

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675796	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Meridian Care of Hebbbronville		STREET ADDRESS, CITY, STATE, ZIP CODE 606 W Gruy Hebbbronville, TX 78361	
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 readmit one of five residents (Resident #1), immediately, or to the next available bed after the hearing officer determined the discharge was inappropriate. The ADM failed to allow Resident #1 to return to the facility when the hearing officer determined Resident #1's discharge was inappropriate and Resident #1 won his discharge appeal. This failure could place residents at risk of not receiving the appropriate care and services to maintain their highest practicable well-being and at risk of a diminished quality of life. The findings included: Record review of Resident #1's face sheet dated 10/28/25 revealed a [AGE] year-old male with an admission date of 04/17/23 and a discharge date of 04/11/25. Resident #1's pertinent diagnosis included bipolar disorder (a chronic mental health condition characterized by extreme mood swings between highs and lows). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated his cognition was intact. Record review of Resident #1's comprehensive care plan dated 04/11/25 revealed the focuses [Resident #1] demonstrates verbally abusive behaviors daily toward staff and residents, 4/11/25 = UPDATE: Resident continues to be verbally abusive towards staff/residents calling them names, cursing at them, and I have a cognitive impairment due to: Bipolar Disorder. Record review of discharge notice given to Resident #1 dated 04/11/25 revealed Resident #1 was discharged from the facility effective 04/11/25 because his behavioral status endangers the safety of individuals in the facility. Further review revealed Resident #1 had the Right to Appeal: as outlined in the Department of Human Services' Fair Hearings Fraud and Civil Rights Handbook, you have a right to appeal to the Facility's decision to discharge you. Record review of Fair Hearing document on Resident #1's discharge date d 07/28/25 revealed the Lead Hearings Officer gave the following instructions to the facility: Instructions: In accordance with this decision, [facility] is instructed to allow Appellant to remain in, or immediately be re-admitted back into, its facility, if the Appellant and his representative so desire, and not transfer or discharge the Appellant from the facility. Record review of the Action Taken on Hearing Decision document produced by the facility dated 08/08/25 revealed the facility stated there was no action required because Facility does not have an attending physician that will accept resident back into facility. In an interview with the MD at 4:20 PM on 10/28/25, the MD stated he was the medical director and primary physician for every resident at the facility. The MD stated he had taken care of Resident #1 at the facility before his discharge on [DATE]. The MD stated Resident #1 was extremely disruptive while he was a resident at the facility and he did not want to treat him anymore. The MD stated he recommended Resident #1 go to a behavioral facility. The MD stated he did not want Resident #1 back at the facility. The MD stated there were no other doctors that he knew of around the facility that could treat Resident #1. In an interview with the DON at 10:01 AM on 10/29/25, the DON stated Resident #1 was involved in a lot of incidents at the facility including threatening physical violence against both residents and staff. The DON stated she believed the reason Resident #1 was not allowed back in the facility was because there was not a physician to oversee his care. In an interview with the ADM at 10:59 AM on 10/29/25, the ADM stated Resident #1 was discharged from the facility on 04/11/25 because she was concerned about the safety of other residents and her staff. The ADM stated she understood that Resident #1 won his appeal on his discharge from the facility. The ADM stated the MD did not want Resident #1 back in the facility and he refused to treat him. The ADM stated there were no other doctors in the area that could treat Resident #1 in the facility, so they were unable to readmit him. The ADM stated she spoke to Resident #1 on the phone after the appeal decision, but she told him he could not come back because the MD refused to treat him. The ADM stated she sent the response to the Hearings Officer on 08/08/25 that stated that there were no doctors at the facility to treat Resident #1 so they could not readmit him. The ADM stated she had not heard anything since then from the Hearings Officer. The ADM stated she did not attempt to find a new doctor that could treat Resident #1 at the facility. A policy was requested from the ADM on 10/28/25 outlining the proper procedures for a discharge but none was provided. The ADM did provide a signed admission agreement by Resident #1, but it did not list the specific information that was required during the appeal process of a discharge.		

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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 interviews and record review, the facility failed to ensure that one of five residents (Resident #1) reviewed for transfer or discharge had the required contents in the written notice. The facility discharged Resident #1 on 4/11/25 without including a specific location where Resident #1 was going after discharge. This failure could put residents at risk for inappropriate discharge from the facility. The findings included: Record review of Resident #1's face sheet dated 10/28/25 revealed a [AGE] year-old male with an admission date of 04/17/23 and a discharge date of 04/11/25. Resident #1's pertinent diagnosis included bipolar disorder (a chronic mental health condition characterized by extreme mood swings between highs and lows). Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated his cognition was intact. Record review of Resident #1's comprehensive care plan dated 04/11/25 revealed the focuses [Resident #1] demonstrates verbally abusive behaviors daily toward staff and residents, 4/11/25 = UPDATE: Resident continues to be verbally abusive towards staff/residents calling them names, cursing at them, and I have a cognitive impairment due to: Bipolar Disorder. Record review of discharge notice given to Resident #1 dated 04/11/25 revealed Location of discharge: Facility of choice and if you select no location the facility social worker will assist you with locating an appropriate placement. In an interview with the DON at 10:01 AM on 10/29/25, the DON stated she was at the facility when Resident #1 was discharged but did not take part in creating the discharge notice. The DON stated it was not 100% clear on the discharge notice where Resident #1 was being discharged to go. The DON stated it was important to put a specific location on the discharge notice to ensure residents had a safe place to go after leaving the facility. In an interview with the ADM at 10:59 AM on 10/29/25, the ADM stated she filled out the discharge notice but received assistance from her regional team. The ADM stated it was not 100% clear on the discharge notice where Resident #1 was being sent. The ADM stated Resident #1's home address was written at the top of the discharge notice, and that was the location he was being sent to. The ADM stated it was important to be clear with the discharge notice to ensure residents had a safe place to go after leaving the facility. A policy was requested from the ADM on 10/28/25 outlining the proper procedures for a discharge but none was provided. The ADM did provide a signed admission agreement by Resident #1, but it did not list the specific information that was required to be on a discharge notice.		