STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 interview and record review, the facility failed to ensure the basis for discharge was documented in the residents medical record for 1 out of 4 residents (Resident #1) reviewed for inappropriate discharges. The facility failed to document the basis for Resident #1's discharge prior to discharge. This failure could place residents at risk of diminished continuity of care and unsafe and/or improper discharges. The findings include: Record review of Resident #1's clinical record from 02/28/2025 indicated there was no basis for discharge documented. Record review of Resident #1's face sheet dated 11/18/2025 indicated he was a [AGE] year-old male initially admitted [DATE] and re-admitted [DATE]. Resident #1 diagnoses included: generalized edema (body swelling), shortness of breath, chronic pain, muscle weakness, and hypertension (high blood pressure.) Record review of Resident #1's care plan dated 02/20/2025 indicated he had no history of mood behavior nor any sexual behaviors towards resident's or staff. Record review of Resident #1's minimum data sheet dated 02/18/2025 indicated he had a BIMS score of 15 showing he was cognitively intact. He had no history of mood disorders, dementia, nor disorganized thought process. It also indicated Resident #1 had no physical, verbal, or sexual behavioral symptoms towards others. Record review of Resident #1's nursing progress notes dated 02/18/2025 made by ADON A indicated (in part): she was notified Resident #1 had inappropriately touched a female resident and then he was discharged to Family member B. Record review of Resident #1's progress notes indicated there were no discharge notes that showed the facility considered the care giver's availability, capacity, and/or capability to perform needed care to the resident following discharge. Further review indicated that there were no discharge notes from the social worker. Record review of Resident #1's order summary indicated there was no order nor documentation regarding the reason for discharge provided by a physician or nurse practitioner. During an interview with Resident #1 on 11/18/2025 at 11:46 a.m. he said he was told by unknown staff member that his wife was called for her to pick him up immediately. Resident #1 said he didn't know what he did wrong. During an interview with Resident #1's Family Member B on 11/18/2025 at 11:55 a.m. she stated, she was called approximately at 8:00 p.m. by an unknown staff member and told you need to come pick up your husband immediately because he had his hand up a women resident's shirt. She said staff refused to give any more details on the incident despite her request. She said when she arrived at the facility, she was never given discharge instructions, discharge documents, nor was she asked to sign any discharge paperwork. Resident #1's Family Member B said she was never contacted by the facility ever again. During an interview with the DON on 11/18/2025 at 12:15 a.m. she said that the Administrator and her jointly made the decision together to discharge Resident #1 immediately due to him having his hand up a women resident's shirt. The DON said she told ADON A to call Resident #1's Family Member B and she needed to pick up Resident #1 immediately for discharge. She said no staff member notified the ombudsman of the discharge or called Family Member B after the incident to follow- up with discharge instructions. The DON said ADON A called the physician to inform him of the incident but did not receive an order for discharge from the physician nor nurse practitioner before discharge. The DON said she was not up to date on the facilities immediate discharge policy and procedure. She said the Administrator and her were out of town for work resulting in an inappropriate discharge for Resident #1. The DON said she was responsible for responsible for ensuring staff follow facility policy/procedures. She said the ombudsman should have been notified of Resident #1 discharge, the facility should have had a physician order for discharge, and they should have documented the basis for Resident #1's discharge in his medical records prior to discharge. She said if the discharge policy is not followed it could cause residents to have improper discharges. During an interview with the Administrator on 11/18/2025 at 12:40 p.m. he said the DON and him jointly made the decision together to discharge Resident #1 immediately due to the incident. He said the DON told ADON A to call Resident #1's Family Member B and tell her to pick -up Resident up immediately for discharge. He said no staff member notified the ombudsman of the discharge or called the wife after the incident to follow- up with discharge instructions. The Administrator said the facility did not properly discharge Resident #1 nor did they follow their policy for resident discharges. He said the facility did not have a physician's order for discharge. He verbally acknowledged the facility should have had a physician's order before discharge and they should have documented the basis for Resident #1's discharge in his medical records prior to discharge. The Administrator said if the discharge policy is not followed it leads to residents not being properly discharged