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	12/11/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents were screened for mental illness and coordinate with the State mental health authority the need for services for 1 of 4 residents (Resident #99) reviewed for PASARR screening. The facility failed to recognize that Resident #99's PL1 was inaccurate, which resulted in the resident not being referred to the local authority for a PE. The failure placed residents with mental illness at risk of not receiving services they were entitled to receive. Findings included:Record review of Resident #99's admission MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of bipolar disorder. His BIMS score was 15, indicating he was cognitively intact. His Functional abilities assessment revealed he required substantial assistance with his ADLs. Record review of Resident #99's care plan, dated 12/14/25, reflected he had an ADL self-care deficit, he was on an anti-psychotic medication for bipolar disorder, and he had depression. Record review of Resident #99's PASRR Level 1 screening, dated 09/15/25, reflected he did not have a primary diagnosis of dementia, and there was no evidence of mental illness. Record review of Resident #99's EHR revealed no PASRR 2 assessment had been completed by the local mental health authority. Interview on 12/09/25 at 10:44 AM, Resident #99 denied any mental illness stating, I'm fine. He had no complaints about his care. Interview on 12/11/25 at 11:26 AM, MDS Coordinator A stated Resident #99 had been referred to the local mental health authority on 09/16/25 and had been evaluated by them on 12/09/25, but the resident refused services. Interview on 12/11/25 at 12:30 PM, MDS Coordinator B stated Resident #99 had not been referred to the local mental health authority. She discovered on 12/09/25 that Resident #99 had not been referred, so she initiated the referral at 12:21 PM on 12/09/25. She stated the resident's assessment was scheduled for 12/12/25. She stated the risk of not having him assessed could be him not receiving services he might qualify for. She stated she and the other MDS Coordinator were responsible for performing the MDS assessments and referring residents to the local authority if indicated. She stated she did not know why Resident #99 had not been referred for PASRR services in September 2025. She stated there had been confusion about the resident's insurance coverage, which might have contributed to him not being referred for PASRR services. Interview on 12/11/25 at 1:13 PM, RN C stated Resident #99 had no behavior issues. She stated the resident was very laid back and did not require a lot of interventions. She stated the CNAs helped him dress in the mornings, got him into his wheelchair, and he was independent after that. Record review of the facility's policy PASRR Level 1 Screen Policy, dated 03/06/19, reflected: It is the policy of [Corporate Entity] facilities to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via the portal timely per PASRR Regulatory timeframes. PASRR is a federally mandated program requiring all states to pre-screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who they live with and the training and therapy they need to live as independently as possible.

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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 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** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident medical, nursing, mental, and psychosocial needs for 2 of 20 residents (Residents #14 and #76) reviewed for care plans. 1. The facility failed to develop a care plan addressing Resident #14's nail care refusal.2. The facility failed to develop a care plan addressing Resident #76's right hand contracture. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included:1. Record review of Resident #14's quarterly MDS reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The residents' diagnoses included diabetes, seizure disorder, history of TIA (a temporary blockage of blood flow to the brain; mini stroke) and cerebral infarction (blockage of blood vessel in the brain cutting off blood flow and oxygen). The resident had a BIMS of 5 which indicated his cognition was severely impaired. Record review of Resident #14's care plan dated 11/17/25 reflected the resident had ADL self-care performance deficit. Interventions included he required supervision to limited assistance of 1 staff for personal hygiene. The care plan did not address Resident #1's refusal of care. Observation and interview on 12/09/25 at 2:46 PM of Resident #14 revealed he was in his room sitting on his bed with the covers over his head. The resident removed the covers when he was spoken to, and it was noted four of his fingernails on his right hand were about three quarters of an inch long and the nail on his thumb was short. His fingernails on his pinky and ring finger of his left hand were about one inch long, and the three other fingernails were about half an inch long. The resident was asked if his fingernails had ever been cut, to which he replied, Yes, I have people that do that. He did not provide any further information. Resident #14 was asked if he wanted his fingernails cut, and he said he did. The resident then quickly put the covers back over his head. Interview on 12/10/25 at 1:41 PM, RN C revealed she had asked Resident #14 several times if she could cut his fingernails and each time the resident refused. RN C said the resident refused most care and only friends or family could convince him to get any type of care including showers. Observation on 12/10/25 at 1:45 PM revealed RN C went into Resident #14's room. She asked Resident #14 if she could cut his fingernails. The resident said he had people that did that for him but did not elaborate on who the people were. The resident then said no and pulled the covers back over his head. RN C said she thought she had documented in the resident's progress notes his refusals to have his fingernails cut. Interview on 12/10/25 at 1:47 PM, CNA I revealed he worked with Resident #14. He stated every time he asked if he could cut the resident's fingernails or give the resident a shower, the resident refused and always pulled his covers back over his head. Interview on 12/11/25 at 1:32 PM, ADON E revealed it was normal for Resident #14 to refuse all care including having his fingernails cut. She said each time they ask the resident he will agree and when they go to provide the care Resident #14 would refuse. ADON E said it was the responsibility of ADONs, DON and MDS Coordinators to update resident care plans but the bulk of them were done by the MDS Coordinators if they are told of any resident care concerns. ADON E said she was not aware Resident #14's care refusals were not documented or care planned. ADON E further stated it was important to care plan the residents' refusals because it painted a picture of their care, so the staff knew how to care for the residents. Interview on 12/11/25 at 12:29 PM, MDS Coordinator B revealed nursing staff were responsible for updating resident care plans for any care refusals. MDS Coordinator B said she would also update the care plan if staff made her aware of any issues/concerns. MDS Coordinator B stated she was not aware of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's care refusal, which included refusing nail care. She stated it was important to keep the care plans updated, so the staff knew what the resident's current plan of care was.2. Record review of Resident #76's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old resident who admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer's dementia, other reduced mobility, and muscle weakness. The resident had a BIMS of 5 which indicated her cognition was severely impaired. Record review of Resident #76's care plan initiated on 05/07/25 did not reflect the resident had a right-hand contracture. Observation on 12/09/25 at 2:46 PM of Resident #76 revealed her right hand was contracted. The resident was asked if she could open her hand, and the resident tried but was not able to open it. There was no device in place for the right-hand contracture. Interview on 12/11/25 at 9:55 AM, LVN J stated Resident #76's right hand was contracted. LVN J stated Resident #76 did not have a device in place for contracture management because the resident would complain and pull out whatever they would put in place. LVN J said therapy worked with the resident for some time, and the resident was given a splint, but the resident would never keep it in place. Interview on 12/10/25 at 3:08 PM, the Director of Rehabilitation revealed they had worked with Resident #76's contracture. She said they had tried to put a splint in the resident's contracture, but Resident #76 would pull it out and never leave it in. Interview on 12/11/25 at 3:44 PM, ADON D revealed Resident #76 had been admitted to the facility with her right-hand contracture. ADON D said there should have been a care plan addressing Resident #76's hand contracture. ADON D stated the IDT should have noticed it during their weekly care plan meetings. ADON D did not know why it had not been caught. ADON D stated it was important to care plan the resident's contracture and its care to ensure the resident was getting the care she needed. Interview on 12/11/25 at 12:33 PM, MDS Coordinator B revealed she was not aware Resident #76's right hand was contracted. She said the resident's care plan should have reflected the contracture, care, and refusals to keep her splint in place. MDS Coordinator B said any nursing staff could update the care plan or she would do it if staff would let her know of the issue. MDS Coordinator B further stated it was important to have care plans updated so staff could follow their plan of care. Record review of the facility's undated policy titled Comprehensive Care Planning 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.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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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** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 20 residents (Resident #33) reviewed for ADLs. The facility failed to ensure Resident #33 received showers/bed baths as scheduled for the months of November 2025 and December 2025. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem.Findings included:Record review of Resident #33's annual MDS assessment, dated 10/05/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #33 had diagnoses of chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), non-Alzheimer's Dementia (brain disorder caused by damage to nerve cells in the brain), and diabetes mellitus (a chronic disease characterized by high level of sugar in the blood). He had a BIMS score of 15, which indicated his cognition was intact. Record review of Resident #33's care plan, revised 09/22/25, reflected: The resident has an ADL Self Care Performance Deficit. Goal: The resident will improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Interventions: Bathing: requires staff x1 for assistance. BATHING: Provide the resident with a sponge bath when a full bath or shower cannot be tolerated.Record review of Resident #33's November 2025 POC History reflected the resident was supposed to receive bathing/showers on Mondays, Wednesdays, and Fridays on the 6:00 AM-2:00 PM shift. It reflected: Turn in shower sheet to charge nurse during shift. In the Task section under Bathing it indicated Not applicable for Monday, Wednesday, and Friday. It was unknown if Resident #33 received a shower/bed bath or if the resident refused. Record review of Resident #33's Dember 2025 POC History reflected the resident was supposed to receive bathing/showers Mondays, Wednesdays, and Fridays on the 6:00 AM-2:00 PM shift. It reflected: Turn in shower sheet to charge nurse during shift. In the Task section under Bathing it indicated Not applicable for Monday, Wednesday, and Friday. It was unknown if Resident #33 had received any shower/bed bath or if the resident refused. Observation and interview on 12/09/25 at 10:37 AM revealed Resident #33 lying in bed. He stated he was doing well. Resident #33 stated he did not get showers, he preferred bed baths, and his days were Monday, Wednesday and Fridays. He stated the last time he received a bed bath was some day last week either Monday or Wednesday. He stated he did not get his bed baths on the days that he should. He stated when he requested a bed bath staff made an excuse and told him they were short of staff. Resident #33 denied having any skin issues. Interview on 12/11/25 at 11:06 AM, CNA K revealed she was the CNA assigned to Resident #33 today (12/11/25). She stated Resident #33's shower days were Monday, Wednesday, and Fridays during the 2:00 PM-10:00 PM shift. She stated most of the time Resident #33 refused his bed baths. CNA K stated they documented on the shower sheets and on the POC. Record review of facility shower binder located on 200 hall nurses station revealed no shower sheets for Resident #33. On 12/11/25 at 11:20 AM, ADON D was asked to provide Resident #33's shower sheets. The shower sheets were not provided prior to the survey team's exit.Interview on 12/11/25 at 1:13 PM, CNA L revealed she had been the CNA assigned to Resident #33 on the 2-10PM shift. She stated Resident #33's showers were provided during the 2:00 PM-10:00 PM shift; however, the resident did refuse his bed baths but not all the time. She stated if a bed bath was provided or if the resident refused, she documented it in the POC. She stated if the POC showed Not Applicable it meant the shower was not provided, and it did not happen. CNA L stated she had not completed any (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower sheets for Resident #33. She stated there was no potential risk to the resident. Interview on 12/11/25 at 2:49 PM, CNA M revealed she was the 2:00 PM-10:00 PM CNA assigned to Resident #33 today (12/11/25). She stated she had provided Resident #33 with bed baths. She stated she had last given him a bed bath was sometime last month, but she could not remember the date. She stated Resident #33 had complained about not receiving his showers, and she reported it to the nurse. She stated she would provide Resident #33 with a bed bath upon his request. CNA M stated she documented in the POC. She stated if the POC showed Not Applicable it meant the shower was not provided or offered to the resident. She stated the potential risk if the resident did not receive his shower/bed bath would be lack of hygiene. Interview on 12/11/25 at 3:10 PM, LVN N revealed she was the nurse assigned to Resident #33. She stated Resident #33 was provided with his bed baths during her 2:00 PM-10:00 PM shift. LVN N stated Resident #33 was provided with his bed baths on his shower days; however, at times the resident refused. She stated staff documented on the shower sheets and on the POC. She stated she was not sure why Resident #33's POC showed Not applicable. She stated there was no potential risk to the resident because he was getting his bed baths. Interview on 12/11/25 at 3:17 PM, ADON D revealed they were no longer doing shower sheets and staff should be documenting in the POC. She stated based on the POC documentation she could not prove if Resident #33 received any of his showers. ADON D stated if it was not documented it did not happen. She stated if a resident refused a shower, the CNA must notify the nurse. ADON D stated the potential risk if showers were not provided would be infections. Interview on 12/11/25 at 4:00 PM, the DON revealed as far as she knew Resident #33 was receiving his bed baths. She stated his showers days were Monday, Wednesday, and Fridays. She stated the CNAs should document the showers in the POC. The DON stated she was not sure what the CNAs were clicking on the POC to show Not Applicable. She stated based on the documentation she could not confirm if Resident #33 received any of his showers. She stated it was the responsibility of the nurses in charge and ADON to ensure showers or bed baths were being provided to the residents. She stated if a resident refused a shower, the CNA must notify the nurse. She stated the potential risk if showers were not provided would be skin breakdowns. Record review of the facility's current, undated Bedbath Complete policy, reflected the following: The complete bedbath is performed for those residents on bedrest who need total or partial assistive care. Based on bedrest status, ability for movement in bed, skin integrity, and general condition, a complete bedbath can be performed daily or alternated with a partial bedbath.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 2 residents (Resident #114) reviewed for pressure ulcer treatment.The facility failed to ensure Resident #114 received wound care for his pressure ulcers on the weekend of 12/06/25-12/07/25.This failure could place the residents at risk of Infection and worsening wounds.Findings included:Record review of Resident #114's admission MDS assessment, dated 12/05/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. The residents' diagnoses included methicillin resistant staphylococcus aureus infection (a type of staph that can be resistant to several antibiotics). Resident #114 had severe cognitive impairment with a BIMS score of 2. The MDS indicated that Resident #114 had four Stage 3 pressure ulcers that were present upon admission/entry to the facility. Record review of Resident #114's care plan, dated 12/04/25, reflected: Focus: [Resident#114] has a pressure ulcer or potential for pressure ulcer development and/or is at risk for impaired skin integrity: Right gluteal fold - pressure injury, sacrum - pressure injury, scrotum - pressure injury, left buttock - pressure injury, left right ankle - pressure injury hip - pressure injury. Goal: [Resident #114] Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN. Assess/record/monitor wound healing at least weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report declines to the MD.Record review of Resident #114's Initial Wound Evaluation & Management Summary, dated 12/04/25, reflected the following wound assessments, treatment plans, and orders: Left hip pressure injury unstageable present upon admission - 9.00 cm x 7.00 cm x 0.80 cm - Cleanse with normal saline/wound cleanser. Pat dry apply Santyl (a topical medication used to remove dead tissue from wounds) and Hydrofera Blue (a type of wound dressing) and cover with bordered gauze/foam dressing daily and prn for soiled or dislodgment. Right gluteal fold pressure injury Stage 3 present upon admission - 3.50 cm (length) x 3.50 cm (width) x 0.70 cm (depth); Cleanse with normal saline/wound cleanser. Pat dry apply collagen and Hydrofera Blue then cover with bordered gauze/foam dressing daily and prn for soiled or dislodgement. Sacrum pressure injury Stage 3 present upon admission - 4.50 cm x 5.00 cm x 0.20 cm - Cleanse with normal saline/wound cleanser. Pat dry apply collagen and Hydrofera Blue and cover with bordered gauze/foam dressing daily and prn for soiled or dislodgment. Left buttock pressure injury Stage 3 upon present upon admission - 7.00 cm x 24.50 cm x 3.00 cm - Cleanse with normal saline/wound cleanser. Pat dry apply collagen and Hydrofera Blue and cover with bordered gauze/foam dressing daily and prn for soiled or dislodgment. Right ankle pressure injury Stage 3 present upon admission - 1.50 cm x 2.40 cm x 0.00 cm - Cleanse with normal saline/wound cleanser. Pat dry apply collagen and Hydrofera Blue and cover with bordered gauze/foam dressing daily and prn for soiled or dislodgment. Left ankle pressure injury unstageable present upon admission - 3.00 cm x 4.30 cm x 0.20 cm - Cleanse with normal saline/wound cleanser. Pat dry apply Santyl and Hydrofera Blue and cover with bordered gauze/foam dressing daily and prn for soiled or dislodgment.Record review of Resident #114's eTAR for December 2025 reflected there was no documentation showing that wound care was provided on Saturday (12/06/25) and Sunday (12/07/25) for any of Resident #114's wounds.Record review of Resident #114's Weekly Ulcer Assessment, dated 12/Interview on 12/09/25 at 11:50 AM, Resident #114 stated he had received his wound care from Monday to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Friday, but he did not receive it on the weekend.Interview on 12/10/25 at 11:53 AM, ADON E, who worked on the weekend, revealed that she knew Resident#114 had multiple wounds. She stated she knew she was supposed to perform wound care on Resident#114 because the treatment nurse did not work on the weekends. She stated wound care treatment was on a different treatment administration record, and she thinks she missed it. ADON E stated she left early both days and she forgot to let the nurses that came to relieve her know that she had not performed wound care on Resident#114. ADON E stated failure to perform wound care on Resident#114 could lead to infection and more skin breakdown. She stated she had not done training on wound care. Interview on 12/10/25 at 1:34 PM, Wound Care Nurse F revealed Resident #114 admitted to the facility with multiple wounds. She stated her work schedule was from Monday-Friday. She stated weekend staff were supposed to have provided wound care during the weekend to Resident #114. She stated she saw Resident #114 on 12/05/25 and wound care was provided. She stated when she came on Monday 12/8/25 Resident#114 still had the old dressing she had put on 12/05/25. She stated wound care should have been completed on Saturday and Sunday. Wound Care Nurse F stated her expectation was the nurses or the wound care nurses were responsible for performing wound care. She stated she did not notify the management because she expected the management to go through the treatment records and check whether care was being provided. She stated failure to follow the doctors' orders could result in worsening wounds. Interview on 12/11/25 at 9:51 AM, ADON D stated it was the responsibility of the nurses to perform wound care when the Wound Care Nurse was not in the facility. She stated she expected her staff to follow the treatment orders. She stated she was not aware wound care was not performed on 12/06/25 and 12/07/25 until it was brought to her attention by the DON. She stated both she and the DON were responsible for checking the MARs and TARs to ensure care was being provided. She stated she knew she was supposed to be checking the wound care TARs, and she had not checked it for Resident #114, so it was missed. She stated the potential risk of not performing wound care was the wounds deteriorating and getting infected. She stated she had not done in-services on wound care.Interview on 12/11/25 at 10:30 AM, the DON revealed she was not aware wound care was not provided to Resident #114 over the weekend. She stated weekend staff were responsible for performing wound care on Resident #114, since they were aware treatment nurse only works Monday through Friday. She stated she expects her staff to follow the treatment orders. She stated the ADON was responsible for going behind nurses and ensuring the MAR/TAR were being checked off. She stated the potential risk could result in the wounds worsening and getting infected. She stated she had not done in-service on wound care.Interview on 12/11/25 at 12:42 PM, the Wound Care NP revealed when treatment orders were provided to the facility, the nurses or wound care nurse was supposed to follow them. The Wound Care NP stated if treatment was missed, Resident #114 was at risk for infection and the wound getting worse. Record review of the facility's current Pressure Injury: Prevention, Assessment and Treatment policy, dated 05/05/25, reflected: . 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will:1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician.

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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** Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 1 resident (Resident #116) reviewed for PICC lines.1. The facility failed to ensure the dressing on Resident #116's PICC line (used to deliver medications and other treatments directly to the large central veins near heart) was changed every seven days as ordered by the physician, which resulted in the resident's PICC line dressing not being changed on 12/06/25.2. LVN X failed to perform hand hygiene during medication administration through Resident #116's PICC line.The failures could affect residents by placing them at risk for infections and cross-contamination. Findings included: Record review of Resident #116's admission MDS assessment, dated 12/02/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #116 had a diagnosis of septicemia (an infection caused by large amounts of bacteria entering the bloodstream). He had a BIMS score of 14, which indicated his cognition was intact. The MDS reflected that the resident was on intravenous medications.Record review of Resident #116's physician's orders dated 12/01/25 reflected: PICC Line (a long, thin tube that is inserted through a vein in the arm and passed through to the larger vein near the heart) Dressing Change q 7days one time a day every Mon PICC line dressing weekly. Record review of Resident #116's December 2025 TAR reflected there was no documentation reflecting his PICC line dressing had been changed on 12/06/25. There also was no documentation reflecting the resident had refused the dressing change.Record review of Resident #116's Care Plan Report, initiated 11/30/25 and revised 12/10/25, reflected Resident #116 had an IV access with a goal of the resident not having any complications related to IV therapy. The care plan interventions included: administering IV fluids as ordered; administering IV medications as ordered; checking the dressing at the IV site daily to monitor for signs and symptoms of infection; flushing the ports/lines as ordered; changing the dressing every 7 days and PRN.Observation and interview on 12/09/25 at 12:00 PM revealed Resident #116 in his room, in his bed. He was observed to have a PICC line dressing on his right arm dated 11/29/25. The dressing was peeling, and the surface of the dressing was dirty. Resident #116 stated the PICC line dressing was put on at the hospital, and it had not been changed since he had been at the facility. He stated no staff had requested to change the dressing. There were no signs or symptoms of infection noted at the PICC line site. Observation and interview on 12/09/25 at 1:53 PM with LVN O revealed Resident #116 had a PICC line in his right arm covered with a transparent dressing that was peeled and dated 11/29/25. LVN O revealed she was aware the dressing was supposed to be changed every 7 days and as needed when dirty. LVN O stated the dressing looked dirty on the surface. She stated she had tried to change Resident #116's PICC line dressing, but he had refused and did not want her to do it. She stated she notified ADON D and should have changed it before then since it was due every 7 days. She said she had not done training on PICC line dressings. Observation of the PICC line insertion site revealed it was clean with no signs of infection.Observation on 12/10/25 at 4:11 PM revealed LVN X administering the intravenous medication, Daptomycin 500 mg/50 ml (a cyclic lipopeptide antibiotic used to treat complicated bacterial infections), to Resident #116 via the resident's PICC line (a long, thin, flexible tube inserted into a vein in the arm, threaded up to a large vein near the heart, providing long-term IV access for medications). LVN X was observed putting on gloves and a gown before washing her hands. LVN X explained the procedure to Resident #116, she then positioned the resident and prepared the medications. She hung the IV bottle on the pole and connected the tubing. She then labeled both with the date, time, and her initials. Next, she removed her gloves and put on new gloves without washing her hands. She then (continued on next page)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleansed the PICC line tip with an alcohol swab and connected the IV tubing. She allowed the medication to flow for 30 minutes. She then removed her gloves, left the room without washing her hands, and walked down the hall with the medication cart.Interview on 12/10/25 at 4:27 PM, LVN X revealed she forgot to perform hand hygiene before and after medication administration. LVN X stated she was expected to wash hands before and she put on gloves and gown and after medication administration, but she forgot. She stated failure to wash hands before and after contact could lead to cross contamination and infection. She stated she has done training on handwashing, but she could not recall when.Interview on 12/11/25 at 9:40 AM, the ADON D revealed she expected the nurses to check Resident #116's PICC line dressing and to change it if needed. She stated the nurses failed to do their job. She stated the PICC line dressing was supposed to be changed on 12/06/25, but they missed it. She stated she was responsible for checking behind the nurses and ensuring the PICC line dressing was changed, but she also missed it. She stated they had orders in the facility to change PICC line dressings every Monday and as needed. She stated failure to change a PICC line dressing as ordered would lead to infection. She also stated she expected staff to complete hand hygiene before contact with residents and after medication administration. She stated LVN X was supposed to complete hand hygiene when providing Resident #116 with care to prevent cross contamination and infection. She stated the nursing staff had been provided in-service training on hand hygiene and infection control. Interview on 12/11/2025 at 10:12 AM, the DON revealed she expected staff to change PICC line dressings every seven days and as needed to prevent infection. She stated it was the responsibility of the ADON to check after the nurses to ensure all orders were being followed. She stated she had not done training with staff on dressing changes before 12/09/25, but she had already started doing skill checks with some nurses. Records of the skill check assessments were provided, and LVN O was not in attendance. She stated LVN X was supposed to wash her hands before she put on a gown and gloves, after the procedure, and when her hands got contaminated. She stated failure to perform hand hygiene could place the resident at risk of infection.Record review of the facility's current Care of Central Venous Catheter, Dressing Change policy, dated 2003, reflected the following: Dressing changes are performed every 48hrs and as needed if gauze is used or every week if transparent dressing is used. sterile technique is used.Record review of the facility training records was requested on 12/11/25 and none was provided. Record review of the facility's current, undated Hand Washing policy reflected: . Hand hygiene continues to be the primary means of preventing the transmission of infection. When to perform hand hygiene Upon and after coming in contact with a resident's intact skin '

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 16 of 40 days (06/08/25, 07/05/2025, 07/06/25, 07/12/25, 07/19/25, 07/27/25, 08/09/25, 08/10/25, 08/31/25, 10/11/25, 10/12/25, 10/17/25, 10/18/25, 11/15/25, 12/06/25 and 12/07/25) reviewed during a look back period from 06/07/25 to 12/18/25 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 06/08/25, 07/05/2025, 07/06/25, 07/12/25, 07/19/25, 07/27/25, 08/09/25, 08/10/25, 08/31/25, 10/11/25, 10/12/25, 10/17/25, 10/18/25, 11/15/25, 12/06/25 and 12/07/25.This failure could place residents at risk of not having their nursing and medical needs met and improper care.Findings included:Record review of the facility's Timecard Reports from 06/07/25 to 12/18/25 reflected the following:- Sunday 06/08/25: ADON D: Shift In 20:37 (8:37 PM)- Shift Out 23:13 (11:13 PM); 2 hours and 36 minutes worked RN G: Shift In 22:00 (10:00 PM)- Shift Out 6:55 AM (Monday); 2 hours worked on 06/08/25.- Saturday 07/05/25: RN B: Shift In 17:53 (5:53 PM)- Shift Out 0:27 (12:27 AM) (Sunday); 6 hours and 7 minutes worked; andRN G: Shift In 22:15 (10:15 PM)- Shift Out 7:42 (Sunday); 1 hour and 45 minutes worked on 07/05/25.- Sunday 07/06/25: RN B: Shift In 17:15 (5:15 PM)- Shift Out 22:42 (10:42 PM); 5 hours and 27 minutes worked; and RN G: Shift In 22:22 (10:22 PM)- Shift Out 7:10 (Monday); 1 hour and 38 minutes worked on 07/06/25.- Saturday 07/12/25: RN H: Shift In 17:40 (5:40 PM)- Shift Out 6:12 AM (Sunday); 6 hours and 20 minutes worked on 07/12/25.- Saturday 07/19/25: RN H: Shift In 17:43 (5:43 PM)- Shift Out 6:33 AM (Sunday); 6 hours and 17 minutes worked on 07/19/25.- Sunday 07/27/25: ADON D: Shift In 8:28 AM - Shift Out 12:19 PM; 3 hours and 51 minutes worked and then returned at: Shift In 17:37 (5:37 PM) - Shift Out 23:22 (11:22 PM); 5 hours and 45 minutes worked.- Saturday 08/09/25:ADON D: Shift In 12:38 PM - Shift Out 17:23 (5:23 PM); 4 hours and 45 minutes worked; and RN F: Shift In 20:01 (8:01 PM) - Shift Out 00:01 (12:01 AM) (Sunday); 4 hours worked.- Sunday 08/10/25: ADON D: Shift In 6:51 AM - Shift Out 11:45 AM; 4 hours and 54 minutes worked; and RN F: Shift In 20:01 (8:01 PM) - Shift Out 00:01 (12:01 AM) (Monday); 4 hours worked on 08/10/25. - Sunday 08/31/25: RN G: Shift In 22:22 (10:22 PM) - Shift Out 6:52 AM (Monday); 1 hour and 38 minutes worked.- Saturday 10/11/25:RN H: Shift In 17:46 (5:46 PM)- Shift Out 6:37 AM (Sunday); 6 hours and 14 minutes worked on 10/11/25.- Sunday 10/12/25:RN B: Shift In 14:15 (2:15 PM)- Shift Out 18:24 (6:24 PM); 4 hours and 9 minutes worked; RN H: Shift In 17:53 (5:53 PM)- Shift Out 6:13 AM (Monday); 6 hours and 7 minutes worked on 10/12/25; and RN G: Shift In 22:11 (10:11 PM)- Shift Out 6:36 AM (Monday); 1 hour and 49 minutes worked on 10/12/25.- Saturday 10/17/25:RN H: Shift In 21:04 (9:04 PM)- Shift Out 6:11 AM (Sunday); 2 hours and 56 minutes worked on 10/17/25.- Sunday 10/18/25:RN H: Shift In 17:46 (5:46 PM)- Shift Out 8:14 AM (Monday); 6 hours and 14 minutes worked on 10/18/25.- Saturday 11/15/25:RN C: Shift In 4:54 AM- Shift Out 10:02 AM; 5 hours and 8 minutes worked.ADON D: Shift In 7:55 AM- Shift Out 11:18 AM; 3 hours and 23 minutes worked.- Saturday 12/06/25 RN H: Shift In 18:11 (6:11 PM)- Shift Out 6:34 AM (Sunday); 5 hours and 49 minutes worked on 12/06/25.- Sunday 12/07/25: ADON D: Shift In 13:42 (1:42 PM)- Shift Out 19:38 (7:38PM); 5 hours and 25 minutes worked; and RN H: Shift In 17:45 (5:45 PM)- Shift Out 6:20 AM (Monday); 6 hours and 15 minutes worked on 12/07/25.Interview on 12/11/25 at 8:59 AM, the Staffing Coordinator revealed she had been employed at the facility since April 2025 and took the Staffing Coordinator position in July 2025. She stated she was responsible for completing the nursing schedules. She stated ADON D reviewed the nursing schedules once they were completed. The Staffing Coordinator stated she was aware of the 8 consecutive hours; however, she was not aware that midnight was the cut off. She stated she was not made aware it had to be the same day and thought that as long as she had an RN for 8 consecutive (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours it was fine. The Staffing Coordinator stated the potential risk of not having an RN for 8 consecutive hours would be something happening to a resident and an RN not being in the building to assist. Interview on 12/11/25 at 1:08 PM, ADON D revealed the Staffing Coordinator was responsible for completing the nursing schedules. She stated the DON was responsible for reviewing the schedules once completed. ADON D stated she would only assist with the schedules when someone calls off or to ensure they have enough coverage. Interview on 12/11/25 at 4:07 PM, the DON revealed the Staffing Coordinator was responsible for completing the nursing schedules. She stated she would review the schedules when Staffing Coordinator finds issues with coverage or needs to move staff around. The DON stated the Staffing Coordinator completes monthly schedules and prints the schedules a week in advance. She stated she was not aware of the 8 consecutive hours same day. The DON stated there was no potential risk to the residents because nursing staff had access to an RN and she was available if needed. Interview on 12/11/25 at 4:22 PM, the Administrator revealed the Staffing Coordinator was responsible for completing nursing schedules and the DON was responsible for reviewing them. He stated he was aware of the 8 consecutive hours; however, he was not aware it was not being scheduled correctly. He stated the potential risk would be patient care. Interview on 12/11/25 at 4:50 PM, the RCN revealed the facility did not have a policy for RN Coverage and followed the regulation for 8 hours daily.

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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** Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goal and preferences for 1 of 20 resident (Resident #116) reviewed for pharmacy services.The facility failed to ensure Resident #116's intravenous medication bag and tubing was labeled with date, time, and initials.These failures could place residents at risk for medication error, delay in medication administration and infection.Findings included:Record review of Resident #116's admission MDS assessment, dated 12/02/25, reflected the resident was a [AGE] year-old male who was admitted to facility the on 11/29/25. Resident #116 had a diagnosis of septicemia (It is an infection caused by large amounts of bacteria entering the bloodstream). He had a BIMS score of 14, which indicated his cognition was intact. The MDS reflected that the resident was on intravenous medications.Record review of Resident #116's physician's orders dated 12/01/25 reflected an order for: Daptomycin Intravenous Solution Reconstituted 500 MG (Daptomycin [a cyclic lipopeptide antibiotic used to treat complicated bacterial infections]) Use 50 ml intravenously one time a day related to sepsis until 12/18/25.)Record review of Resident #116's Care Plan Report, initiated 11/30/25 and revised 12/10/25, reflected Resident #116 had an IV access with a goal of the resident not having any complications related to IV therapy. The care plan interventions included: administering IV fluids as ordered; administering IV medications as ordered; checking the dressing at the IV site daily to monitor for signs and symptoms of infection; flushing the ports/lines as ordered; changing the dressing every 7 days and PRN.Observation on 12/09/25 at 12:00 PM revealed Resident #116 in his room, lying in bed. He was observed to have a PICC line dated 11/29/25. The intravenous medication bag was hanging on the pole. The IV bag was not labeled with the date, time, and initials to indicate when it was hung. A second empty bag was also observed in the resident's room, and it also did not have a date, time or initials to indicate when it had been hung or administered. Observation and interview on 12/09/25 at 1:53PM with LVN O revealed she was not the one who hung the bag. She stated she saw the unlabeled, empty bag hanging on the pole. It was hung by the 2:00 PM-10:00 PM nurse. LVN O said the IV bag and the tubing were supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated failure to put the date, time, and initials could make Resident #116 miss the next dose or get an overdose since she was not aware when he got the last dose and that would lead to medication error. She stated failure to label the tubing with the date and time could lead to infections because the tubing was only good for 24 hours. Interview on 12/10/25 at 3:20 PM, LVN X revealed she was the one, who administered Daptomycin 500 mg/50 ml to Resident #116 during 2:00 PM-10:00 PM shift .She stated she was aware she was supposed to label the bag and the tubing with date, time, and initials, 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 forgot. She stated failure to label the bag, and the tubing could lead to omission of a dose and not putting date on tubing's could lead to infection because tubing's are, good for 24 hrs. LVN X stated she had done training on IV administration. Record review revealed she had done skills checks on IV administration on 11/05/25.Interview on 12/11/25 at 9:40 AM, the ADON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous medications to prevent infection and medication error. She stated the tube should be changed every 24 hours. She stated she had done training with staff on labeling and putting initials on bags and tubing and nurses had done skill checks.Interview on 12/11/25 at 10:26 AM, the DON revealed she expected (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to date and initial intravenous bags and tubing when administering intravenous medications to prevent infection and medication error. She stated the tube should be changed every 24 hours. She stated she had done training with staff on labeling and putting initials on bags and tubing and, she had done skill checks with the nurse on 11/05/25.Record review of the facility's current Medications, Intravenous Infusion policy, dated 2003, reflected the following: . 7. Record the drug name, dose, rate, date, and time the drug was added on the container label.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 20 residents (Resident #33) whose medications were reviewed for gradual dose reduction. The facility's Pharmacy Consultant recommended the physician should consider a gradual dose reduction for Resident #33's Amitriptyline (used to treat depression) on 08/29/25. The facility failed to ensure this was communicated to the resident's primary care physician regarding the recommendation. This failure could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition.Findings included:Record review of Resident #33's annual MDS assessment, dated 10/05/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #33 had a diagnosis of depression (mood disorder that causes a persistent feeling of sadness and loss of interest),. He had a BIMS score of 15, which indicated his cognition was intact. The MDS Section N - Medications indicated he had taken antidepressants. Record review of Resident #33's care plan, revised 09/22/25, reflected: [Resident #33] received antidepressant medication. Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions: Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Record review of Resident #33's current Order Summary Report, order date range 01/01/25-12/31/25, reflected the following: Amitriptyline HCl Tablet 100 MG Give 1 tablet by mouth one time a day related to major depressive disorder. The order date and start date for the Amitriptyline was 01/24/25. Record review of Resident #33's Medication Regimen Record review, dated 08/29/25 reflected: Gradual Dose Reduction Request: Medication: Amitriptyline HCl Tablet 100 MG Give 1 tablet by mouth one time a day. Per CMS regulations, residents who use psychotropic drugs must have gradual dose reduction attempts, unless clinically contraindicated, in an effort to discontinue these drugs.Record review of Resident #33's November and December 2025 MAR reflected he received amitriptyline everyday as ordered. Interview on 12/09/25 at 10:37 AM, Resident #33 stated he received all his medications as prescribed; however, he could not recall the name of his medications.Interview on 12/11/25 at 3:29 PM, ADON D revealed she was responsible for reviewing pharmacy recommendations. She stated Resident #33's August 2025 GDR was missed for his antidepressant medication. She stated she did not forward the Resident #33's August 2025 pharmacy recommendations for a GDR to the attending physician. ADON D stated the pharmacist completed their review, made a recommendation, and the attending physician was the one who would give the order to change the medication. She stated the potential risk if a GDR was not completed would be medications adjustments not being completed. Interview on 12/11/25 at 4:10 PM, the DON revealed ADON D was responsible for reviewing pharmacy recommendations. She stated she started working for the facility in August 2025. She stated she was unaware Resident #33's August pharmacy recommendation for a GDR was missed. She stated her expectations were for the pharmacy recommendation to be reviewed monthly, be sent to the physician for review and enter any new orders. The DON stated if a pharmacy recommendation was not followed up on or a GDR was not attempted, the potential risk would be not decreasing a medication that would be decreased or medication burden. Record review of (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility Psychotropic Drugs policy, dated 10/25/17, reflected the following: The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, the facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete in accordance with accepted professional standards and practices for 1 of 20 residents (Resident #10) whose clinical records were reviewed for accuracy. The Social Worker failed to document in Resident #10's clinical record when the resident's family/legal representative was invited to participate in the resident's quarterly care plan meetings.The failure placed residents at risk of not having their care and services accurately documented. Findings included:Record review of Resident #10's significant change in status MDS assessment, dated 10/11/25, reflected the resident was a [AGE] year-old female who was admitted to facility the on 09/30/18. Resident #10 had a diagnosis of sequelae of cerebral infarction (long-term problems or consequences that linger long after a stroke), dysphasia (partial loss of language), gastrostomy status (a surgical opening into the stomach for nutritional support or gastric decompression), anxiety disorder a mood disorder characterized by excessive, persistent, and uncontrollable fear and worry about everyday situations), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and schizophrenia (a severe, chronic brain disorder that disrupts how a person thinks, feels, and behaves). She had a BIMS score of 00, which indicated his cognition was severely impaired. Record review of Resident 10's Care Plan Report, dated 10/27/25, reflected the resident wished to remain at facility for long term care. The care plan interventions included discussing options at each care plan meeting unless otherwise notified.Observation on 12/09/25 at 10:52 AM revealed Resident #10 in bed. An attempt was made to interview Resident #10, but she did not rouse when spoken to. Interview on 12/10/2025 at 9:02 AM, Resident #10's Family Member A revealed no concerns regarding the care that the resident was receiving at the facility. He stated he had received calls if there was any change in condition; however, he had never attended a care plan meeting in person or by phone. He stated he does not recall ever been told or been invited to any care plan meetings in the last year. He stated he would like to be invited so that he could be updated on the residents' care. Interview on 12/11/25 at 10:57 AM, the Social Worker revealed it was her responsibility for scheduling quarterly care plan meetings. She stated the MDS Coordinator, Therapy, Activity Director, Nursing and herself attend the care plan meetings. She stated residents and families were also invited to the care plan meetings. The Social Worker stated Resident #10 family had been invited several times; however, family does not attend. She stated she used to send letters home regarding the care plan meeting; however, she now calls the family. The Social Worker stated it usually takes about 3-4 attempts to contact Resident #10's family. The Social Worker stated she documents her attempts and will locate the documentation. Interview on 12/11/25 at 12:43 PM, the Social Worker revealed she was unable to locate the documentation of her attempts. The Social Worker stated she completed her telephone calls a week prior to the care plan meeting. She stated if there was no response, she would leave a voice message. She stated Resident #10 had been at the facility for years and the resident's Family Member had never attended a care plan meeting. She stated she had attempted to invite family; however, she had not documented her attempts. She stated family members should be invited to care plan meetings, so that the family were kept informed about the residents' condition and could address any concerns the family might have. She stated there was no potential risk if documentation was not completed. Interview on 12/11/25 at 4:05 PM, the DON revealed the Social Worker was responsible for scheduling care plan meetings. She stated the Social Worker should notify the family by phone or by letter to give them the option to attend. The DON stated any attempts should be documented. She stated the (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	12/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential risk would be family not able to give input about the resident care. Interview on 12/11/25 at 4:20 PM, the Administrator revealed the Social Worker was responsible for scheduling care plan meetings. He stated family should be invited to attend. The Administrator stated the Social Worker should be documenting the attempts made, so they have proof that family was contacted. He stated the potential risk would be family not informed about the patient care. Record review of the facility's current, undated Documentation policy reflected the following: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure each bed had suspended ceiling curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains for 3 of 21 residents (Residents #74, #95, and #99) reviewed for privacy curtains. The facility failed to ensure Residents #74, #95, and #99 were ensured full visual privacy.This could place the residents at risk of lower self-esteem. Findings included:1. Record review of Resident #74's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included bone infection, multiple pressure ulcers, and cerebral palsy. Her BIMS score was 15, indicating she was cognitively intact. Her Functional Abilities assessment reflected she required staff assistance with all of her ADLs. Record review of Resident #74's care plan, dated 12/04/25, reflected she had bowel and bladder incontinence, had an ADL self-care deficit, and was at risk of skin breakdown. Observation on 12/09/25 at 10:27 AM revealed Resident #99 was in bed. The resident's privacy curtain was pulled closed, but the end of her bed was not covered by the curtain, which left the end of the resident's bed exposed. Interview on 12/11/25 at 10:20 AM Resident #99 stated she did not like having the end of her bed exposed. She stated she would be upset if someone came in while she was being changed. She stated she would like the curtain to provide full coverage, but she did not know that was an option. 2. Record review of Resident #95's quarterly MDS, dated [DATE], reflected the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke affecting the right side of his body, diabetes, and heart disease. His BIMS score was 12, indicating he was cognitively intact. His Functional Abilities assessment indicated he required limited assistance with his ADLs. Record review of Resident #95's care plan, dated 12/04/25, reflected he had an ADL self-care deficit. Observation on 12/09/25 at 11:09 AM revealed Resident #95 was in bed. The resident's privacy curtain was pulled closed, but the end of his bed was left exposed. Interview on 12/11/25 at 10:10 AM, Resident #95 stated having the end of his bed exposed did not really bother him, but he would not like someone walking in while he was changing. He stated the curtain had been that way since he was admitted . 3. Record review of Resident #99's admission MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke affecting the left side of his body, muscle weakness, and diabetes. His BIMS score was 15, indicating he was cognitively intact. His Functional Abilities assessment indicated he required substantial assistance with his ADLs. Record review of Resident #99's care plan, dated 12/14/25, reflected he had an ADL self-care deficit. Observation on 12/09/25 at 10:44 AM revealed Resident #99 was in bed. The resident's privacy curtain was partially closed. When the privacy curtain was fully closed, the curtain did not wrap around to cover the end of the resident's bed. Interview on 12/11/25 at 10:10 AM, Resident #99 stated he was not bothered about the end of his bed not being covered by the curtain. He stated the staff close the door when they are providing care, but he would not like it if someone came in and saw him exposed. Interview on 12/11/25 at 10:30 AM, the Regional Maintenance Specialist stated maintenance was responsible for hanging any privacy curtains that needed to be hung. He stated staff would have to notify them when a curtain needed to be hung. Interview on 12/11/25 at 10:40 AM, RN-C stated it was important for residents to have privacy when in bed to prevent them from being seen by their roommate or people from the hallway. She stated housekeeping was responsible for monitoring the curtains and replacing them as needed. Interview on 12/11/25 at 10:43 AM, the ADON stated the resident's needed privacy in their beds to prevent being embarrassed when staff are providing care. She stated the nurses and CNAs were primarily responsible for letting (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	housekeeping know if a curtain needed to be placed or replaced, but any staff member could notify housekeeping. Interview on 12/11/25 at 10:46 AM, the DON stated it was important for residents to have privacy for their dignity while care was being provided. She stated the nurses and CNAs were responsible for letting housekeeping know if a curtain needed attention. Maintenance would then hang the curtain when it was ready. She stated there was not a policy addressing privacy curtains specifically.