

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Arlington Heights Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4825 Wellesley St Fort Worth, TX 76107	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that an alleged violation involving abuse was reported immediately but not later than 2 hours after the allegation was made to the Administrator of the facility for 1 of 3 residents (Resident #1) reviewed for abuse.</p> <p>LVN A failed to immediately report an abuse allegation to the Administrator, who was the facility's abuse coordinator, when she overheard CNA B verbally abusing Resident #1 in early May 2025.</p> <p>This failure could have caused residents to experience abuse by staff.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission Record, dated 06/04/25, reflected she was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 04/01/25, reflected she had a BIMS score of 06, which indicated severe cognitive impairment. Her active diagnoses included Non-Alzheimer's Dementia (a general decline in cognitive abilities that affects a person's ability to perform everyday activities), Schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), and Borderline Personality Disorder (a mental health condition that affects the way people feel about themselves and others).</p> <p>Observation and attempted interview on 06/04/25 at 10:00 AM with Resident #1 revealed she was lying in bed in her room. Resident #1 did not answer any questions the surveyor asked, instead she just stared at the surveyor.</p> <p>Interview on 06/04/25 at 9:31 AM with LVN A revealed she worked with Resident #1 on the secured unit. LVN A said she saw CNA B go in to provide care to Resident #1 one day in early May 2025 and overheard the aide tell the resident, You need to get your pissy ass back in bed. LVN A said she wrote out a witness statement and turned it into the Administrator who was the Abuse Coordinator for the facility since this was an instance of verbal abuse.</p> <p>Interview on 06/04/25 at 10:15 AM with the Administrator revealed he had not received any witness statements regarding an abuse allegation and CNA B or Resident #1.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER  Arlington Heights Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4825 Wellesley St Fort Worth, TX 76107	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/04/25 at 10:52 AM with CNA B revealed she cared for Resident #1 but had never abused her. CNA B said she never said anything verbally abusive towards Resident #1 or any other resident. CNA B said she felt like LVN A was trying to get her in trouble or fired because they did not get along as co-workers. CNA B said she no longer worked with Resident #1.</p> <p>Follow-up interview on 06/04/25 at 11:30 AM with LVN A revealed she wrote a witness statement informing the Administrator about the verbal abuse she witnessed by CNA B towards Resident #1. LVN A said the Administrator's door was closed at the time, but she put it under his door. LVN A said she never received any follow-up from the witness statement but did not bring it up again to the Administrator. LVN A said she thought she followed the procedure by filling out the witness statement and giving it to the Administrator.</p> <p>Interview on 06/04/25 at 12:57 PM with the Interim DON revealed when she interviewed LVN A about the abuse allegation regarding CNA B and Resident #1, LVN A said she wrote a witness statement and left it under the Administrator's door. The Interim DON said LVN A should have called the Administrator instead of just writing a witness statement, so she was immediately in-serviced on the facility's abuse policy.</p> <p>Interview on 06/04/25 at 2:26 PM with the Administrator revealed he interviewed LVN A about the abuse allegation regarding CNA B and Resident #1. The Administrator said LVN A told him she wrote a witness statement and then slipped it under his door while he was out on PTO. The Administrator said when he returned from PTO, there was nothing under his door. The Administrator said all staff knew to report all abuse to him immediately, which usually meant they would call or text him; even if he was out on leave or out of the building. The Administrator said the purpose of staff immediately reporting abuse allegations to him was to protect the residents from further abuse. The Administrator said if staff did not immediately report an abuse allegation to him then the same situation could happen with another resident. The Administrator said all staff were responsible for ensuring they reported any allegation of abuse to him immediately. The Administrator expected that all staff immediately report any abuse allegation to him.</p> <p>Record review of the facility's Abuse/Neglect policy, revised 03/29/18, reflected:</p> <p>.E. Reporting .1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator [sic], state and/or adult protective services .2. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called .</p>		