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	05/29/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure when discharge is anticipated, a resident had a discharge summary that included, but not limited to a recapitulation of the resident's stay, that included but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultant results and a final summery of the resident's status to include items, at the time of the discharge that was available to release to authorized persons and agencies, with the consent of the resident or resident's representative for 1 of 3 residents (Resident #1) reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #1. This failure could place residents at risk of not having complete records after permanent discharge from the facility. Findings included: Record review of Resident #1's face sheet, dated 05/29/25, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Record review of Resident #1's Discharge MDS Assessment, dated 02/11/25, reflected Resident #1 was discharged to Long-Term Care Hospital without a return anticipated. Resident #1 had diagnoses which included unspecified dementia (decline in mental ability, affecting thinking, and memory), anxiety disorder (a type of mental health condition), bipolar disorder (extreme mood swings, ranging from periods of elevated mood), schizophrenia (a chronic brain disorder that affects thinking, feeling, and behavior), and insomnia (sleep disorder), unspecified . Resident #1 cognitive skills for daily decision making was modified independence. Resident #1 required maximal/moderate assistance with toileting, showering and personal hygiene. Record review of Resident #1's physician order, dated 02/11/25, reflected May transfer out to [Hospital]. Record review of Resident #1's nursing progress note by LVN A, dated 02/11/25 at 14:30 [2:30 PM], reflected Res. has discharged to [Hospice Name] in [city]. Res. alert and oriented x3, able to make needs known. Res. stable, no c/o pain or discomfort. Wheeled to front door for his transportation to [city]. 127/65, 71, 18, 97.9, 96% RA. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Summary Episode Note, dated/timed 02/11/24 8:40 PM, reflected resident information, emergency contact, allergies, assessment, diagnosis, goals, medications names, immunizations, and problems. Summary Episode Note did not address reason for discharge, date of discharge, reconciled medications sent to new facility, personal belongings disposition or physician signature. Record review of Resident #1's care plan, revised date 02/13/25, did not address discharge goals. Record review of Resident #1's clinical records reflected no discharged summary. Interview with on 05/29/25 at 2:15 PM with LVN A revealed she was notified Resident #1 was discharging from the facility and to get him ready. She stated when Resident #1 discharged , she provided a copy of the Resident #1's face sheet, medication orders and belongings. She stated she documented in the Resident #1's progress notes of where he was going. Interview on 05/29/25 at 4:46 PM with the DON revealed Resident #1 transferred to another facility. She stated prior to the change of management, the nurse, who discharged a resident, was responsible for documenting in the progress notes when a resident transferred or discharged from the facility regarding where the resident was going. The nurse would also be responsible for obtaining a physician order, and then their electronic health records systems, PCC, would generate a summary episode note. She stated the summary episode note provided the resident information. The DON stated she considered the Summary Episode Note, physician order, and progress note the discharge summary. She stated she was not sure of another discharge summary. Interview on 05/29/25 at 5:29 PM with the Administrator revealed she had been employed at the facility since mid-March 2025. She stated based on the new company's policy expectations the staff were expected to document any discharge planning with the family, discharge physician order, medications, belongings, and to document in the progress notes. She stated she was still not familiar with PCC clinical standpoint; however, the Social Worker would initiate the discharge summary. If the Social Worker was not in the facility, the discharge nurse would complete it. She revealed she was only familiar with the new company's policy regarding discharge summaries. She stated Resident #1 discharged prior to the change of management which occurred at the beginning of March 2025. Record review of the facility's Transfer and Discharge (including AMA), dated 09/1/23 and revised 04/25/25, reflected the following: . A member of the interdisciplinary team will complete relevant sections of the Discharge summary. The nursing caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy and pertinent lab, radiology, and consultation results. A final summary of the resident's status. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). A post discharge plan of care that is developed with the participations of the resident and the resident representative(s) which will assist the resident to adjust to his or her new living environment.