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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455819 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER Arlington Heights Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 Wellesley St Fort Worth, TX 76107 | |

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) |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observation, interview, and record review, the facility failed to 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 one (Resident #1) of four residents observed for infection control.</p> <p>The facility failed to prevent Resident #1's indwelling urinary Foley catheter device from contact with the floor.</p> <p>This failure could place the residents at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 06/07/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. One of his diagnoses was obstructive and reflux uropathy (a condition where urine cannot flow because of blockage in the urinary tract).</p> <p>Review of Resident #1's Quarterly MDS Assessment, dated 05/04/2024, reflected Resident #1 had a moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment also indicated the resident had an indwelling catheter.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 05/11/2024, reflected Resident #1 had an indwelling catheter due to obstructive uropathy and one of the interventions was to the anchor catheter to prevent tension.</p> <p>Review of Resident #1's Physician Order, dated 10/04/2023, indicated, Monitor F/C q shift for leakage, blockage, sediment buildup, or low output. Every shift.</p> <p>Observation and interview with Resident #1 on 05/25/2023 at 10:12 AM revealed Resident #1 was in his bed, resting. Resident #1 had a Foley catheter tubing hanging at the side of the bed. At the end of the Foley catheter tubing, a catheter bag was attached. The catheter bag was observed flat on the floor. Resident #1 stated he had a catheter even before he was admitted to the facility. He said he was not aware if the staff would hang the catheter or not.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation and interview with LVN A on 05/25/2024 at 2:42 PM, LVN A stated the catheter bag should have been off the floor because it could cause infection. LVN A went inside the resident's room and acknowledged that Resident #1's catheter bag was on the floor. LVN A put on a pair of gloves, picked up the catheter bag, hung it on the railing below the bed, and put the catheter bag in a privacy bag that was also on the floor beside the catheter bag. She said she would also empty the catheter bag.</p> <p>In an interview with CNA B on 05/25/2024 at 3:10 PM, CNA B said she did not notice that the catheter bag was on the floor when she checked on the resident. She said she should have noticed it and hung it on the railing below the bed. CNA B said the catheter bag should be off the floor for infection control and to make sure it would not be pulled from his bladder.</p> <p>Interview with the DON on 05/25/2024 at 3:26 PM, the DON stated the catheter bag should be off the floor to prevent cross contamination and infection. The DON said the best practice still was to keep the catheter bag below the bladder and hanging below the bed when the resident was in his bed. The DON said all the staff, including her, were responsible in making sure the catheter was not touching the floor. She said it should be checked everytime a staff entered the room to check on the resident. The DON said the expectation was for the staff to make sure the catheter bag was off the floor when the resident was in the bed or in the wheelchair. She concluded that she continually reminded the staff the importance of catheter care through an in-service.</p> <p>Interview with the Administrator on 06/07/2024 at 3:30 PM, the Administrator stated the catheter bag was not touching the floor to prevent possible infection. He said the expectation was for the staff to do the best practice to prevent infection of any kind. He said they already did an in-service about making sure the catheter bag was off the floor.</p> <p>Review of facility policy, Catheter Care Nursing Policy & Procedure Manual 2003 revealed, General Guidelines . 10. Be sure the catheter tubing and drainage bag are kept off the floor.</p> | | |