STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay that included diagnoses, course of treatment, pertinent labs, a final summary of the resident's status and reconciliation of all pre-discharge medications with the resident's post-discharge medications for 1 of 5 residents (Resident #1) reviewed for closed records. The facility failed to ensure Resident #1 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 dated 09/09/2025, reflected the [AGE] year-old female resident was admitted to the facility on [DATE]. Diagnoses included: cerebrovascular disease (a condition that affects blood vessels in the brain, leading to reduced blood flow and oxygen to the brain), type 2 diabetes mellitus without complications (a chronic condition characterized by high blood sugar levels), adjustment disorder with anxiety (a mental health condition characterized by excessive worry, nervousness and fear), morbid obesity, hemiplegia affecting left side (paralysis or severe weakness on one side of the body), cerebral infarction (blood flow to the brain is interrupted, resulting in cell death and brain damage), muscle wasting and atrophy (the loss of muscle mass and strength). Further review of the Resident #1's MDS, dated [DATE], revealed the resident's BIMS score was 12, indicating moderately impaired cognitive function. The resident used a wheelchair and required assistance for transfers, showering, personal hygiene and toileting. The resident was incontinent of bowel and bladder. A record review of Resident #1's progress notes revealed the resident discharged the facility on 09/03/2025. The final progress note stated the following: Resident discharged from facility with daughter [NAME] and transported to a care home in [NAME] called A place like home. Resident left in stable condition. Resident/daughter [NAME] stated no questions/concerns on departure. Resident left with medications/facesheet. Resident has all her belonging. Room empty. Will inform oncoming nurse. Record review of Resident #1's Comprehensive Care plan initiated 05/27/2025 and closed 09/05/2025 revealed the following: Focus: At risk for impaired cognitive function or impaired thought processes r/t prior CVA and new environment. Goal: Will maintain current level of cognitive function through the review date. Interventions included: Engage in simple, structured activities that avoid over demanding tasks. During an interview with the SSD on 09/09/2025 at 2:20 PM, the SSD confirmed that Resident #1 did not have a discharge summary in her closed electronic records. When asked who is responsible for charting the discharge summary, the SSD stated it was her responsibility to initiate it. When asked why the discharge summary for Resident #1 was not completed, the SSD stated she was not sure why she didn't do it or how she missed it. Record review of the facility's Discharge Process policy, latest revision dated 07/2015, stated the following: It is the policy of this facility that the Social Service Designee and/or Case Manager, with consultation from the Interdisciplinary Team, shall provide a discharge planning service and process, for each resident admitted , that identifies and evaluates the resident's needs and assists him/her in moving from one environment to another. The purpose of discharge planning is to ensure that each resident has a planned program of continuing care, which meets his/her post discharge plan of needs.