted staff logging each flush and provided staff examples from other buildings. The State Surveyor requested logs for the last 4 quarters. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and record review on 11/01/24 at 11:22 AM the VP of Facilities Management and Development revealed water flushes were completed on 10/10/2023, 02/05/2024, and 06/17/2024. He said they missed a quarter between Q3 and Q4. He stated the risk to residents according to the CDC, was they could get airborne particles and could get pneumonia from Legionella. He said there was an excuse why the flush was not completed and stated it was a labor shortage. He said the former Maintenance Director left for another facility which left a gap. He stated the Administrator was responsible for ensuring the flushes were completed quarterly. Record review of Water Management Plan log revealed start times, temperatures, locations, opening and closing of fixtures for 10/10/2023, 02/05/2024, and 06/17/2024 signed by Maintenance and Housekeeping Directors. Record review of Legionella Water Management Plan, undated, reflected in part: During the Lunch Meal on a Quarterly basis (March, June, September & December), all staff and residents will be alerted to not use water in Resident's Rooms, Showers, and Nourishment Rooms. The Maintenance Director will increase the water temperature on Hot Water Tanks serving these areas to > 150 F. Once the tank has reached > 150 F, the Maintenance Director will turn on each faucet and showerhead to run for 5 minutes and then proceed to shut off. Maintenance Director will lower the water temperature on the Hot Water Tanks to < 120 F and after cooling down, he will check a faucet to ensure not> 110 F. Staff and Residents will be informed when it is safe to again use the hot water. Housekeeping will be asked to clean all faucets and showerheads with a chlorine (bleach) solution following the flushing. 4. Record review of Resident #23's face sheet dated 11/01/2024, revealed she was readmitted to facility on 01/24/2024 with an initial admission of 12/14/2022. Admitting diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; type 2 diabetes mellitus without complications; and cerebral infarction, unspecified. Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed R#23 was assessed and had a Cognitive BIMS summary score of 99, which indicated severely impaired cognition-decisions, poor; cues/supervision required. Total dependence on staff on eating, locomotion, personal hygiene, bathing, and toilet use. R#23 is a one-to-two-person physical assist in transferring. Record review of Resident #48's face sheet dated 11/01/2024 revealed she was readmitted to facility on 02/14/2024 with an initial admission of 07/01/2021. Admitting diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; type 2 diabetes mellitus with other diabetic ophthalmic complications; and essential (primary) hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed R#48 was assessed and had a Cognitive BIMS summary score of 05/15, which indicated severely impaired cognition-decisions, poor; cues/supervision required. Total dependence on staff on eating, locomotion, personal hygiene, bathing, and toilet use. R#48 is a one-to-two-person physical assist in transferring. In an observation on 10/30/2024 at 10:45 AM, Hospice CNA Q placed soiled linen in a bag belonging to Resident #23 on Resident #48's bed. Resident #23 and Resident #48 were both in their beds. This failure would cause contamination and the spread of infection from Resident #23 to Resident #48. Interview on 10/30/2024 at 11:00 AM, DON revealed that the hospice agencies were expected to train their staff on infection control. The hospice agencies are to follow the same infection guidelines that are required in the nursing facility. Interview on 10/30/2024 at 3:30 p.m. the Administrator revealed she expected the hospice agency to follow the same regulations as the facility r/t infection control. The ADM revealed that she was not aware the facility has been given the trainings provided to hospice staff. The ADM states she will have the DON and ADONs review infection control practices with the hospice agency. The ADM's goal is to have the ADONs take over monitoring the Hospice staff while they were in the facility. If the infection control guidelines are not followed this failure could place all residents at risk for cross-contamination and infections, Interview on 11/08/2024 at 11:17 a.m. with Hospice Supervisor revealed she was aware of the incident with CNA Q related to infection control that occurred on 10/30/2024. The Hospice Supervisor stated that the agency would retrain the employee at the facility and review the checklist for re-orientation to assist the employee with corrections from the mistake made. The Hospice Supervisor would follow-up with the facility ADM and the facility DON. Record review of facility policy titled Handwashing/Hand Hygiene revised June 2010 reflected in part: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . Record review of facility policy titled Policies and Practices - Infection Control revised August 2007 reflected in part: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections . I. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675930	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbrook Plaza	401 W Arbrook Blvd Arlington, TX 76014

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interviews and record review the facility failed to ensure that the resident's medical record included documentation that indicated the resident or resident's representative were provided education regarding the benefits and potential side effects of influenza immunization; and that the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal for 1 of 6 (Resident #299) residents reviewed for immunizations. The facility failed to offer Resident #299 an influenza immunization. This failure could place residents at risk of harm, by contracting and spreading influenza. Findings included: Record review of Resident #299's Admission Record, dated 11/01/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of malignant neoplasm of unspecified part of unspecified adrenal gland. Record review of Resident #299's BIMS assessment, dated 10/19/2024 revealed a score of 15, indicating intact cognition. Record review on 10/31/24 of Resident #299's EHR reflected refused and not eligible under immunizations for influenza. Record review of Resident #299's informed consent for influenza vaccination, e-signed by Resident #299 on 10/21/2024, indicated she wanted the influenza vaccine. Interview on 10/30/2024 at 10:30AM, Resident #299 stated she did not have any complaints except she had not had the flu shot yet. Resident #299 stated she got to the facility around 10/16/2024. She stated she thought the vaccine would be good to have since she had lung cancer. She stated staff did not ask her if she wanted the flu or pneumonia vaccine. Interview on 10/31/2024 at 3:32 PM, LVN M stated flu and pneumonia immunizations were offered, and she asked residents at admission if they had one already. She stated they should have a consent and the ADON kept up with all the consents. LVN M stated even if she got the consent the ADONs would administer them. She said she did not remember asking Resident #299 if she wanted the flu vaccine. She stated the risk for not providing immunizations was the resident would be more susceptible to the flu. Interview on 10/31/2024 at 4:00 PM, ADON A stated all residents were offered the flu, pneumonia, and COVID vaccine. She said the concierge usually did the paperwork and had the resident sign the consent. She said they had 72 hours to get with the family or resident, then she would confirm those answers. She said some residents would tell the concierge no and when she went back to ask the resident again, they would say yes. She said she usually goes back to check the consents. ADON A said Resident #299 did not ask her for the flu vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/31/2024 at 4:32 PM, CNA H stated he did the admission packet with the residents or family members. He stated if the resident was able to sign, they would E-sign the consent forms. He stated he did not remember asking Resident #299 because he did so many. He stated if a resident marked yes on a vaccine consent form he would relay the message. Interview on 11/01/24 at 3:29 PM, the acting DON stated residents were to receive vaccines within the first few days of admission. She said if residents were not offered a vaccine, they could get sick. Review of the facility's policy titled Influenza Vaccine revised August 2016, reflected in part: All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives) .1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medical contraindicated, or the resident or employee has already been immunized.