STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675471	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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 ensure the discharge information was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider for 1 of 6 (Resident #1) residents reviewed for transfer and discharge process. The facility failed to ensure the necessary information, including a discharge summary was included in Resident #1's discharge with applicable information to include contact information of the practitioner responsible for the care of the resident, Advance Directive information, special instructions or precautions for ongoing care, and comprehensive care plan goals, was completed. This failure could result in poor continuity of care and harm or injury to resident during transition of care. Findings included: Record review of Resident #1's face sheet dated 03/06/2026 revealed a [AGE] year-old female admitted [DATE] and discharged [DATE] with diagnoses that included cerebral infarction with right sided hemiplegia (interrupted blood flow in the brain resulting in right sided paralysis), dysphagia (swallowing difficulty), hyperlipidemia (high cholesterol), Buerger's disease (a rare disorder where veins in the hands and feet become clogged with clots), psychotic disorder (severe mental illness causing a loss of contact with reality), and major depressive disorder (mood disorder defined by persistent sadness or loss of interest that impairs daily life). Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident presented with short-term and long-term memory deficits, required modified independence in daily decision making, and presented with inattention and disorganized thinking. Resident #1 was verbal and exhibited other behavioral symptoms that occurred 4-6 days. The activities of daily living and nutritional approaches revealed the resident was independent in eating, and totally dependent in toileting, bathing, dressing and bed mobility and required a mechanically altered diet. Record review of Resident #1's care plan closing date 11/14/25 revealed Resident #1 had a history of poor safety choices, DNR (Do Not Resuscitate in the event of cardiac arrest) status, refusal of housekeeping assistance in room, refusal of psychiatric treatment with active behavior management focus areas to include yelling out, cursing at staff, derogatory comments, false accusations and refusing to allow staff to remove meal trays, required use of bedside loops to assist in bed mobility, anticoagulant-use. Resident #1 had contractures of her left hand and foot drop (the inability to lift the front part of the foot) to left foot, refusal of incontinent care and actual impairment to skin integrity as evidenced by wound (abrasion) to right foot. Record review of Resident #1's EMR revealed there was no physician's order to discharge, no Interdisciplinary Team Discharge plan and no completed discharge summary. During an interview on 03/06/2026 at 11:50 a.m., LVN A stated that for all discharges, she would include the resident's face sheet, medication list, call the accepting facility or hospital and provide a verbal report, notify the responsible party, and obtain a discharge order from the physician. LVN A stated that if the discharge was planned, the IDT members usually initiate a discharge assessment, but if it is unplanned, such as a hospital or emergency room visit, the discharging nurse would complete the transfer documents. During an interview on 03/06/2026 at 12:10 p.m., LVN B stated that she worked at the facility for 3 weeks as the MDS Nurse. LVN B stated that there was a difference in the (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge documents for residents with a planned or unplanned discharge. LVN B stated that the discharging nurse should complete a packet with documents to include a face sheet, medication list, laboratory results, if pertinent, and physician's recent progress note or H & P to reflect resident's care. LVN B stated, additionally, if transfer was to a hospital or alternate facility, the nurse should call a report with pertinent information about the resident. LVN B stated that the resident MDS should reflect a planned or unplanned discharge and if services were coordinated. During an interview on 03/06/2026 at 12:25 p.m., LVN C stated she had been working at the facility for less than three weeks but was aware that a resident discharge would require a physician's order and progress note reflecting the purpose of the discharge, responsible party notification and any pertinent information pertaining to the resident's care. LVN C stated that normally a Discharge Assessment form is completed and sent with the resident along with a face sheet. During an interview on 03/06/2026 at 1:00 p.m., the DON stated that the discharge nurse completed a progress note on the day of discharge that indicated Resident #1was transferred to the accepting facility via ambulance, provided medications and was transferred with her personal belongings. The DON stated that neither a transfer form or discharge assessment and discharge summary were completed to reflect what location the resident was transferred to, whether a nurses' report was provided and clinical records were sent to the accepting facility to include current physician's orders, care plan, psychiatric progress notes and a physician's history and physical. The DON stated that she would provide an in-service for nursing staff regarding the discharge process for planned and unplanned discharges. The DON stated she expected the nurses to complete the appropriate assessments for discharged residents. The DON confirmed that Resident #1 discharged to an alternate nursing facility of her choice with her medications and personal belongings. The DON stated that the discharge was initiated by Resident #1, that referrals were sent to multiple locations and facility was notified of bed availability at the accepting location on the date of discharge. The DON stated the physician was aware of the anticipated discharge pending acceptance at a nursing facility. Attempted interview with discharge nurse LVN D on 03/06/2026 at 1:05 p.m. was unsuccessful. During an interview on 03/06/2026 at 1:10 p.m., the Administrator stated that she expected the nursing staff to complete the appropriate assessments and documentation for all discharge residents, and the DON was responsible for overseeing this process and ensuring accuracy. The Administrator stated that a poor or inaccurate discharge system could result in harm to residents because the accepting agency would not have a full picture of the resident's needs. Record review of the facility's policy titled Discharge or Transfer to another facility, dated 12/14/2027, reflected: Information conveyed to receiving provider.the following information must be conveyed to the receiving provider: Contact information of the practitioner responsible for the care of the resident;Resident representation information including contact information;Advance Directive information;All special instructions or precautions for ongoing care, as appropriate;Comprehensive care plan goals;All information necessary to meet the resident's needs, which includes, but may not be limited to:Resident status, including baseline and current mental, behavioral and functional status, reason for transfer, recent vital signs;Diagnoses and allergies;Mediations (including when last received; andMost recent relevant labs, other diagnostic tests and recent immunizations.