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	09/26/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review the facility failed to incorporate the recommendations from the Preadmission Screening and Resident Review (PASARR) Level II determination and the PASARR evaluation report for 8 (Residents #2, #3, #15, #23, #29, #39, #62, #71) of 10 residents reviewed for PASARR assessments. The facility failed to submit a Nursing Facility Specialized Services (NFSS) form request by the specific deadline for Residents #2, #3, #15, #23, #29, #39, #62, and #71. This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included: Review of Resident #2's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #2's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected a BIMS of 06 indicating severe cognitive impairment. Resident #2 had diagnoses of anxiety disorder (significant and uncontrollable feelings), Depression (mental state of low mood), and Schizophrenia (mental disorders of hallucinations, delusions, disorganized thinking, and behavior). Review of Resident #2's care plan revealed she has a Mental Illness & Intellectual Disability Diagnosis and was PASRR positive. Diagnoses of Schizophrenia, Schizoaffective Disorder, Major Depressive Disorder, Developmental Disorder of Scholastic Skills. Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included Specialized Services of Habilitation Coordinator, Physical Therapy and Occupational Therapy will be provided per Local Authority recommendations. [DATE] Local Authority Representative here in the facility will add Customized Manual Wheelchair and also Pressure Reducing Mattress (seat cushion and back support). Will continue with Physical Therapy & Occupational Therapy. Local Authority will be invited annually to the care plan meeting for review of Specialized Services. Review of Resident #3's face sheet, dated [DATE], reflected a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected a BIMS of 11 indicating moderate cognitive impairment. Resident #3 had a diagnoses of anxiety disorder (significant and uncontrollable feelings), Psychotic Disorder (severe mental disorders that cause abnormal thinking and perceptions), and Schizophrenia (mental disorders of hallucinations, delusions, disorganized thinking, and behavior), Intellectual Disabilities (learning disability formally known as mental retardation). Review of Resident #3's care plan revealed he has a diagnosis of Intellectual Disability and was PASRR positive. Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included Quarterly PASRR meeting held. Will continue with Habilitation Coordinator and Resident to be placed on Physical Therapy services. Specialized Services, Habilitative Services, will be provided per Local Authority recommendations. Local Authority will be invited annually to the care plan meeting for review of Specialized Services. Review of Resident #15's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #15's most recent Comprehensive MDS (Minimum Data Set) Assessment, dated [DATE], reflected she had a BIMS of 04 indicating severe cognitive impairment. Resident #15 had diagnoses of Non-Traumatic Brain Dysfunction (injuries caused by internal factors), anxiety disorder (significant and uncontrollable feelings), Major Depressive Disorder (clinical depression), Pseudobulbar Affect (uncontrollable episodes of crying or laughing). Review of Resident #15's care plan revealed she has a Diagnosis of Intellectual Disability and was PASRR positive. Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included [DATE] PASRR here for Resident's Quarterly meeting/review. Specialized Services of Occupational Therapy with a specialized wheelchair will be provided per Local Authority recommendations. Local Authority will be invited annually to the care plan meeting for review of Specialized Services. Review of Resident #23's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #23's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected she had a diagnoses of Anxiety Disorder (significant and uncontrollable feelings), Depression (mental state of low mood), Bipolar Disorder (mental disorder by periods of depression and periods of abnormally elevated mood), Psychotic Disorder (mental illness that cause a person to lose touch with reality), Schizophrenia (mental disorder by hallucinations, delusions, disorganized thinking and behavior), Mental Disorder (mental illness or psychiatric disability). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's care plan revealed she has diagnoses of Mental Illness, Intellectual Disability and was PASRR positive. Diagnoses of Schizoaffective Disorder, Bipolar II Disorder, Psychosis, Developmental Disorder of Scholastic Skills, Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included Specialized Services Habilitation Coordinator and Therapy Services will be provided per Local Authority recommendations. [DATE] Local Authority Representative here in the facility discussed that will continue with Habilitation Coordinator and Physical Therapy. Local Authority will be invited annually to the care plan meeting for review of Specialized Services. Review of Resident #29's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Review of Resident #29's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected she had a BIMS of 08 indicating moderate cognitive impairment. Resident #29 had diagnoses of Schizophrenia (mental disorder by hallucinations, delusions, disorganized thinking, and behavior), borderline personality disorder (emotionally unstable personality disorder), Mild Intellectual Disabilities (learning disability formerly mental retardation). Review of Resident #29's care plan revealed she has diagnoses of Mental Illness, Intellectual Disability and was PASRR positive. Diagnoses of Schizoaffective Disorder, Borderline Personality Disorder, Mild Intellectual Disabilities, Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included PASRR here for Resident's Quarterly meeting. Resident to continue Physical Therapy, Occupational Therapy, Habilitation Coordinator, and Independent Living Services. Resident will be receiving therapy and Habilitation Coordinator services. Specialized Services, and Resident is on ILS and Habilitative Services which will be provided per Local Authority recommendations. Review of Resident #39's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #39's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected she had a diagnosis of Moderate Intellectual Disabilities. Review of Resident #39's care plan revealed she has diagnoses of Mental Illness, Intellectual Disability and Developmental Disability and was PASRR positive. Diagnoses of Scholastic Skills, Mental Disorder, Schizoaffective Disorder, Moderate Intellectual Disability, Personality Disorder, Psychosis, Major Depressive Disorder. Goal included resident will have specialized services recommended by local authority per PASRR. Specialized Services program as needed. Interventions included [DATE] PASRR here for Resident's Quarterly review. Resident to remain on Physical Therapy, Occupational Therapy and Habilitation Coordinator services. Specialized Services Habilitation Coordinator and Physical Therapy will be provided per Local Authority recommendations. [DATE] Local Authority Representative here in the facility Discussed that will continue with Habilitation Coordinator and Physical Therapy. Local Authority will be invited annually to the care plan meeting for review of Specialized Services Review of Resident #62's face sheet, dated [DATE], reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #62's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected she had a BIMS of 02 indicating severe cognitive impairment. Resident #62 had diagnosis of Intellectual Disabilities (learning disability formerly mental retardation). Review of Resident #62's care plan revealed she has diagnosis of Intellectual Disability and was PASRR positive. Goal included resident will have specialized services recommended by local authority per PASRR Specialized Services program as needed. Interventions included Specialized Services will be provided per Local Authority recommendations. Local Authority will be invited annually to the care plan meeting for review of Specialized Services Review of Resident #71's face sheet, dated [DATE], reflected a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #71's most recent Quarterly MDS (Minimum Data Set) Assessment, dated [DATE], reflected he had a BIMS of 08 indicating moderate cognitive impairment. Resident #71 had diagnosis of Intellectual Disabilities (learning disability formerly mental retardation). Review of Resident #71's care plan revealed he has diagnosis of Intellectual Disability and was PASRR positive. Goal included resident will have specialized services recommended by local authority per PASRR Specialized Services program as needed. Interventions included [DATE] PASRR here for Resident's Quarterly review. Resident to remain on Physical Therapy, Occupational Therapy, Habilitative Coordinator, and Independent Living Services. Specialized Services Occupational Therapy and Physical Therapy will be provided per Local Authority recommendations. Local Authority will be invited annually to the care plan meeting for review of Specialized Services Request for Residents #2, #3, #15, #23, #29, #39, #62, #71's NFSS forms revealed forms were not available. In an interview on [DATE] at 3:55 PM the Director of Rehabilitation stated she was hired mid [DATE]. The Director of Rehabilitation stated she had not been formally trained on the PASRR process however, she was responsible for filling out the NFSS forms, placing them in a box for the physician to sign, and after she got them back with the physician's signature she would then give the forms to the Administrator. The Director of Rehabilitation stated after the Administrator signed and reviewed the forms she would contact her supervisor, the Regional Operations Director, to let her know the forms were ready to upload along with the evaluations. The Director of Rehabilitation stated she was not sure how to upload the documents in the portal and that she had not been trained to do so, therefore her supervisor (Regional Operations Director) would ensure the forms were uploaded to the portal in a timely manner. The Director of Rehabilitation stated once the documents were uploaded, she would get an email from her supervisor to reflect which forms had been uploaded. According to the Director of Rehabilitation not getting the forms uploaded in a timely manner would place resident at risk of not getting the desired PASRR services. Record review of an email dated [DATE] reflected the Regional Operations Director emailed the Local Authority. The email revealed I am trying to help staff get PASSR up and going at the facility. I had some submitted prior and the Medicaid number failed. I also had some that were submitted as restart and should have been recertification. We have a new director at this site, and we are trying to get them completed. The original email was sent to the wrong person, and I was notified of the meeting today. I will be working on getting these corrected and up to date. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an email dated [DATE] reflected the Local Authority responded to the Regional Operations Director. The email revealed, Since the authorizations have mostly been expired, you will need to do all the NFSS forms as NEW and start from the very beginning. It is recommended to do the recertifications about a month to two weeks BEFORE the expiration of the authorizations to ensure there is no lapses in the coverage dates. Since we are having PASRR meeting tomorrow, [DATE] you will have 20 business days to submit the services (NEW NFSS forms)- so that would make it a [DATE]th, 2024, deadline. 1. Resident #3 - Habilitation Coordinator and Physical Therapy 2. Resident #39 - Physical Therapy 3. Resident 71 - Physcial Threapy and Occupational Therapy 4. Resident #29 - needed services of Physical Therapy, Occupational Therapy and Speech Therapy 5. Resident #15 - Physical Therapy, Occupational Therapy, and Speech Therapy 6. Resident #62 - Physical Therapy and Occupational Therapy 7. Resident #2 - needs a customized manual wheelchair, Physical Therapy, Occupational Therapy 8. Resident #23 - Physical Therapy and Occupational Therapy. In an interview on [DATE] at 4:16 PM with the Regional Operations Director, she stated the Director of Rehabilitation was fairly new to the position, so she was responsible for ensuring NFSS documents were uploaded to the portal after they were filled out and signed by the physician and Administrator. The Regional Operations Director stated for some time there was an Interim Director of Rehabilitation at the facility and thought the documents from the [DATE] meeting may have gotten lost. The Regional Operations Director stated by the time she received the notice that they missed the deadline to upload the documents it was too late, and the forms were past due. She stated she did upload the documents to the portal once she found out, however, several documents were with errors, so they were kicked back. The Regional Operations Director stated she was currently working with the Local Authority to correct the errors and get the documents uploaded as quickly as possible. Regional Operations Director stated she did not see a risk to the residents as their services were going and they did not have a lapse in services. The Regional Director of Operations stated the Director of Rehabilitation was responsible for ensuring the NFSS documents were uploaded to the portal. Interview and record review on [DATE] at 4:30 PM with the Regional DON revealed she was not aware the PASARR forms for Residents #2, #3, #15, #23, #29, #39, #62, and #71 were late. Record review of the portal revealed the NFSS forms were not uploaded, and she could not clearly identify the last time they had been uploaded to the portal. The Regional DON said the purpose of submitting the forms on time was so that the resident had access to the agreed upon services. The Regional DON said she was not sure why the forms were late however she would speak with the Director of Rehabilitation who was responsible for uploading the NFSS forms to make sure they were submitted as soon as possible. In an interview on [DATE] at 4:45 PM with the DON revealed the facility did not have a PASARR policy that covered PASRR positive policy and procedures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 6 residents (Residents #13 and Resident #63) reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #13's care plan was revised to include her pleasure feedings. 2. The facility failed to ensure Resident #63's care plan was revised to include his dialysis treatment. This failure could place residents at risk of not having their individual needs met, not receiving necessary care and services, and a decreased quality of life. Findings included: 1. Record review of Resident #13's Face Sheet, dated 09/26/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #13's quarterly MDS assessment, dated 09/24/24, reflected her diagnoses included metabolic encephalopathy (brain dysfunction), hypertension (high blood pressure), Alzheimer's disease (brain disorder), seizure disorder, paroxysmal atrial fibrillation (irregular heartbeat), reduced mobility. Resident #13's BIMS score was not completed due to resident being rarely/never understood. The MDS further revealed Section K - Nutritional Approaches were feeding tube. Record review of Resident #13's physician order dated 02/02/24, reflected Regular diet, Pureed texture, Nectar consistency, pleasure feeds. Record review of Resident #13's care plan, revised date 07/13/24, reflected Focus: [Resident #13] requires tube feeding r/t Dysphagia, Swallowing problem. Goal: The resident will remain free of side effects or complications related to tube feeding through review date. Interventions: The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. The care plan does not address pleasure feedings. Observation on 09/24/24 at 11:06 AM revealed Resident #13 lying in bed sleeping. Observed a feeding pump next to Resident #13's bed, infusing. A bag of enteral feeding was hanging from the pole of the feeding pump with a date of 09/23/24, time 9:00 PM, rate of 60 ml/hr. Observation on 09/25/24 at 12:15 PM revealed Resident #13 was being fed by CNA E. Resident #13 was observed eating her lunch which consisted of puree texture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 12:37 PM with LVN F revealed Resident #13 had a g-tube and was on continues feedings. She stated Resident #13 also received pleasure feedings. She stated they had an order for pleasure feedings. LVN F stated she was unaware if Resident #13's pleasure feedings were care planned. LVN F reviewed Resident #13's care plan and stated the pleasure feeding was not care planned. She stated pleasure feedings should be cared plan so that staff knew what interventions were in place. She stated it was the responsibility of the DON to update care plans. Interview on 09/26/24 at 1:03 PM with the MDS Coordinator D revealed the MDS Coordinators were responsible for updating care plans. She stated anything that was triggered in the resident's MDS should be care planned and care plans were updated quarterly or as needed. The MDS Coordinator D stated if a resident had an order for pleasure feedings the resident's care plan should be updated. She stated she was unaware Resident #13 was not care planned for pleasure feedings. She stated the risk of not care planning pleasure feedings would be staff not knowing the interventions. 2. Record review of Resident #63's admission record, dated 09/26/24, revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included end stage renal disease, type two diabetes mellitus with diabetic chronic kidney disease, metabolic encephalopathy, dependence on renal dialysis, and congestive heart failure. Record review of Resident #63's undated orders revealed, May go to Dialysis on MWF Chair time 3pm . and Dialysis Every Mon-Wed-Fri. Record review of Resident #63's most recent quarterly MDS assessment, dated 09/18/24, revealed he had a BIMS score of thirteen, which indicated the resident was cognitively intact. Record review of Resident #63's care plan on 09/26/24 revealed no indication that the resident received dialysis. Observation and interview on 09/26/24 at 10:35 AM with Resident #63 revealed that the resident went to dialysis three times per week on Monday, Wednesday, and Friday. Interview with CNA A on 09/26/24 at 10:42 AM revealed she read the part of the electronic health record accessible to the direct care staff that mirrors the resident's care plan. CNA A stated that it was important to read this part of the EHR because it told her how to provide specific care to each resident. CNA A said that if she didn't read this, then she would not know how to handle the resident, and the resident could get hurt. Interview on 09/26/24 at 11:53 AM with the MDS Coordinator D revealed the importance of an updated, correct care plan was continuity of care for the resident. The MDS Coordinator D also stated Resident #63's dialysis was not in his care plan as it should have been. The MDS Coordinator D did not recall if Resident # 63 was admitted on dialysis. The MDS Coordinator D continued and said that the resident was at risk for fluid volume deficit if direct care does not monitor and document the resident's urine output. The MDS Coordinator D also revealed that it was her responsibility to update Resident #63's care plan with any changes and that they should been updated quarterly. The MDS Coordinator D also stated that she was last in-serviced about two months ago from her corporate supervisor about the MDS Coordinator's responsibility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/26/24 at 1:32 PM with the DON revealed everybody was responsible for care plans. The DON stated that everything should be care planned to include pleasure feedings, and dialysis. The DON stated it was not just the responsibility of the MDS Coordinator to complete care plans but everyone. She stated everyone was responsible for overseeing care plans and updating them. The DON stated that if the residents had incorrect or incomplete care plans, the staff would not know how to provide needed care to the residents. Record review of the facility's current, undated Comprehensive Care Planning policy reflected the following: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. 48236

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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** 44937 Based on observations, interviews, and record reviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Residents #25) of five residents reviewed for ADL care. The facility failed to provide Resident #25 assistance with timely incontinence care. The failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: 1. Record review of Resident #25's face sheet, dated 09/26/24, indicated Resident #25 was a [AGE] year-old male, admitted to the facility on [DATE], and readmitted on [DATE]. Record review of Resident #25's admission MDS assessment, dated 09/05/24, revealed Resident #25's BIMS score was 11 indicating his cognition was moderately impaired. Resident #25 required substantial/maximal assistance with toileting. Resident #25 was dependent on staff for shower/bathing and personal hygiene. Resident #25 was at risk of pressure ulcer/injuries. Diagnoses included Cerebrovascular Accident (Stroke), Hemiplegia (weakness of one entire side of the body) following stroke to right dominate side, muscle weakness. Record review of Resident #25's care plan, undated, indicated Resident #25 had ADL self-care performance deficit related to right side weakness and immobility. Goal: Resident will remain maintain current level of function. Interventions included: Resident #25 required extensive assistance by 2 staff for incontinent care. Resident #25 has bowel incontinence related to right side weakness and immobility. Goal: Resident will have less than 2 episodes of incontinence per day. Interventions included: Check resident every 2 hours and assist with toileting as needed. Provide pericare after each incontinent episode. Resident had functional bladder incontinence related to stroke and immobility. Goal: Resident will remain free from skin breakdown due to incontinence and brief use. Interventions: Incontinent - check every 2 hours and as needed for incontinence. Wash, rinse, and dry perineum. Change clothing as needed after incontinence episode. Have call light within easy reach. Interview and observation on 09/24/24 at 12:13 PM with Resident #25 revealed he was in bed, and the room was free of odors. Resident #25 stated he had concerns with his care. Resident #25 stated he had been up since 6:00 AM this morning, with a brief change at 4 AM. Resident #25 stated I haven't had another change since then and it is now 12:15 PM. Resident #25 stated staff had not come in to provide incontinent care. When asked if he was wet and needed to be changed, Resident #25 looked at surveyor and responded Yes, of course I'm wet. Resident #25 activated his call light, and LVN F answered the call light. (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 09/26/24 at 9:25 AM Resident #25 stated his last brief change was at 4:00 AM this morning, and staff had not been in to check on him during 6:00 AM-2:00 PM shift. Resident #25 stated he was checked on at 1:00 AM or 2:00 AM and the last change was 4:00 AM this morning. Resident #25 stated that he was currently wet and needed to be changed. Observation on09/26/24 at 9:43 AM of incontinent care for Resident #25 with CNA H and LVN I revealed staff to remove soaked, wet blankets, a gown, a bed pad and a bottom sheet which left the mattress wet and prompted a smell of heavy urine. Interview on 09/26/24 at 10:11 AM with CNA H, she stated she worked 6:00 AM-2:00 PM shift Monday-Friday. CNA H stated Resident #25 was total care assisted by 2 staff with incontinent care. CNA H stated she checked Resident #25 during morning rounds about 7:40 AM and he was not wet. CNA H stated she rounded on him every 2-3 hours on Tuesdays and Thursdays, and that on her busier days which were Mondays, Wednesdays, and Fridays she rounded less frequently. CNA H stated she was responsible for completing incontinent care for Resident #25, to ensure he was dry to prevent skin irritation. According to CNA H she knew to provide incontinent care every 2 hours and as needed. When asked about her morning routine and why Resident #25 was not getting changed during morning rounds, CNA H stated when she checked with him, he was dry. CNA H stated she was alerted by the nurse on 09/24/24 that Resident #25 wanted to be changed. CNA H stated during both brief changes, on 09/24/24 and 09/26/24 that Resident #25 was soaked down to his mattress. Interview on 09/26/24 at 10:22 AM with LVN I revealed her expectation was for CNAs to do proper care, to check and change residents to ensure residents were clean and dry. LVN I stated CNAs were responsible to check on residents every 2 hours and to alert her if they need help or were not able to complete rounds. LVN I stated she observed Resident #25 was soaked down to his mattress, and this was not ok, LVN I stated this placed Resident #25 at risk for skin breakdown, pressure ulcer, and skin damage. LVN I stated when CNAs arrive for their 6am shift they should be rounding residents to ensure they are clean and dry prior to breakfast and every 2 hours after that. Interview on 09/26/24 at 1:39 PM LVN F stated when she answered Resident #25's call light Resident #25 expressed to her that he was wet and needed to be changed, and that staff had not changed him since 4:00 AM. LVN F stated she was not working the hall, however she stopped to answer the light. LVN F stated she alerted aide CNA H to come and change Resident #25. LVN F stated she did not return to see if Resident #25 had been changed. LVN F stated she expected CNAs to check and change residents at least every two hours, not doing so placed residents at risk of bedsores and skin break down. Interview on 09/26/24 at 1:20 PM with the DON revealed she was not alerted to Resident #25 being soaked during incontinent care observation. The DON stated CNAs were responsible for doing rounds on residents to ensure they were clean and dry and that nurses were responsible to ensure CNAs were completing their tasks. According to the DON not changing Resident #25 placed him at risk of skin breakdown, infection, and pressure sores. Review of facility policy provided titled Perineal Care Male last revised on 12/08/09 reflected: Purpose: To clean the male perineum without contaminating the urethral area with germs from the rectal area. (continued on next page)

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	455819	A. Building B. Wing	09/26/2024

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy revealed an outlined procedure for cleaning the perineum and buttocks after an incontinence episode. The policy included equipment and procedure to be used during incontinence care.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 (Resident #81) of 2 residents reviewed for intravenous fluids. The facility failed to ensure Resident #81's intravenous medication bag and tubing were labeled with the date, time, and initials. The facility failed to ensure Resident #81 received timely PICC line (used to deliver medications and other treatments directly to the large central veins near heart) dressing change. Resident #81 went without a dressing change for 8 days. The failures could affect residents by placing them at risk for infections and cross-contamination and at risk for medication error, and delay in medication administration. Findings included: Review of Resident #81's entry MDS assessment, dated 09/24/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses including which included: Pneumonia, (lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe). Resident #81 had intact cognition with a BIMS score of 14. She had intravenous access. Review of Resident #81's physician's orders dated 09/18/24 reflected: (Cubicin solution reconstituted 500mg (Daptomycin)use 600 milligrams intravenously every 48hours for infection until 10/02/2024). There were no orders for PICC line dressing changes and flushes. Review of Resident #81's Treatment Administration Records dated for September 2024 revealed there was no documentation of any PICC line dressing changes or in the progress notes. Review of Resident #81's current care plan initiated 09/23/24 revealed IV medication was addressed with a goal of not having any complications. Interventions included monitoring for signs and symptoms of infection at the insertion site. The care plan addressed PICC line dressing changes every 7 days and as needed. The care plan was completed before the entrance date. Observation and interview on 09/24/24 at 11:00 AM revealed Resident #81 was in her room, lying in bed. She was observed to have a PICC line dressing dated 09/16/24, intact but looked dirty on the surface. The intravenous medication bottle was hanging on the pole. The IV bag and the tubing were not labeled with the date, time, and initials to indicate when it was hung. Resident #81 stated the peripherally inserted central catheter dressing was put on at the hospital the facility had not changed it. Observation of Resident #81 on 09/24/24 at 12:47PM with LVN B revealed the resident had a PICC line in the right upper arm covered with a transparent dressing dated 09/16/24 and the bag and the tubing were not dated. The dressing was dated 09/16/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 12:47 PM with LVN B revealed she hung the bag that was currently infusing. LVN B said the IV bag was supposed to have the correct resident's name, date, time and initials of the nurse administering the medications. She stated she was aware she was supposed to label the bag and the tubing, so other staff were aware when the bag was hung, to prevent omission of a dose or overdose but she did not. She stated she was new in the facility, and it was her first time working in a nursing facility. She stated failure to label the bag, the tubing and change the dressing could lead to overdose, omission of a dose and infection control. LVN B stated she was aware the dressing was supposed to be changed 7-10 days and she was not sure of the facility policy, and she did not have no orders for changing the dressing. She said she had not done training on intravenous medication administration. Observation/Interview on 09/25/24 at 12:05PM with LVN C revealed the PICC line remained in the resident's right upper arm and the dressing was dated 09/16/24. LVN C revealed she had flushed the PICC line in the morning of 09/25/24. She said she had checked the site for infection and bleeding and the site was okay. She stated she saw it was dated 09/16/24 and it was past changing time because they were supposed to change every seven days. She stated the dressing was dirty and she was supposed to have changed it when she noticed but she did not. LVN C stated failure to change the dressing on time or when it is dirty could lead to infection. She stated she was the one that admitted Resident #81 and she was supposed to put orders for dressing changes and PICC line flushes, but she forgot. She stated management was supposed to check the orders after the nurses and ensure none were missing but they did not because Resident #81 did not have orders for a dressing change. She stated she had done training on IV administration and skills checks. Interview on 09/25/24 at 12:15 PM with the DON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous medications and to change the dressing every seven days to prevent infection and medication error. She stated the admitting nurse was supposed to put the orders on the medication administration record, but she did not, and she was not aware. She stated it was the responsibility of the DON and the ADON to check after the nurses and ensure all orders were in place. She stated the facility had standard orders for dressing changes and flushes. She stated she had checked with the ADON whose last day was 09/20/24 and he had assured the DON he had checked all the orders for new admissions, and they were up to date. She stated she had done training with staff on labeling and putting initials on bags and tubing and on dressings. Review of the facility training record reflected skill checks and certifications regarding IV therapy competency on 03/15/24.The training reflected: remember to date, initial and time all tubing's and medication and LVN C attended the training. Review of the facility's current, undated Medication, intravenous infusion undated policy, reflected the following: Dressing changes will be completed to maintain sterility of the insertion site and allow for inspection of insertion site as follows: 1. Clear dressing should be changed every week with physician orders. .7. Record the drug name, dose, rate, date, and time the drug was added on the container label .

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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** 42859 Based on observation, interview, 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 on 1 of 4 medication carts (100 Hall medication aide cart) and 2 of 2 residents (Residents#36 and #57) reviewed for pharmacy services. The facility failed to ensure the 100 Hall medication aide medication cart contained accurate narcotic logs for Residents #36 and #57. These failures could place residents at risk for medication error, drug diversion, and delay in medication administration. Findings included: 1. Review of Resident# 36's Quarterly MDS Assessment, dated 08/08/24, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included encounter for palliative care. The resident had severe impaired cognition with a BIMS score of 3. She received scheduled pain medication regimen. Review of Resident #36's physician's orders dated 7/13/24 reflected an order for the resident to receive one tablet of Hydrocodone 10 mg/acetaminophen 325 mg (pain medication) by mouth every six hours. 2. Review of Resident# 57's Quarterly MDS assessment, dated 07/23/24, reflected the resident was [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included pain. The resident had severe cognitive impairment with a BIMS score of 0. Review of Resident #57's physician's orders dated 07/31/24 reflected an order for the resident to received Tylenol with codeine #3 tablet 300-30mg (acetaminophen-codeine 1 tablet by mouth three times a day for Pain. Observation and record review on 09/25/24 at 12:58 PM, of 100 hall MA's medication cart and the narcotic administration record, with MA G, revealed the following: Resident #36's Narcotic Administration Record sheet for hydrocodone-acetaminophen 10-325 mg was last signed off on 09/24/24 for one-tablet dose given at 8:00 PM, for a total of 13 pills remaining, while the blister pack count was 11 pills. Resident #57's Narcotic Administration Record sheet for Tylenol with codeine #3 tablet 300-30mg was last signed off on 09/24/24 for a one-tablet dose given at 7:00 PM for a total of 102 pills remaining while the blister pack count was 101 pills. (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 MA G on 09/25/24 at 1:06 PM revealed she administered oxycodone 10-235 mg 1 tablet to Resident #36 two times at 7:00 AM and 12:00 PM and Tylenol with codeine #3 tablet 300-30mg 1 tablet to Resident #57 at 7:00 AM and she had not signed off on the narcotic administration record log. She stated she gave the residents the medication, but she forgot to sign off on the narcotic administration log. She stated she knew she was supposed to sign-out on the narcotic count sheet after administration and on the Medication Administration Record, but she did not. She stated failure to log off would cause the narcotic count to show less on the next count, and it could lead to medication error. She stated she had done an in-service on medication administration. Interview on 09/26/24 at 2:27 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. The DON stated failure to document could lead to discrepancy and adverse effects. She stated it was her responsibility to perform random checks on the medication carts, and she stated she had checked two weeks ago. She stated she had done training of staffs on narcotic logs documentation. Review of the facility trainings reflected in-services on all narcotics needed to be signed as staff gave them on 03/31/24. MA G attended the training. Review of the facility's current Medication Administration procedures policy, dated October 2017, reflected: .5. After the resident has been identified, administer the medications and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration.