STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Road Dallas, TX 75230

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit, to remain in the facility, and not be discharged from the facility without ensuring appropriate information was communicated to the receiving health care institution or provider for 1 of 4 residents (Resident #1) reviewed for discharge. The facility failed to obtain and communicate to the receiving facility an agreed upon discharge date for Resident #1 prior to his discharge on [DATE]. The facility failed to communicate a nurse-to-nurse report and to communicate to the receiving facility prior to the discharge of Resident #1 on 06/04/26 that Resident #1 was receiving PASRR services. This failure could place residents at risk for an unsafe and ineffective discharge, delays in services, and unmet needs. Findings included: Review of Resident #1's face sheet dated 05/20/26 reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: epilepsy (brain condition that causes recurrent seizures), cerebral palsy (condition affecting movement, balance and posture caused by damage to a baby's brain). The face sheet reflected Resident #1 had a legal guardian who was also Resident #1's medical and financial power of attorney. Review of Resident #1's admission MDS dated [DATE] reflected Resident #1 had a BIMS of 0, indicating severe cognitive impairment. The MDS reflected Resident #1's goal was to discharge to another facility/institution per the resident and legal guardian. Review of Resident #1's care plan with initiated date of 05/21/26 reflected Resident #1 had a focus of impaired cognitive function/dementia with impaired thought processes and an intervention that included to discuss concerns about confusion, disease process, nursing home placement with the resident and family. The care plan did not address discharge. Review of the physician Discharge summary dated [DATE] reflected Resident #1 was discharged to a group home on 6/04/26 with his condition at discharge reflected as good and his rehabilitative potential as fair. The discharge summary reflected follow-up and discharge medications were sent with the resident as were a list of his reconciled medications and belongings.Review of Social Services Notes dated 6/5/26 at 11:43 a.m., by the SW, reflected Resident #1's Legal Guardian called to inform the SW of an upcoming PASRR meeting and requested an update on discharge and reports. The SW informed the Legal Guardian that Resident #1 had been discharged yesterday (6/04/26) and provided the Legal Guardian with contact information again. Review of Social Services Notes reflected a late entry was made by the SW on 6/5/26 at 11:40 a.m. regarding Resident #1 that reflected the SW called the Receiving Facility Personnel on 6/4/26 to discuss transferring patient to the group home today (6/05/26) and that the Receiving Facility Personnel was agreeable and the Receiving Facility Personnel had spoken with the Legal Representative who was agreeable to the transfer. Review of Social Services Notes reflected a late entry regarding Resident #1 was made by the SW on 6/5/26 (time unknown). The note reflected that on 6/03/26 the Receiving Facility Personnel had visited the facility and, Patient is approved for admission. This late entry also reflected that the Receiving Facility Personnel was calling the Legal Guarding to discuss transfer. In an interview on 06/16/26 at 2:59 p.m., LVN A stated she was the nurse who discharged Resident #1 on 6/04/26 and she had attempted to provide a nurse-to-nurse report prior to his discharge, but the receiving facility did not return her call. LVN A (continued on next page)

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	stated she left a voicemail requesting a return call and planned to provide report by phone. LVN A stated this was the first time a receiving agency had not returned a phone call, but if the social worker put the notes for transfer that is what they go by. In an interview on 6/16/26 at 10:19 a.m., the receiving facility personnel stated that the group home is a hospice group home, and she was told that Resident #1 had a discharge diagnosis of malnourishment, but she was not told that Resident #1 was receiving PASRR services. She stated that when she visited the facility on 6/03/26, the facility DON stated Resident #1 was not going to be transferred for several weeks. The receiving facility personnel stated Resident #1 had not been accepted for transfer to the group home when he arrived on 6/04/26, she stated that they did not have a bed ready when he arrived. She decided to accept Resident #1 at that time and did not attempt to get the facility to take him back. The interview did not reflect that Resident #1 experienced physical or emotional harm or distress, but that he did have to wait for a room to be made ready. She stated that the facility SW called her the next day (6/05/26) apologizing for the mix up and thanking her for taking Resident #1 into the facility. The receiving facility personnel stated that the discharge paperwork did not include that Resident #1 was receiving PASRR services and that the facility SW was not aware that Resident #1 was receiving those services. In an interview on 06/16/26 at 2:34 p.m., the MDS Nurse stated PASRR information is entered within 72 hours of receipt. If a PASRR is not received, the management team, admissions, and marketing are notified. PASRR documentation is scanned into the medical record. The MDS nurse stated the risk of PASRR not being in the system is that residents may miss services, including day habilitation and federally approved services. The MDS nurse stated Resident #1 was admitted on [DATE] with an incorrect PASRR from the hospital. As of 5/29/26, the corrected PASRR had not been received. A county representative later confirmed Resident # 1 was PASRR positive. The MDS nurse stated this information was communicated in morning meetings and group messaging. The MDS nurse reported that the PASSR second level evaluation was completed on 6/1/26 and uploaded on 6/4/26. The MDS nurse stated this information was provided to the treatment team through their official meetings and group text where everyone was informed of Resident # 1's PASRR-positive status. In an interview on 06/16/26 at 02:59 p.m., LVN A reported she attempted to provide nurse-to-nurse report, but the receiving facility did not return her call. LVN A stated she left a voicemail requesting a return call and planned to provide report by phone. LVN A stated this is the first time the receiving agency has not returned a phone call. She stated that it was very unusual but if the social worker put the notes for transfer that is what they go by. She stated notifying the receiving facility to give nurse to nurse report was the responsibility of the nurse discharging the resident. She stated she notified her DON that she was unable to reach the receiving facility. She did not state the risk to the resident of failing to provide nurse to nurse report.In an interview on 6/16/26 at 01:08 p.m., the DON stated that it was her expectation that upon discharge the facility had provided discharge instructions, notified the receiving facility, ensured resident belongings were packed, informed the family, and had provided nurse-to-nurse report to the receiving facility. The DON stated that the risk of transferring a resident to a facility without providing nurse to nurse report was, we like to give an update of who the patient really is so they can be prepared in their facility. The DON stated that the risk of transferring a resident to a facility without informing the facility of their PASRR services was, that would be more of a question for the MDS nurse. In an interview on 06/16/26 at 1:48 p.m., the SW stated Resident # 1's, Legal Guardian wanted placement in a group home specialized for Resident # 1's needs. The SW reported that the nursing staff contacted her to discuss the matter on the day of transfer, but she did not answer the phone. The SW stated the receiving facility did know that Residence # 1 was coming that day, he stated the receiving facility personnel were not at the facility on the day of discharge. He said there was a delay because the receiving facility could not allow Resident #1 to enter the building without the receiving facility personnel. The SW believed Resident #1 was waiting in the van for about 45 minutes until the receiving facility personnel arrived. The SW stated he was unaware that Resident # 1 was PASRR positive. The SW stated it's unusual for residents with short-term services to receive (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASRR services. The SW stated on the day of discharge, staff had difficulty reaching the guardian and were unable to contact her. The SW stated that on discharge day (6/04/26) the nursing staff had difficulties reaching the receiving facility to conduct the nurse one on one. The SW stated he did not contact the Legal Guardian on the day of discharge. In an interview on 06/16/26 at 3:33 p.m., the ADM stated nursing was responsible for discharge summaries and physician orders, while social services coordinated placement and transportation. The ADM stated social services typically contacted family members prior to discharge and completed follow-up within 48-72 hours after discharge. The ADM stated her expectations included notifying family members, ensuring belongings accompany the resident, and providing communication with the receiving facility.Review of the facility policy titled, Discharge Planning Process Policy with revision date 03/09/18 reflected: .to develop an interdisciplinary team discharge plan designed to ensure that the resident's needs will be met after discharge from the facility, including resident and family/caregiver education needs.

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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 notify, consistent with his or her authority, the resident representative when there was a decision to transfer or discharge1 of 3 residents (Resident #1) reviewed for discharge. The facility did not notify Resident #1's legal guardian he was being discharged on 06/04/2026. This failure could place residents at risk of ineffective and unsafe discharge and emotional distress.Findings included: Review of Resident #1's face sheet dated 05/20/26 reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: epilepsy (brain condition that causes recurrent seizures), cerebral palsy (condition affecting movement, balance and posture caused by damage to a baby's brain). The face sheet reflected Resident #1's Legal Guardian was also Resident #1's medical and financial power of attorney. Review of Resident #1's admission MDS dated [DATE] reflected Resident #1 had a BIMS of 0 indicating severe cognitive impairment. Review of Resident #1's care plan with initiated date of 05/21/26 reflected Resident #1 had a focus of impaired cognitive function/dementia and an intervention that included to discuss concerns about confusion, disease process, and nursing home placement with the resident and family. In an interview on 6/16/26 at 11:00 a.m., the Legal Guardian of Resident #1 stated that the SW notified her (date unknown) the facility wanted to transfer Resident #1 to a group home due to his behavior. She stated that the SW did not inform her that the receiving facility was a hospice group home. She stated that she told the SW she would need to first verify that the facility was licensed to care for residents receiving PASRR services and she did not give him permission to transfer Resident #1. The Legal Guardian stated that she called to update the SW on 6/05/26 and was notified they had moved Resident #1 to the group home on [DATE]. She stated she never agreed to the transfer and was never informed that Resident #1 was being transferred by anyone until 06/05/26, the day after transfer. In an interview on 06/16/26 at 2:59 p.m., LVN A stated she was the nurse who discharged Resident #1 on 6/04/26 and she called the Legal Guardian approximately three times and left messages. LVN A stated she had not left a message stating that Resident #1 would be discharged , she only requested a return phone call. She stated it was unusual that the Legal Guardian did not return the calls. LVN A stated she reported this to the DON who advised she would attempt to contact the Legal Guardian. In an interview on 6/16/26 at 01:08 p.m., the DON stated it was her expectation that upon discharge the facility had provided discharge instructions, notified the receiving facility, ensured resident belongings were packed, informed the family, and had provided nurse-to-nurse report to the receiving facility. She stated, The patient is not moved without getting in touch with the family. She further stated she had not been aware of any breakdown between nursing and social services during discharge planning. She stated that on the day of Resident #1's discharge (6/04/26), she was notified by LVN A that she had been unable to reach the Legal Guardian by phone. She stated she notified the SW that LVN A had not been able to reach the Legal Guardian and assumed this was handled by the SW. She stated the risk of not notifying a resident's guardian of discharge was, It can cause emotional distress to the patient. In an interview on 06/16/26 at 1:48 p.m., the SW stated he had spoken to the Legal Guardian on 06/02/26 about discharging Resident #1. He did not state that he had provided the Legal Guardian with a discharge date . The SW stated that the day after discharge (6/05/26), Resident #1's Legal Guardian contacted him regarding PASRR and he informed the Legal Guardian that Resident # 1 had been discharged the day before (6/04/26). SW stated the Legal Guardian filed a grievance, indicating she had not agreed with the discharge and was upset. The SW also stated that the Receiving Facility Personnel stated they were going to call the Guardian about placement. However, in an interview on 06/16/26 at 10:19 a.m., the Receiving Facility Personnel stated they had not accepted Resident #1 or agreed upon the discharge date . The Receiving Facility Personnel stated they did not have a bed ready for Resident #1 on the day Resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 unexpectedly arrived. Review of records reflect that on the day that the Legal Guardian filed a grievance, the SW made multiple late entry progress notes reflecting he had received approval from the Receiving Facility Personnel and the Legal Representative to discharge Resident #1 prior to his discharge with no discharge date stated in the progress notes.Review of a Grievance submitted to the SW by the Legal Guardian on 6/05/26 reflected the Legal Guardian reported she was not notified prior to Resident #1's discharge to the group home and that all of Resident #1's belongings were not sent with him. The summary of findings reflected that the prior ADM and SW reviewed the electronic medical record and noted the discharge was discussed at the care plan meeting on 5/26/26. The summary also referenced the late entry progress note by the SW which indicated the discharge was discussed over the phone with the Receiving Facility Personnel. The summary indicated Resident #1's belongings were delivered to the group home by the SW on 6/08/26.In an interview on 06/16/26 at 3:33 p.m., the ADM stated nursing was responsible for discharge summaries and physician orders, while social services coordinated placement and transportation. The ADM stated social services typically contacted family members prior to discharge and completed follow-up within 48-72 hours after discharge. The ADM stated facility expectations included notifying family members, ensuring belongings accompany the resident, and providing communication with the receiving facility. Review of the facility policy titled, Discharge Planning Process Policy with revision date 3/9/2018 stated that a post-discharge plan of care will be developed with the participation of the resident, and with the resident's consent, the resident representative (s).