STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455872	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Residence and Rehabilitation Center	405 Duncan Perry Rd Arlington, TX 76011

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative and the Office of the State Long-Term Care Ombudsman representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood for one (Resident #1) of three residents reviewed for discharge rights. The facility failed to provide a copy of the written notice of immediate discharge to Resident #1 and the Ombudsman when the facility decided that Resident #1 needed to be immediately discharged on [DATE], due to non-compliance with the smoking policy. This failure placed residents at risk of not having access to available advocacy services, discharge options, and appeal processes. Findings included: Record review of Resident #1's Face Sheet, dated 11/07/24, reflected the resident was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included: fibroblastic disorder (tumors that affect connective tissue), Type II diabetes (body's inability to control blood glucose), muscle weakness, personality disorder, and acquired absence of right leg below the knee. Record review of Resident #1's Quarterly MDS Assessment, dated 07/19/24, reflected the resident had a BIMS score of 15 which indicated the resident's cognition was intact. The MDS Assessment also reflected Resident #1 required set-up assistance and supervision with most ADLs. Record review of Resident #1's care plan, dated 04/24/24, reflected the resident had impaired cognitive function/dementia or impaired thought processes related to dissociative and conversion disorder (personality disorder) with interventions that included administering meds as ordered, communicating with the resident/family/caregivers regarding resident's capabilities and needs, and monitoring/documenting/reporting any changes to cognition. The care plan also reflected the resident had a behavior problem related to resident's non-compliance with smoking policy. An update on 06/29/24 reflected Resident #1 signed the smoking policy; however, she violated the smoking policy on 09/27/24 by refusing to hand over smoking paraphernalia. Interventions included a 30-day discharge notice to be given, medications administered as ordered, caregivers to provide opportunity for positive interaction/attention, explain all procedures to the resident before starting and allowing the resident time to adjust, and explain/reinforce why behavior was inappropriate. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a letter titled 30-Day Discharge Collection Letter, dated 09/27/24, reflected it was a written notification that Resident #1 would be discharged from [nursing facility] 30 days from the date of the letter due to refusal to adhere to the smoking policy set by the facility Administrator. The notice included information on how to contact the Ombudsman and was signed by the former Administrator, ADON, and a notation that Resident #1 refused to collect and sign. Record review of a letter titled Immediate and Effective Discharge Collection Letter, dated 10/02/24, reflected it was a written notification that Resident #1 would be immediately and effectively discharged from [nursing facility] due to refusal to adhere to the smoking policy set by the facility Administrator. The notice reflected the Social Worker would work with Resident #1 to make necessary preparations for a safe transition. The notice also included information on how to contact the Ombudsman. Further review reflected no handwritten signatures or notations regarding lack of signatures. Record review of Resident #1's progress notes, 10/02/24-11/08/24, reflected there was no documentation to show that Resident #1 and the Ombudsman were provided with or attempted to be provided with a written copy of the immediate and effective discharge collection letter. Record review of Resident #1's care plan conference note, dated 10/02/24, reflecte it could not initially be viewed by the investigator in the electronic record due to it not being completed and signed. The note reflected that it could only be edited, printed, or completed. The ADON later provided a hard copy of the care plan conference note that was locked and signed by the DON on 11/08/24 at 12:17 PM and reflected in part the following: [Resident #1] requested to meet [Ombudsman], after she was found violating smoking policy, [Ombudsman] present in the meeting and [Resident #1] admitted that she violated the smoking policy and that she will not follow the facilities [sic] rule of supervised smoking and will not return paraphernalia. Facility issues her notice immediate/effective discharge. In an interview on 11/07/24 at 09:25 AM, the DON stated Resident #1 had been discharged from the facility because she was non-compliant with the facility's smoking policy. The DON stated Resident #1 refused to turn in her lighter and cigarettes and would go outside and smoke whenever she wanted, outside of scheduled smoke times. The DON stated the behavior was dangerous to Resident #1 and other residents in the facility. The DON stated Resident #1 was issued an immediate discharge on 10/02/24 during a care plan meeting with the Ombudsman and the former Administrator. The DON stated Resident #1 also had labs drawn on 10/02/24 that came back critical for low sodium and the resident was sent to the local hospital. In an interview on 11/07/24 at 03:56 PM, a representative at the local hospital stated Resident #1 arrived at the hospital on 10/03/24 and was diagnosed with low sodium which was a reason for her to be admitted . The representative stated Resident #1 was medically cleared and ready for discharge on 10/05/24; however, the facility refused to allow the resident to return to the facility and Resident #1 had been at the hospital for 34 days with no place to go. The representative stated the facility informed them that Resident #1 had been issued a 30-day notice of discharge from their facility due to non-compliance with the smoking policy. The representative stated he understood the facility's reason for discharging Resident #1; however, if she was issued a 30-day discharge notice and was still within the 30 days, the facility should have been responsible for taking Resident #1 back to the facility and helping her find alternative placement. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/07/24 at 04:53 PM, the Ombudsman stated she recalled having to visit with Resident #1 on multiple occasions to convince her to turn over smoking paraphernalia and follow the smoking policy; however, the resident always refused. The Ombudsman stated she last visited Resident #1 a day or two before she discharged to the hospital to again attempt to collect smoking paraphernalia and the resident refused. The Ombudsman stated she informed the former Administrator to follow the facility's policy and do what they needed to do as far as discharging Resident #1. The Ombudsman stated she was aware of the 30-day discharge notice that had been issued to Resident #1 at the end of September 2024; however, she was not aware of an immediate discharge notice issued on 10/02/24. The Ombudsman stated she was aware that the facility wanted to discharge Resident #1 because her behavior was a safety hazard; however, they had issued and rescinded discharge notices on multiple occasions to give the resident a chance to cooperate. The Ombudsman stated she could not recall receiving an official immediate discharge letter for Resident #1, but she needed to check her emails to confirm. In an interview on 11/08/24 at 09:42 AM, Resident #1 stated she was currently at [local hospital] waiting for the Social Worker to find her a place to stay because [nursing facility] would not allow her to go back until they got a new administrator. Resident #1 stated she admitted to the hospital on 10/03/24 and was ready for discharge just a few days later. Resident #1 stated [nursing facility] refused to take her back because she did not follow their smoking policy. Resident #1 stated she was given a 30-day discharge notice a couple of weeks before being sent out to the hospital, so she still had time at the facility to work with them and the Ombudsman to find placement. Resident #1 stated she was not issued an immediate discharge notice prior to going to the hospital and was only aware of the 30-day notice. In further interview on 11/08/24 at 9:48 AM, the Ombudsman stated according to her notes, she visited Resident #1 on 10/01/24 after the facility continuously called her about the resident's non-compliance with the smoking policy. The Ombudsman stated her note reflected that Resident #1 could be discharged ; however, there was not an official immediate discharge notice sent to her. In an interview on 11/08/24 at 12:28 PM, the Corporate Nurse stated the facility was currently without an administrator and they had 30 days to find a replacement. She stated she was maintaining her position as the corporate nurse; therefore, all documentation left by the former Administration regarding the discharge of Resident #1 should be reviewed. The Corporate Nurse did not provide any further details. In further interview on 11/08/24 at 01:26 PM, the DON stated she was not normally responsible for discharges and placement of residents. The DON stated she would only provide clinical information as needed. The DON stated the social worker and administrator handled the discharge process; however, the facility did not currently have a social worker or an administrator. The DON stated the former Administrator who dealt directly with the discharge of Resident #1 was no longer with the company and all they had were her notes. The DON stated Resident #1 was aware that she was receiving an immediate discharge because it was mentioned in the care plan meeting held on 10/02/24 and there was also an immediate discharge letter in the former Administrator's file. The DON stated the immediate discharge letter was not signed by Resident #1 because she always refused to sign anything that was given to her. The DON stated since she did not deal directly with the discharge, she could not confirm that an official immediate discharge letter had been provided to the Ombudsman. The DON stated the risk of not properly notifying a resident/RP and ombudsman of a discharge could be the resident not being assisted with finding placement and being safely discharged . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Transfer or Discharge, Emergency policy and procedure, revised December 2016, reflected in part the following: Policy Statement: Emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s). Policy Interpretation and Implementation 1. Residents will not be transferred unless: a. The safety of individuals in the facility is endangered due to clinical or behavioral status of the resident. .4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution our facility will implement the following procedures: .c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member; .g. Others as appropriate or as necessary.