STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675439	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mullican Care Center	105 N Main St Savoy, TX 75479

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 notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understood and sent a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 4 residents (Resident #1) reviewed for discharge. 1.The facility failed to notify the resident representative, (Office of the State Long-Term Care Ombudsman,) of the transfer or discharge with the reasons for the move in writing in a language and manner they understand. 2.The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #1. 3.The facility failed to notify Resident #1's responsible party of his discharge prior to him being discharged from the facility. These failures could place residents at risk of not receiving an advocate who could inform them of their options, rights, and the added protection from being inappropriately transferred or discharged . Findings included:Record review of Resident #1's face sheet, dated 02/04/2026, indicated an [AGE] year-old male who was re-admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), diabetes mellitus (chronic disease in which the body is unable to produce or properly use insulin), high blood pressure, and depression (a mood disorder that cause a persistent feeling of sadness and loss of interest). Record review of the Resident #1's facility-initiated discharge protocol, dated 01/09/2026, indicated Resident #1 was to be discharged on 01/09/2026. The facility-initiated discharge protocol also indicated the ombudsman portion was not completed. Record review of Resident #1's discharge MDS assessment, dated 01/16/2026, indicated he was discharged on 01/16/26 to an inpatient psychiatric facility. The MDS also indicated he had a BIMS score of 2, which indicated he had severe cognitive impairment. Resident #1 required supervision for ADLs. Record review of Resident #1's eTransfer form, dated 01/16/2026 at 3:00 PM, completed by the ADON, indicated he was transferred on 01/16/2026 at 3:00 PM to an inpatient psychiatric hospital. The eTransfer form indicated the transfer was not an emergency transfer and the facility doctor and the resident representative were notified of the transfer on 01/16/26 at 9:00 AM. During an interview on 02/04/2026 at 1:27 PM, the local facility ombudsman said she was never notified of Resident #1 being discharged from the facility. The facility ombudsman said she found out Resident #1 was discharged on 01/21/2026. During an interview on 02/04/2026 at 2:31 PM, with Resident #1 revealed he was in the secure unit. Resident #1 said he went to the hospital the first time and did not respond to any further questions. During an interview on 02/04/2026 at 3:25 PM, the ADON said Resident #1 was sent to a behavioral health unit to try to ensure the residents of the facility were safe. The ADON said Resident #1 received a 30-day notice, but she did not know when because nursing was not involved with the 30-day discharge process. The ADON said she was not involved with Resident #1's discharge to the behavioral health unit. The ADON said she (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 - Few	completed the discharge assessment to help RN A because he was swamped that day. The ADON said she did not verbally verify with RN A if he contacted Resident #1's family when he was discharged to the behavioral health unit. The ADON said when a resident went to the hospital the family should be contacted prior to the discharge. The ADON said she was not sure where the communication failed with Resident #1's family, but the family should always be notified when a resident was discharged from the facility. The ADON said if a family member was not notified of the residents discharge it could cause the family member to be concerned. The ADON said she was not sure how the resident could be affected. During the interview on 02/04/2026 at 3:58 PM, the Administrator said he was in contact with Resident #1's family member about not being able to fulfill Resident #1's needs at the facility around 01/13/2026. The Administrator said he spoke to Resident #1's family member about discharging him from the facility permanently. The Administrator said he provided a 30-day notice to Resident #1's family member, but he was unsure of the date when he provided it. The Administrator said Resident #1 had increased behaviors, and on 01/16/2026, they decided to send him to a behavioral hospital by obtaining an order from the county judge. The Administrator said when Resident #1 was discharged from the facility the doctor and his family should have been notified. The Administrator said to his knowledge they were not required to notify the ombudsman when a resident discharged to the hospital. The Administrator said he expected the nurses to ensure the doctor and family were notified when a resident was discharged from the facility. The Administrator said the Social Worker notified the doctor of Resident #1's discharge to the behavioral hospital on [DATE]. The Administrator said he was supposed to call Resident #1's family when he was sent to the behavioral hospital, but he forgot to notify them. The Administrator said it was important for the family to be notified of a resident's discharge, so they immediately knew what was happening with the resident. The Administrator said he was not sure how the family not being notified of a resident's discharge could affect the resident, but it could have an adverse effect. During an interview on 02/04/2026 at 3:44 PM, the DON said the facility had several behavior incidents with Resident #1 and she was not involved. She said she did not handle anything with the discharge or the transfer of the Resident #1. The DON said the resident did know the Administrator handed the 30-day discharge to Resident #1's responsible party for Resident #1 to be discharged . The DON said after the notice, the Social Worker stepped in to find placement for Resident #1. The DON said the discharge plan was set by the Social Worker. The DON said she expected the floor nurse to have notified the family and the doctor of Resident #1's discharge and ensured transportation was set up. The DON said she expected the ADON to ensure the family and the MD were notified prior to documenting the information on the eTransfer assessment. The DON said the failure placed a risk of the family not knowing Resident #1 was discharged and the family's rights to know any change in Resident #1's care. During an interview on 02/04/2026 at 4:20 PM, the Social Worker said Resident #1 had several behaviors. The Social Worker said she had been trying to get him into a behavior center, and she went to the local justice of peace and got a detention order from the courthouse in order for the behavior center to be able to take him. The Social Worker said the plan was for Resident #1 to go get treatment and return to the facility. The Social Worker said she heard the Administrator gave a 30-day notice to Resident #1's responsible party, but unsure if it was ever completed. The Social Worker said on 1/16/2026, she was not involved in notification of the family nor the doctor. The Social Worker said typically she handled discharges, but she never completed a discharge the way Resident #1 was discharged . The Social Worker said the Administrator said he was going to notify the responsible party of Resident #1's discharge but she was unsure if he did or not. The Social Worker said normally if she completed a discharge for a resident, she notified the family and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the doctor. The Social Worker said importance of notifying the ombudsman was unknown and she was not aware if the ombudsman needed to be notified. The Social Worker said she did not know the risk associated with the family and doctor not being notified. During an interview on 02/04/2026 at 4:33 PM, the Administrator said it was an oversight that he did not complete the ombudsman notification portion on the Facility initiated Discharge Protocol, dated 01/09/2026. The Administrator said the notification to the ombudsman should have been completed when the form was completed and when Resident #1 was discharged from the facility. During an interview on 02/04/2026 at 4:37 PM, Resident #1's responsible party said the facility gave her a 30-day notice and the discharge date was the day of the notice on 1/9/26. The responsible party said Resident #1 was discharged on 1/16/26 and no one at the facility called to notify her of the discharge. The Responsible party said she spoke with the Administrator on January 16th, and he did not notify her of Resident #1 being discharged . Resident #1's responsible party said she did not know Resident #1 was discharged until the 21st of January when her and the local ombudsman came to visit. During an interview on 02/04/2026 at 4:41 PM, RN A said to the best of his knowledge Resident #1 was discharged prior to the start of his shift, and he was not involved in Resident #1's discharge from the facility to the behavioral health unit. RN A said the ADON and the DON told him the discharge process had been completed when he arrived for his shift. RN Asaid when a resident was discharged , the responsible party and doctor should be notified of the resident's discharge. RN A said the responsible party should be notified in case there were decisions that needed to be made, so they were aware of where the resident was being transported to and why the resident was discharged . Record review of the facility, undated, policy Facility Initiated Discharge indicated:The facility will permit each resident to remain in the facility and not transfer or discharge the resident from the facility. In the following limited circumstances, this facility may initiate transfers or discharges.This facility will ensure the discharge planning process addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.Emergent Transfers to Acute CareResidents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected. When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be provided to the resident and resident representative as soon as practicable. Copies of notices for emergency transfers will also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative, and will also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman.