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	07/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to develop a care plan for Resident #1's Foley catheter. This failure placed resident at risk of not receiving appropriate care. Findings included:Record review of Resident #1's MDS dated [DATE] reflected the resident was [AGE] year-old male admitted to the facility on [DATE] and discharged [DATE]. The MDS reflected Resident #1's cognition was intact with a BIMS score of 15, and his diagnoses included quadriplegia (a condition characterized by the loss of function or paralysis in all four limbs and sometimes the torso), neurogenic bladder (a dysfunction that results from interference with the normal nerve pathways associated with urination), and Stage 2 pressure ulcer of the right buttock (a shallow open wound, where the skin has broken down, revealing the dermis (the second layer of skin). The MDS reflected the resident was dependent upon staff for toileting hygiene, and he had a catheter for the entire 7 days of the assessment. Record review of Resident #1's care plan, dated 05/16/25, reflected it did not address the resident's Foley catheter.Record review of Resident #1's physician orders, dated 05/09/25, reflected there were no physician orders addressing the resident's Foley catheter.Record review on 07/15/25 at 11:07 AM of the Nurse Practitioner Notes, dated 05/21/25, reflected: ensure catheter securement device is in place to prevent pressure. Interview on 07/15/25 at 1:40 PM, LVN A revealed Resident #1 had been a resident at the facility for over a month. She stated she was aware the resident had a Foley catheter, but she was not sure of the orders to change the Foley catheter. She stated she knew he had once gone to be seen by the urologist, but she did not document any notes. She stated she remembered Resident #1 telling her his Foley catheter was changed at the doctor's office. LVN A further stated staff was aware of Foley catheter care, which consisted of emptying the catheter bag each shift and cleansing the catheter even if it had not been cared planned. She stated it was the responsibility of the ADON and DON to care plan the Foley catheter for Resident #1. Interview attempted via telephone on 07/15/25 at 3:24 PM with Resident #1; however, the attempt was not successful. Interview on 07/15/25 at 4:36 PM, the Regional Compliance Nurse revealed it was the nurse's responsibility to initiate a baseline care plan upon a resident's admission. She stated she and the interdisciplinary team were responsible for updating care plans, since the facility did not have a Director of Nursing. She stated the interdisciplinary team was responsible for initiating care plans according to their disciplines. She stated to have a Foley catheter care planned there were supposed to be orders and assessments in the resident's record, and they were missed from admission. She stated she was supposed to have followed up to ensure the care plans were updated, but the care plan was missed. She stated the purpose of the care plan to ensure continuity of care.Record review of the facility's current, undated Comprehensive Care Planning policy, reflected:Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goal, and address the resident's medical, physical, mental and psychosocial needs. Comprehensive care Plans will be: -Developed within 7 days after completion of the comprehensive assessment.Prepared and /or contributed to by an interdisciplinary that includes, but is not limited to: -a. The Attending Physician.b. A Registered Nurse who has responsibility for the resident.c. A member of food and nutrition services staff.d. The Social Services Worker responsible for the resident.e. To the extent practicable, the participation of the resident and the resident's representative.f. Nursing assistants responsible for the resident's care.k. Other appropriate staff or professional or professional in discipline as determined by the resident's needs or as requested by the resident .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who enters the facility with an indwelling catheter receives appropriate treatment and services for 1 of 3 (Resident #1) reviewed for catheters.The facility failed to obtain physician orders to address the treatment and services that were to be provided to care for Resident #1's Foley catheter.The failure placed residents at risk for catheter complications and infection. Findings included: Record review of Resident #1's MDS dated [DATE] reflected the resident was [AGE] year-old male admitted to the facility on [DATE] and discharged [DATE]. The MDS reflected Resident #1's cognition was intact with a BIMS score of 15, and his diagnoses included quadriplegia (a condition characterized by the loss of function or paralysis in all four limbs and sometimes the torso), neurogenic bladder (a dysfunction that results from interference with the normal nerve pathways associated with urination), and Stage 2 pressure ulcer of the right buttock (a shallow open wound, where the skin has broken down, revealing the dermis (the second layer of skin). The MDS reflected the resident was dependent upon staff for toileting hygiene, and he had a catheter for the entire 7 days of the assessment. Record review of Resident #1's care plan, dated 05/16/25, reflected it did not address the resident's Foley catheter.Record review of Resident #1's physician orders, dated 05/09/25, reflected there were no physician orders addressing the resident's Foley catheter.Record review on 07/15/25 at 11:07 AM of the Nurse Practitioner Notes, dated 05/21/25, reflected: ensure catheter securement device is in place to prevent pressure. Interview on 07/15/25 at 1:40 PM with LVN A revealed Resident #1 had been a resident at the facility for over a month. She stated she was aware he had a Foley catheter, but she was not sure of the orders to change the Foley catheter. She stated it was the admitting nurse's responsibility to put orders in and other nurses to notify the doctor if the orders were missing. She stated she had not noticed the Foley catheter orders were missing. She stated failure to have orders could result in the resident missing care and could cause infection. She stated she had done in-service training on documentation of orders, but she could not remember when.Interview on 07/15/25 at 3:18 PM with the Regional Compliance Nurse revealed her expectation was that the admitting nurse would ensure the orders were put in the electronic records system. She stated it was her responsibility and the ADON to follow-up the next morning and ensure all orders were correct, accurate, and entered on the MAR and TAR. She confirmed the orders were missed. She stated the facility failed to follow-up with the primary physician to get the Foley catheter orders from admission, since he did not come with Foley orders on his discharge orders. She stated failure to have orders could lead to the resident missing care like having his Foley catheter changed. She stated Foley catheters were only changed as needed or as instructed by the physician. She stated the facility had done training regarding the documentation of orders, but she did not provide evidence of the training. Interview with the ADON on 07/15/25 at 4:22 PM revealed it was her responsibility to follow-up on admissions and ensure the orders were correct. She stated she was also supposed to follow-up when there was a new order. She stated the orders for the resident's Foley catheter were missed. The risk of not having a physician order for the Foley catheter care was that it could lead to infection.Record review of the facility's Physician's Orders policy, dated 2015, reflected: Nurse will review the order and if needed contact the prescriber for any clarification.