

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Arbor Lake Nursing & Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Pennsylvania Ave Fort Worth, TX 76104	

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. (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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to act as a fiduciary of the residents' funds and hold, safeguard, manage and account for the personal funds of the resident deposited with the facility for nine (Residents #1, #2, #3, #4, #5, #6, #7, #8 and #9) of nine residents reviewed for resident trust accounts. The facility did not monitor resident trust fund account balances to ensure funds did not exceed Medicaid resource limits. The facility allowed Residents #1, #2, #3, #4, #5, #6, #7, #8 and #9 trust funds to remain over \$3,000, which placed them at risk of losing their Medicaid eligibility. This deficient practice could affect all residents with a resident trust account by placing their Medicaid eligibility at risk and becoming ineligible for nursing facility care, financial hardship, and possible involuntary discharge for nonpayment. Findings included: 1. Record review of Resident #1's Face Sheet dated 09/08/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1's diagnoses included senile degeneration of brain (a progressive decline in cognitive function that occurs with aging), major depression disorder (persistent sadness), dementia (progressive cognitive impairments in memory, thinking, and reasoning that interfere with daily life) and reduced mobility. Resident #1 was listed as his own responsible party with a family member being an emergency contact. Record review of Resident #1's significant change MDS assessment dated [DATE] reflected he had no hearing, speech or vision issues, and his BIMS score was a 15, which indicated no cognitive impairment. Review of Resident #1's Trust Fund Statement dated 09/08/25 reflected his current balance was \$9,717.03. On 08/15/25, Resident #1 received a payment from Social Security for \$9,113. Aside from his monthly care costs paid to the facility (\$1,398) and \$50 allowance withdrawals, no other debits were made from his trust fund account to assist in spending down his excess finances. 2. Record review of Resident #2's Face Sheet dated 09/08/25 reflected he was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's diagnoses included aphasia (difficulty expressing wants and needs), reduced mobility, deafness, dysphagia (difficulty swallowing) and dementia. Resident #2 did not have a medical or durable power of attorney listed nor any emergency contacts. Resident #2 was listed as his own responsible party. Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected his hearing was highly impaired, he had unclear speech, was rarely understood by others, and he had moderately impaired vision. Resident #2 had short/long term memory impairment and moderately impaired cognitive skills for daily decision making. Record review of Resident #2's Trust Fund Statement dated 09/08/25 reflected his current balance was \$7,383.40. His account had been over \$7,000 for the past three months and there was no evidence the facility completed a spend down for him. Debits from Resident #2's account for the past three months included monthly care cost payment to the facility for \$774 and \$50 of allowance debits total. 3. Record review of Resident #3's Face Sheet dated 09/08/25 reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #3's diagnoses included right eye blindness, multiple sclerosis (a chronic autoimmune disease that affects the central nervous system), cognitive communication deficit and dysphagia. Resident #3 did not have a medical or durable power of attorney listed and had a family member listed as an emergency contact. Resident #3 was listed as her own responsible party. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected no hearing or speech issues and was sometimes able to make herself understood. Her BIMS score was a 06, which indicated severe cognitive impairment. Record review of Resident #3's Trust Fund Statement dated 09/08/25 reflected her current balance was \$5,536.98. On 08/01/25 her balance was \$7,348.84, on 07/01/25 it was \$5,366.84 and on 06/02/25 it was \$3,976.82. There was no evidence the facility completed a spend down for her over the past quarter. Debits from Resident #3's account for the past three months included monthly care cost payment to the facility for \$504.56 and two advanced cash payments of \$75 and \$60. There were no other debits from her trust fund account to assist in spending down her excess finances. 4. Record review of Resident #4's Face Sheet dated 09/08/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #4's active diagnoses included COPD (a long-term lung disease), abnormalities of gait and mobility and cirrhosis of liver (scar tissue on liver that interferes with functioning). Resident #4 did not have a MPOA/DPOA or any emergency contacts listed. Resident #4 was listed as his own responsible party. Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #4's Trust Fund Statement dated 09/08/25 reflected his current balance was \$4,270.20. Resident #4's</p>		