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	09/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 6 residents (Resident #2) reviewed for abuse. The facility failed to ensure Resident #3 did not physically abuse Resident #2. On 07/17/25, Residents #2 and #3 physically attacked each other and Resident #2 suffered scratches to her left cheek and lip. The noncompliance was identified as PNC. The noncompliance began on 07/17/25 and ended on 07/17/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk for abuse. Findings included: Record review of Resident #2's Quarterly MDS Assessment, dated 07/23/25, reflected she was a [AGE] year-old female who was originally admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS (cognitive screening tool) score of 2. She was noted to have had physical behaviors directed towards others for 4 to 6 days. Her active diagnoses included non-Alzheimer's disease (a general term for any form of dementia that is not classified as Alzheimer's disease) and unspecified dementia (the specific type of dementia cannot be clearly identified). Record review of Resident #2's Care Plan, revised 07/17/25, reflected the following: Focus: The resident has a potential for psychosocial well-being problem r/t altercation with another resident. Interventions: Empty room at the end of the hall has been locked to prevent residents wandering in and out of the room.The resident needs assistance/supervision/support to identify causative and contributing factors. Focus: [Resident #2] has potential to demonstrate physical behaviors Dementia, Poor Impulse Control. Interventions: If [Resident #2] has physical behaviors towards another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately. Record review of Resident #2's Progress Notes reflected the following two entries:- LVN D wrote on 07/17/25 at 10:10 AM: Location of event: Hallway.Injury: Yes.Describe any injuries: scratches to cheek and lip.4 residents were walking the hallways peacefully, per CNA [Resident #2] and another resident went into an empty room at the end of the hall and closed the door in the other resident's face, other resident became agitated and pushed hard on the door. [Resident #2] opened the door and other resident grabbed her hair and pulled her out of the room. [Resident #2] started screaming and punching other resident while other resident pushed and pulled on other [Resident #2's] [sic] hair.Initial Treatment/New Orders: cleansed scratches no new orders from md.Resident Statement: 'I went into the room with my [family member] and shut the door, that's when she pushed the door a few times to get in, I opened the door and she hit me in the face and started fighting me'.Interventions: separation of residents. - LVN D wrote on 07/17/25 at 10:22 AM: Injury Follow-Up.Location of abrasion: left cheek and lip, Size of abrasion in cm: 5cm x2 and 1cm to lip. Record review of Resident #2's Weekly Skin Assessment, dated 07/17/25, reflected the following: .a. Bruise b. Yes. Aa. Note location, measurements of any bruise: under left eye non measurable still developing.c. Abrasion b. Yes. Cc. Note location, measurements of any abrasion: 5cm 2x to left cheek and 1cm to bottom lip. Observation on 09/04/25 at 11:30 AM of Resident #2 revealed she was walking up and down the hallway alone. Resident #2 was not able to answer any questions and just kept walking past the surveyor. Record review of Resident #3's Quarterly MDS Assessment, dated 07/10/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 01, indicating severe cognitive impairment. Her noted behaviors indicated she had physical behaviors towards other that occurred for 1 to 3 days. Her active diagnoses included non-Alzheimer's disease (a general term for any form of dementia that is not classified as Alzheimer's disease), anxiety disorder (a range of conditions that cause significant and uncontrollable feelings of anxiety and fear), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and psychotic disorder (a severe mental health condition characterized by a loss of contact with reality, often manifesting as delusions and hallucinations). Record review of Resident #3's Care Plan, revised on 07/17/25, reflected the following: Focus: [Resident #3] has potential to demonstrate physical behaviors.Interventions: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.Empty room at the end of the hall has been locked to prevent residents wandering in and out of the room. Record review of Resident #3's Progress Notes reflected the following entry: LVN D wrote on 07/17/25 at 9:21 AM: Event-Other.4 residents were walking the hallways peacefully, per CNA two residents went into an empty room at the end of the hall and closed the door in [Resident #3's] face. [Resident #3] became agitated and pushed

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to ensure Resident #1, who had dementia, was provided with adequate supervision to prevent her from eloping from the facility on 08/08/25. The resident was found half a block away from the facility. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 08/08/25 and ended on 08/08/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents who require supervision at risk of harm, severe injury, and possible death. Findings included:Record review of Resident #1's admission Record, dated 09/04/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included cerebral infarction unspecified (when the blood supply to part of the brain is blocked or reduced which prevents brain tissue from getting oxygen and nutrients and brain tissue begins to die), unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), with unspecified severity and without behavioral disturbance; psychotic disturbance (a severe mental health condition characterized by a disconnection from reality); mood disturbance (mental health conditions that primarily affect a person's emotional state); and anxiety (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs). Record review of Resident #1's Optional State Assessment MDS Assessment, dated 07/13/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had severe cognitive impairment with a BIMS (cognitive screening tool) score of 6. The MDS reflected the resident did not have wandering behaviors. Record review of Resident #1's Elopement Risk Evaluation, dated 07/17/25, which is used to assess the likelihood of a resident leaving a facility without the facility's knowledge and supervision, reflected the resident was at a moderate risk of elopement with a score of 6. Record review of Resident #1's Consent for Secured Unit, dated 08/08/25 reflected Resident #1 gave consent to be placed on the Secured Unit. Record review of Resident #1's Progress Notes from 07/10/25-08/07/25 reflected no documented evidence that she was exit-seeking or had made any elopement attempts. Record review of Resident #1's Progress Notes written by LVN K on 08/08/25 at 6:34 PM reflected: Today around 1500 [3:00 PM] [Resident #1] was found outside down the street by staff members after she escaped our facility by following an unknown someone who was exiting the building after they used the passcode that only staff knows. She was found with her walker outside and was brought back to the facility. We looked through the sign-out binder to see if anyone signed her out today and no one had signed her out. When I asked her roommate if she had any knowledge or warning from [Resident #1] that she was going to try and escape her roommate said 'Yes. [Resident #1] said she was getting out of here.' When I asked [Resident #1] why and how she escaped outside today she said, 'I don't want to be here anymore people are mean to me and call me names.' And when describing how she got out she said, 'Someone got out of a car, went to open the door, as that person was entering, another person exiting, and I followed that person out the door.' I called her Responsible Party to alert her to this elopement, she didn't answer my call, I left a voicemail. Record review of Resident #1's Care Plan, dated 09/05/25, reflected: Focus: [Resident #1] resides in secure unit related to High Risk for Elopement-8/8/25: Actual Elopement.Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the secured unit.Interventions: Admit to secure unit per DR orders. Assist and monitor resident for off unit activities if able.Involve resident in daily activities designed for secured unit. Monitor for s/s of depression, withdrawal from usual activities.Notify MD and family of any changes.Psych services per DR orders. Record review of the facility's Provider Investigation Report, completed by the Administrator on 08/15/25, reflected the following under the Investigation Summary section: On 8/8/2025 at 2:55pm.housekeeper saw what she thought was a resident outside the facility. She came to the administrator's office and wanted to report what looked like a resident outside. Admin started running down towards the exit door. Housekeeper used her car to go down the road. [Housekeeper M] located the resident halfway down the block. [Housekeeper M] placed resident in her car and picked up the admin as well. Admin asked resident, why she left the facility, and she stated she got kicked out. She would not elaborate on anything else. Resident was brought back to the facility around 2:59pm. Resident was placed on the secure unit after being interviewed by the DON. Admin reviewed cameras and resident left from the 300-hall main exit. Video shows the resident walking to the door, an