STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W. Virginia Dr. Dallas, TX 75237

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 - Some	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 complete a discharge summary for 4 of residents (Resident #1, Resident #2, Resident #3, Resident #4) 4 residents reviewed for discharge summaries. 1. The facility failed to ensure 4 of residents (Resident #1, Resident #2, Resident #3, Resident #4) discharged the facility with a discharge summary that included an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions to ensure that care is coordinated and the resident transitions safely from one setting to another. This failure could place residents at risk for not receiving appropriate and timely care due to confusion among various facilities, agencies, practitioners, and caregivers involved with the resident's care.Findings Included:Record review of Resident #1's Face Sheet, printed 06/30/26, revealed the [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on [DATE] with a primary diagnosis of lack of coordination, and secondary diagnoses of chronic kidney failure and heart failure. Resident #1 was discharged to an acute care hospital from the facility on 05/29/26. Record review of Resident #1's assessments in the electronic health records revealed a discharge summary had not been completed. Record review of Resident #2's Face Sheet, printed 06/30/26, revealed the [AGE] year-old male originally admitted to the facility on [DATE], and readmitted on [DATE] with a primary diagnosis of metabolic encephalopathy (a brain dysfunction caused by chemical, hormonal, or systemic problems in the body), and secondary diagnoses of rhabdomyolysis (a serious medical condition involving the rapid breakdown of damaged skeletal muscle), extrarenal uremia (a functional disease of the kidney which is the result of one or more disorders outside the kidney), acute kidney failure (occurs when the kidneys suddenly stop filtering waste from the blood), and chronic kidney disease (the presence of damaged kidneys that cannot filter blood properly). Resident #2 was discharged to an acute care hospital from the facility on 06/24/26. Record review of Resident #2's assessments in the electronic health records revealed a discharge summary had not been completed. Record review of Resident #3's Face Sheet, printed 06/30/26, revealed the [AGE] year-old male originally admitted to the facility on [DATE], with a primary diagnosis of sepsis (the body's extreme, life-threatening response to an infection), and stage 3 chronic kidney disease (the presence of damaged kidneys that cannot filter blood properly). Resident #3 was discharged to an acute care hospital from the facility on 06/25/26. Record review of Resident #3's assessments in the electronic health records revealed a discharge summary had not been completed. Record review of Resident #4's Face Sheet, printed 06/22/26, revealed the [AGE] year-old male originally admitted to the facility on [DATE], with a primary diagnosis of cerebral atherosclerosis (the narrowing of brain arteries due to the buildup of fatty cholesterol plaques), and secondary diagnoses of heart failure (occurs when the heart muscle weakens or stiffens and cannot pump enough oxygen-rich blood to meet the body's needs), and type 2 diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough of it to maintain normal glucose levels). Resident #4 was discharged home from the facility on 06/22/26. Record review of Resident #4's assessments in the electronic health records revealed a discharge summary had not been completed. During an interview with the MDS (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinator on 06/30/26 at 10:51am, she stated she had been employed at the facility for 11 years. The MDS Coordinator stated the Nursing Staff and Social Worker were responsible for opening and closing the discharge summaries for residents. The MDS Coordinator further stated that if she did not open the discharge summary, the IDT would not get a notification they needed to complete their part of it. The MDS Coordinator was asked to verify in the electronic health records if Resident #2 had a discharge summary, and she confirmed it was not completed. The MDS Coordinator stated LVN A should have completed the Discharge Summary for Resident #2. The MDS Coordinator stated the discharge summary should have been completed by nursing staff after residents discharged from the facility. The MDS Coordinator was asked if there was any risk or harm for the residents if their discharge summaries were not completed, and she stated she did not think so because the discharge summaries for the residents were for the facility, and discharge instructions leave with the resident when they were discharged from the facility. During a telephone interview with LVN A on 06/30/26 at 11:07 am, LVN A stated he was off duty and was unavailable to speak to the Surveyor. LVN A stated he would call Surveyor back in an hour to discuss the facility's discharge planning process. An attempted telephone call to the facility's previous Social Worker on 06/30/26 at 11:22 am was unsuccessful. A voicemail message was left for the previous Social Worker and a telephone call was not returned. An attempted telephone call to LVN A on 06/30/26 at 12:24 pm was unsuccessful. During an interview with the Administrator on 06/30/26 at 1:31 pm, she stated she had been employed at the facility for 2 years. The Administrator stated she was not aware that the Discharge Summary for Resident #1, Resident #2, Resident #3, and Resident #4 had not been completed. The Administrator stated the Nurse on duty during the resident's discharge should complete a Discharge Summary for residents. She stated since the facility had a vacant Social Worker position, the Nurse Staff had been directed to complete the Discharge Summaries for the residents. She stated the facility would do an audit on the recently discharged residents to ensure that they had discharge summaries on their EHR file. The Administrator stated the staff would be re-educated and re-trained via in-Service trainings on the discharge planning process, which included ensuring all discharged residents had completed discharge summaries in their EHR files. The Administrator stated there were not any risks or harm to residents if their Discharge Summaries were not completed after they were discharged from the facility. During a telephone interview with LVN B on 06/30/26 at 2:15 pm, she stated she had been employed at the facility for 1 year. LVN B stated she was unaware that Resident #1, Resident #2, Resident #3, and Resident #4 did not have any discharge summaries in the electronic health records, LVN B stated if a resident discharged from the facility during her shift, the Nurse on duty at the time of the resident's discharge was responsible for completing a Change of Condition for the resident. LVN B stated the Change of Condition documented what the vital signs of the resident, a description of what was going on with the resident, including the reason the resident was discharged from the facility. LVN B stated the nurse was also responsible for notifying the resident's physician or doctor, and their RP or POA (if applicable) of the resident's Change in Condition. LVN B stated that the nurses and SW were responsible for completing the Discharge Summary. LVN B stated the facility no longer had a SW, and therefore the nurses were responsible for completing the Discharge Summaries and recapitulation of medications for each discharged resident. LVN B stated there were no risks or harm to residents if their Discharge Summaries were not completed after they were discharged from the facility. Record review of the HR file for the facility's previous Social Worker revealed she was employed at the facility from 02/05/25 to 02/03/26. Record review of the facility's policy, Discharge Summary and Plan, dated December 2025 reflected: Policy StatementWhen a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.Policy Interpretation and Implementation1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living (continued on next page)

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