STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455819	A. Building B. Wing	02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Heights Health and Rehabilitation Center	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43791 Based on interview and record review, the facility failed to ensure residents were treated with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #5) reviewed for resident rights. The facility failed to treat Resident #5 with dignity when staff failed to assist the resident with colostomy care, resulting in it leaking and causing her to feel embarrassed in front of her roommate. This failure could cause the resident embarrassment and a decreased sense of self-worth. Findings included: Record review of Resident #5's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting the rights side of her body, legal blindness, and rectal cancer requiring the creation of a colostomy (opening in the intestine to drain feces into a bag). Record review of Resident #5's quarterly MDS, dated [DATE] reflected a BIMS score of 10 indicating she was moderately cognitively impaired. Her Functional Status reflected she required set-up and clean up assistance with her toileting hygiene. Her Bowel and Bladder assessment indicated she had an ostomy. Record review of Resident #5's care plan, dated 12/22/24, reflected she had a visual impairment related to being legally blind, and ADL self-care deficit related to paralysis, and had an ostomy. (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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(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 - Few	Interview on 02/11/25 at 9:50 AM with Resident #5 revealed she often had to change her briefs because the staff took too long to respond to her call light. Resident #5 stated she thought staff knew if they waited, she would do it herself. She stated she did need staff assistance to make sure she was completely clean, and she needed assistance with applying her colostomy bag to make sure it was on properly to prevent it from leaking. Resident #5 stated in the evening on 02/07/25 her colostomy bag was leaking, and she had tried to clean up with her wipes. She stated CNA B answered her call light and told her he would have to get the nurse to help her. She stated LVN A came to her room and told her she could not help because she was the only nurse monitoring the evening meal in the dining area. She stated LVN A put a new colostomy bag on the resident's overbed table and left. Resident #5 stated she waited for about 20 minutes and no one came to help her, so she applied the bag herself and cleaned herself up. She stated she must not have applied it correctly because later that evening the bag began to leak again. Resident #5 stated her colostomy was very smelly when being changed. She stated she was embarrassed by it leaking because she had a roommate, and the door to the hall was open. Resident #5 stated she usually changed it every other day when she was taking her shower to limit the smell affecting others. She stated a nurse from the night shift helped her secure the bag properly. Interview on 02/11/25 at 3:00 PM with CNA B revealed he responded to Resident #5's call light on 02/07/25. He stated the resident's colostomy bag was leaking and needed to be changed. He stated he told Resident #5 he would have to get the nurse as that was beyond his scope of practice. He notified LVN A, who was monitoring residents in the dining area, and she went to check on the resident. Interview on 02/11/25 at 3:25 PM with LVN A revealed she was called to Resident #5's room by CNA B from the dining area where she was monitoring the evening meal. LVN A stated Resident #5 told her she needed a new colostomy bag, so she put one on the resident's table. LVN A told her she could not help because she had to get back to the dining area. LVN A stated there was a second nurse on the hall, who was supposed to care for the residents, while she was in the dining area. LVN A stated she did not notify the other nurse that Resident #5 needed help. LVN A stated she did not follow-up with Resident #5 when she returned from the dining area. Interview on 02/11/25 at 3:28 PM with LVN C reveale she had not been made aware of Resident #5 needing assistance with her colostomy. She stated LVN A never had a conversation with her on 02/07/25, and the interview with the surveyor was the first she time she had been made aware of the situation. Interview on 02/12/25 at 10:35 AM with the DON revealed his expectation of the nurses would be if they could not assist a resident right away, they should have a conversation with their teammate and ask them to assist the resident. The DON stated that was why they had two nurses on the hall. He stated all residents deserved to be treated with respect and dignity. He stated LVN A did not treat Resident #5 with respect and dignity.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 3 of 10 residents (Residents #2, #3, and #4) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #2, #3, and #4 were free of abuse from Resident #1. Resident #1 hit Resident #2 and #3 with her doll in the face and head when she was upset and punched Resident #4 in the stomach after she approached her boyfriend. An Immediate Jeopardy (IJ) was identified on 02/11/25 at 3:47 PM. The IJ template was provided to the facility on [DATE] at 4:00 PM. While the IJ was removed on 02/13/25, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of physical abuse from other residents. Findings included: Record review of Resident #1's Quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), stroke, seizure disorder, and profound intellectual disabilities. Resident #1 was not able to complete a BIMS due to her impaired cognition and she was rarely understood by others and rarely/never understood others. The MDS further reflected Resident #1 was independent with walking and did not have any impairment to upper and lower extremities. Record review of Resident #1's care plan initiated on 06/16/23 reflected she had the potential to demonstrate physical behaviors related to poor impulse control. Resident #1 had poor impulse control and would utilize her baby doll to make contact with other residents in an aggressive way and would also get upset and physical when felt that others were talking to her boyfriend. Intervention included to analyze key times, places, circumstances, triggers, and what de-escalates the behaviors and document. Other interventions included to intervene before agitation escalated and guide away from source of distress and immediately intervene to protect the residents involved and call for assistance. Record review of Resident #2's Annual MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), stroke, hemiplegia (medical condition that causes paralysis or weakness on one side of the body), reduced mobility, and difficulty in walking. Resident #2 had a BIMS of 13 which indicated his cognition was intact. The MDS also reflected the resident had impairment on one side to his upper extremity and impairment on both sides to his lower extremity and used a wheelchair for mobility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's Quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included coronary artery disease (condition in which the arteries that supply blood to the heart muscle become narrowed or blocked), stroke, difficulty in walking, and muscle weakness. Resident #3 had a BIMS of 8 which indicated his cognition was moderately impaired. The MDS further reflected the resident had impairment on one side to upper and lower extremities. Record review of Resident #4's annual MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included heart failure, stroke, difficulty in walking, weakness and history of falling. Resident #4 had a BIMS of 7 indicating her cognition was severely impaired. The MDS further reflected the resident was independent with walking and most all ADL's. Record review of the facility's Provider Investigation Reports reflected the following: 12/05/24 On 11/25/24, [Resident #2] was sitting one table down from [Resident #1] in the main dining room. According to [Resident #2], [Resident #1] threw her doll at him. He in turn grabbed the doll and threw it on the floor. [Resident #1] got up and picked her doll up and started crying. [Housekeeper D] saw the altercation and intervened. According to her statement, [Resident #1] hit [Resident #2] several times but after interviewing [Resident #2], he was only struck by the doll when it was thrown at him] 01/23/25 [Resident #3] was sitting one table down to [Resident #1] in the dining room during breakfast. After breakfast was complete, [Resident #1] was tapping her foot on the floor and [Resident #3] asked her to stop tapping so loud because he could not hear the TV. [Resident #3] turned back around to look at the TV and [Resident #1] took her doll and hit [Resident #3] in the forehead. Another resident saw the altercation and went to tell the nurse 01/26/25 [Resident #1] was sitting in her usual spot in the dining room. [Resident #4] went up to [Resident #1] to ask her a question. [Resident #1] responded by saying that is my boyfriend don't talk to my man and punched her with a closed hand. [Resident #4] retaliated by hitting [Resident #1]. Residents were pulling hair. Staff intervened and separated both residents Skin assessments were conducted with [Resident #4] showing a quarter size bruise to inner upper left arm. No injuries to [Resident #1] Record review of Resident #1's progress notes on the following dates reflected: 10/21/24 - documented by the Social Worker Visit with [Resident #1] regarding the incident where she threw her baby doll at another resident. She did not act like she knew what this SW was talking about. SW discussed with her that her baby is little and can get hurt. She needs to be a good Mom and not throw her baby. She said she knew not to hurt baby (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11/15/24 - documented by LVN CC Resident continues with loud laughing, taunting other residents in dining room, yelling and crying @ random intervals. Was recently started on Klonopin in afternoon by psych 11/16/24 - documented by LVN E Res in dining room yelling and laughing at other residents, CNA approached and told her to go to her room, res then ran up to cna and grabbed her by her hair, and started hitting her in the face. Another staff member intervene and separates Res from staff 11/25/24 - documented by LVN CC Noted resident sitting in dining room, sticking her tongue out at several male residents and yelling at them get out of here, I don't like you and flipping them off with the middle finger of her left hand. Resident's chair was moved so that her back was turned toward the male residents and toward the TV so she can continue watching the program that was on. She was instructed that this behaviour is not acceptable and she can't remain in the dining room if she continues to act out toward other residents in this way. Resident stated I won't do it and was holding her baby doll and smiling as writer left at table Observation and interview on 02/11/25 at 9:58 AM of Resident #1 revealed she was sitting at a dining room table next to another male resident. The resident had 7 stuffed animals and two dolls in a chair next to her. The two dolls had a soft, cloth stuffing and the hands, feet, and head were a firm plastic/rubber material. Attempted to interview Resident #1 but she was only able to give simple 2 to 3 word sentences and did not recall any incident or altercations with other residents. Observation and interview on 02/11/25 at 10:05 AM with Resident #2 revealed he was in his room. He was slowly self-transferring from his wheelchair to the bed and appeared to have paralysis to the left side of body. Resident #2 was asked about the incident with Resident #1 and he said he was in his room and Resident #1 approached his door and took a few steps inside and threw her doll at him. Resident #2 said the doll hit his face so he then threw the doll back at Resident #1 and she then began to yell and curse. Resident #2 also said there was an incident where Resident #1 pushed his wheelchair with him in it against the wall but he was not hurt and there was no one around at that time nor did he tell anyone. Resident #2 further stated he was not afraid of Resident #1 just rather he was irritated at the things she did. He described Resident #1 as a rude person who cursed and yelled at others so he now preferred to keep his distance and did not go out to the dining room much to avoid Resident #1. Observation and interview on 02/11/25 at 10:52 AM with Resident #4 revealed she was in her room sitting on the side of her bed. She was asked about the incident with Resident #1 and she said she had approached Resident #1's male friend that was sitting with her at the dining room table and asked him for a quarter. At that time Resident #1 told Resident #4 to get away from her man and then stood up and punched her in the stomach so she then in return pulled Resident #1's hair and hit her back. Resident #4 stated she was not afraid but if Resident #1 was going to hit her, she was going to hit her back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview on 02/11/25 at 10:22 AM with Resident #3 revealed he was sitting in the dining room listening to bible study and eating a snack. The resident was observed using a wheelchair and getting up to walk short distances. Resident #3 said Resident #1 has history of acting out in the mornings and said the day of the incident, 01/23/25, Resident #1 was hitting the bottom of the dining room table and he asked her to stop and that is when Resident #1 came around and hit him in the head with her doll. Resident #3 said the doll hurt his head when it made contact with his forehead because the doll contained some hard parts. Resident #3 further stated Resident #1 would get upset with different people when they would talk to her boyfriend who sat at her table and Resident #1 always started the fights. Resident #3 said he was not afraid of Resident #1 but the residents were annoyed with her behaviors. Interview on 02/11/25 at 12:08 PM with Housekeeper D revealed during the incident with Resident #2 she was across the hall and heard yelling but could not make out what was being said. As she turned she saw Resident #1 hitting Resident #2 on the head with her baby doll. This incident occurred outside of the rooms, as they used to be neighbors. Housekeeper D said she separated the residents and went to report the incident to the Administrator. The Housekeeper said had heard Resident #1 yell at other residents but that was the first time she had seen her become physical with them. Interview on 02/11/25 at 12:13 PM with LVN D revealed she was told by CNA F that Resident #1 was in the dining room, on 11/16/24, and she believed Resident #1 might have been trying to hit someone with her baby doll when CNA F tried to intervene. CNA F told her Resident #1 then grabbed CNA F's hair and began to hit her in the face with her other hand. LVN D further stated Resident #1 had a history of becoming verbal with others especially when other residents tried to talk to her male friend that sat with her at the dining room table. Interview on 02/11/25 at 12:29 PM with CNA F revealed she approached Resident #1 and told her to go to her room so she could change her. Resident #1's male friend told Resident #1 she needed to go with CNA F and CNA F touched her male friend on his shoulder and Resident #1 jumped up out of her chair and grabbed CNA F by the hair and began to punch her. CNA F said that had been the first time Resident #1 had hit her and it all happened because Resident #1 would become defensive if anyone was around her male friend. CNA F further stated Resident #1 had a history of hitting others with her baby dolls and cursing at staff and residents all day long. CNA F said it was difficult to prevent Resident #1 from hitting and yelling at others because she would not stay in her room and stayed in the dining room all day long. If and when they tried to redirect Resident #1 she would begin to yell and curse. CNA F also said Resident #2 now preferred to stay in his room to avoid Resident #1 and others resident would also get frustrated and leave the dining room so they did not have to hear Resident #1 yell out. Interview on 02/11/25 at 12:39 PM with the Weekend Supervisor revealed during the incident between Resident #1 and Resident #4, she was in the wound care office next to the dining room when she heard Resident #1 screaming. When they heard Resident #1, they usually knew something was going on because the resident had a history of swinging at people. When the Weekend Supervisor entered the dining room Resident #4 had Resident #1 by her hair and they were immediately separated and Resident #1 was put on 1:1 safety checks. The Weekend Supervisor said she had not worked at the facility long but had been told Resident #1 had a history of hitting but she had never witnessed it prior to that incident. Resident #1 would sit in the dining room all day and yell and scream random things at others and they would try to redirect the resident to her room but she always refused to go. The Weekend Supervisor further stated everyone just had to work around Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 02/11/25 at 12:50 PM with the Social Worker revealed they were seeing some regression with Resident #1's developmental disability and the resident had begun to throw her baby dolls at others and there were not patterns to her behaviors. The Social Worker described Resident to be very territorial of her space and of her male friend that sat with her and they tried to redirect her behavior if they saw it coming. She said Resident #1 has previously been treated for a UTI and they had discussed her behaviors with the PASSR representative. The Social Worker further stated she had spoken to Resident #1 after her physical incidents but due to her cognition the resident did not really seem to recall the incidents and forgot as soon as they occurred. Interview on 02/11/25 at 1:32 PM with the DON revealed he had only been working at the facility for less than 2 months and he had been made aware of the incidents between Resident #1 and Residents #3 and #4. The DON said they had inserviced staff in the past about techniques to deescalate physical altercations between the residents. Staff were also to frequently monitor Resident #1 and they had just adjusted the resident's medications. The DON said they had not tried to take Resident #1's dolls because that would infringe on her rights but they had encouraged her to not have so many baby dolls in the dining room. Interview on 02/11/25 at 1:42 PM with the Administrator revealed they had met and discussed to limit how many dolls Resident #1 kept and to make sure staff frequently monitored to prevent altercations with other residents. The Administrator said there had not been any injuries as a result of the incidents and also said Resident #1 would not let go of her baby dolls because she was really attached to them. Record review of the facility's policy titled Abuse/Neglect revised 03/2018 reflected the following: The resident has the right to be free of abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Resident should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals An Immediate Jeopardy/Immediate Threat was identified on 02/11/25. The Administrator, DON and the Regional Nurse Consultant were notified of the Immediate Jeopardy on 02/11/25 at 3:43 PM. The IJ template was provided to the facility on [DATE] at 4:00 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 02/12/25 at 9:44 AM and reflected the following: Plan for Removal: F600 Failure to Prevent Abuse and Neglect Interventions: Resident #1 was immediately placed on 1:1 supervision on 2.11.25 with facility staff. Resident #1 discharged to alternate facility with guardians' approval 2.11.25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1's baby doll with the plastic heads were immediately removed from Resident #1's possession and from resident #1's room on 2.11.25 by regional compliance nurse. Resident's #1's care plan was reviewed by Regional Compliance Nurse for appropriate interventions to prevent resident and staff altercations on 2.11.25. Resident #1's care plan was updated by the Regional Compliance Nurse to reflect additional interventions of 1:1 supervision and removal of baby dolls with hard plastic pieces on 2.11.25. IDT team will schedule a care plan meeting with Responsible Party, Physician, and Resident to review and evaluate interventions to prevent repeated altercations with staff and residents starting 2.11.25. The Administrator and DON were in-serviced 1:1 by the Regional Compliance Nurse on the following topics. Completed 2.11.25 o Abuse and Neglect- Prevention of abuse/neglect and ensuring interventions listed on the care plan are implemented to prevent abuse. o Behavior Management Policy- Managing behaviors and intervening appropriately. The Medical Director was notified on 2.11.25 of the immediate jeopardy. An ADHOC QAPI was held with the IDT Team on 2.11.25 to discuss the immediate jeopardy and plan of removal. In-services All staff will be in-serviced on the following topics below by the Administrator, Regional Compliance Nurse, DON, and ADON to prevent resident to resident abuse and ensure appropriate response to aggressive behaviors. In-servicing initiated on 2.11.25 and will be completed by 2.12.25. All staff who are not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to starting their shift. o Abuse and Neglect- Prevention of abuse/neglect and ensuring interventions listed on the care plan are implemented. o Behavior Management Policy- Managing behaviors and intervening appropriately. Monitoring of the facility's Plan of Removal included the following: Observation on 02/12/25 at 10:04 AM revealed Resident #1 was no longer at the facility and had been discharged to another nursing facility. Record review of Resident #1's progress notes dated 02/11/25 documented by LVN C reflected the following (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident transferred to sister [facility] due to behaviors. Vitals within normal limits, medication and belongings sent with her. Guardian notified of transfer Record review of the facility's inservices titled Abuse/Neglect dated 02/11/25 reflected all facility staff were educated on the different types of abuse, abuse prevention and ensuring interventions were implemented to prevent abuse, and managing behaviors and intervening appropriately. If staff are to witness resident to resident abuse, they are to immediately intervene, ensure the residents are safe and report the incident to the Administrator. To prevent abuse, staff are to redirect residents away from aggressive or agitated behaviors and watch for signs of aggression. Interviews on 02/12/25 at 1:02 PM to 02/13/25 at 2:35 PM from staff from various shifts were the Administrator, DON ADON P, Weekend Supervisor, Social Worker, Transportation, BOM , Medical Records, Dietary Manager, PTA, OT, LVN A, LVN C, Housekeeper D, LVN E, CNA F, LVN G, MA I, MDS Nurse K, MDS Nurse L, CNA N, CNA O, MA Q, CNA R, Housekeeper T, Housekeeper U, CNA V, [NAME] W, [NAME] X, MA, Z, CNA AA, and CNA BB. All staff were able to identify the following: - The different types of abuse. - What to do if they witness resident to resident abuse. - What signs to watch for in residents to prevent resident to resident abuse/behaviors - Who to report any incidents of abuse - All staff stated there were no other residents they were aware of that were having consistent physical altercations in the facility. The Administrator was notified on 02/13/25 at 3:30 PM, the Immediate Jeopardy was removed. While the IJ was removed on 02/13/25, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #5) reviewed for ostomy care. The facility failed to assist Resident #5 with colostomy care resulting in her colostomy leaking. This failure could place the resident at risk of skin irritation and breakdown from exposure to fecal matter. Findings included: Record review of Resident #5's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting the rights side of her body, legal blindness, and rectal cancer requiring the creation of a colostomy (opeing in the intestines to allow feces to drain into a bag). Record review of Resident #5's quarterly MDS, dated [DATE] reflected a BIMS score of 10 indicating she was moderately cognitively impaired. Her Functional Status reflected she required set-up and clean up assistance with her toileting hygiene. Her Bowel and Bladder assessment indicated she had an ostomy. Record review of Resident #5's care plan, dated 12/22/24, reflected she had a visual impairment related to being legally blind, and ADL self-care deficit related to paralysis, and had an ostomy. Interview on 02/11/25 at 9:50 AM with Resident #5 revealed she often had to change her briefs because the staff took too long to respond to her call light. Resident #5 stated she thought staff knew if they waited, she would do it herself. She stated she did need staff assistance to make sure she was completely clean, and she needed assistance with applying her colostomy bag to make sure it was on properly to prevent it leaking. Resident #5 stated in the evening on 02/07/25 her colostomy bag was leaking, and she was trying to clean up with her wipes. She stated CNA B answered her call light and told her he would have to get the nurse to help her. She stated LVN A came to the resident's room and told her she could not help the resident because she was the only nurse monitoring the evening meal in the dining area. She stated LVN A put a new colostomy bag on the resident's overbed table and left. Resident #5 stated she waited for about 20 minutes, and no one came to help her, so she applied the bag herself and cleaned herself up. She stated she must not have applied it correctly because later that evening the bag began to leak again. She stated a nurse from the night shift helped her secure the bag properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455819	A. Building B. Wing	02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Heights Health and Rehabilitation Center	4825 Wellesley St Fort Worth, TX 76107

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/11/25 at 3:25 PM with LVN A revealed she was called to Resident #5's room by CNA B from the dining area where she was monitoring the evening meal. LVN A stated Resident #5 told her she needed a new colostomy bag, so she put one on the resident's table. LVN A told her she could not help because she had to get back to the dining area. LVN A stated there was a second nurse on the hall, who was supposed to care for the residents, while she was in the dining area. LVN A stated she did not notify the other nurse that Resident #5 needed help. LVN A stated she did not follow-up with Resident #5 when she returned from the dining area. Interview on 02/11/25 at 3:28 PM with LVN C revealed she had not been made aware of Resident #5 needing assistance with her colostomy. She stated LVN A never had a conversation with her on 02/07/25, and the interview with the surveyor was the first she time she had been made aware of the situation. Interview on 02/12/25 at 10:35 AM with the DON revealed his expectation of the nurses would be if they could not assist a resident right away, they should have a conversation with their teammate and ask them to assist the resident. He stated that was why they had two nurses on the hall. The DON stated skin exposure to fecal matter could quickly lead to skin irritation and skin breakdown. Record review of the facility's Ostomy Care policy, dated 2003, reflected: .Goals 1. The resident will maintain continuous or intermittent drainage via bowel diversion without complications. 2. The resident will complete/receive correct and proper care of stoma, skin, and collection procedures. 3. The resident will be maintaining optimal skin integrity at stoma site. .18. Persistent leakage or poorly fitted appliances can cause injury to the stoma and skin breakdown