STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675947	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Care Manor	2736 Farm to Market 775 LA Vernia, TX 78121

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. (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 0555 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 inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements for 1 of 3 residents (Resident #1) reviewed for physician services. The facility failed to inform Resident #1 that his chosen physician did not meet the facility requirements and allow the resident to select a new physician while he was hospitalized beginning on 10/17/2025, leading to the facility refusing readmission of Resident #1. This failure could result in inappropriate discharges or decreased quality of life. Findings included:Record review of Resident #1's face sheet dated 11/20/2025 reflected an [AGE] year-old-male admitted to the facility on [DATE] and discharged on 10/16/2025 to an acute care hospital. Relevant diagnoses included malignant neoplasm (cancer) of left bronchus or lung. The face sheet indicated Resident #1's attending physician was MD B. Record review of Resident #1's quarterly MDS reflected a BIMS score of 13, which indicated intact cognition. Record review of a letter dated 8/05/2025 to Resident #1 from MD A (also the facility's Medical Director) revealed MD A terminated the physician-relationship with Resident #1 effective 9/07/2025 due to conflict with Resident #1's family. Record review of a letter dated 8/28/2025 to Resident #1 from the facility revealed a notice of discharge from the facility effective 9/07/2025 due to the termination of the physician-patient relationship by MD A. The letter instructed Resident #1 to identify a physician prior to 9/07/2025 who is able/willing to serve as Resident #1's attending physician, or he will be discharged to his family member's residence. The letter also included information about residents' rights to appeal discharges. Record review of Resident #1's hospital records dated 10/19/2025 revealed the following:In fact patient was feeling much better was ready to go home and clinically stable we placed the discharge orders andeven did the discharge summary. Later on I was notified by the nursing that doctors at the facility where the patient isresiding are not willing to accept him due to some dispute with the patient's [family member].As such patient will stay in the hospital until this is figured out. Will place a consultation with case management [sic]Record review of Resident #1's hospital discharge records dated 10/24/2025 revealed Resident #1 was discharged from the acute care hospital on [DATE] to a skilled nursing facility. Record review of an e-mail dated 10/20/2025 from the Admin. to the facility's ombudsman indicated the facility would not allow Resident #1 to return to the facility after discharge from the acute care hospital due to concerns about his chosen physician, MD B. The Admin. said MD B was not responsive to the urgent messages communicated by the facility regarding Resident #1, and thus the facility felt MD B could not meet the needs of Resident #1. Therefore, they would not readmit Resident #1. Record review of an e-mail dated 10/21/2025 from the ombudsman to the facility reflected information from the TAC 554.1204 and 554.1201 sent to the facility advising them that it was the facility's responsibility to provide physician services 24-hours a day in the event of an emergency, as well as the responsibility to have a back-up physician available in the event that the primary physician was unavailable. The ombudsman asked in the e-mail if this clarifying information would be sufficient to allow readmission of Resident #1, but no response message was included in the file. In an interview with Resident #1's family member on 11/20/2025 at 12:08 PM, she said she acted as Resident #1's POA and coordinated his medical care. She said she was not notified by the facility during Resident #1's hospitalization beginning on 10/17/2025, that Resident #1 would not be readmitted to the facility. She said she was not contacted by the Admin. at any time during the hospitalization, and she was notified by the hospital's case manager that the facility was refusing readmission. She said she did not receive any documentation, including e-mails or letters, notifying her of Resident #1's discharge. She said Resident #1 had not severed the patient-doctor relationship with MD B at the facility, and he intended to resume care from MD B upon return to the facility. She said she was satisfied with the care provided by MD B, and Resident #1 remained under the care of MD B as of the date of the interview. She said she notified the ombudsman that they wanted to appeal the discharge, but Resident #1 was still refused readmission. Due to the unexpected difficulty with finding new placement, Resident #1's family member said the discharge from the acute care hospital was delayed, and Resident #1 experienced anxiety and sadness about remaining in the hospital without a place to discharge. In an interview with the ombudsman on 11/20/2025 at 2:50 PM, he said that when he became aware of the refusal of the facility to readmit Resident #1 during the hospitalization beginning on 10/17/2025, he notified the Admin. that Resident #1 had a right to return to the facility, and that the actions of the facility constituted dumping. He said the Admin. told him that the facility Resident #1 did not have a physician overseeing his

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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)

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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 permit a resident to return to the facility after hospitalization for 1 of 3 residents (Resident #1) reviewed for discharge rights. The facility failed to allow Resident #1 to return to the facility after hospitalization on 10/17/2025. This failure could lead to psychosocial harm and decreased quality of life. Findings included:Record review of Resident #1's face sheet dated 11/20/2025 reflected an [AGE] year-old-male admitted to the facility on [DATE] and discharged on 10/16/2025 to an acute care hospital. Relevant diagnoses included malignant neoplasm (cancer) of left bronchus or lung. Record review of Resident #1's quarterly MDS reflected a BIMS score of 13, which indicated intact cognition. Record review of Resident #1's EMR did not reveal a discharge summary signed by the resident's physician. Record review of Resident #1's physician orders active as of 10/16, 2025, the date of discharge, did not reveal and order to discharge Resident #1. Record review of Resident #1's hospital records dated 10/19/2025 revealed the following:In fact patient was feeling much better was ready to go home and clinically stable we placed the discharge orders andeven did the discharge summary. Later on I was notified by the nursing that doctors at the facility where the patient isresiding are not willing to accept him due to some dispute with the patient's [family member].As such patient will stay in the hospital until this is figured out. Will place a consultation with case management [sic]Record review of an e-mail dated 10/20/2025 from the Admin. to the facility's ombudsman indicated the facility would not allow Resident #1 to return to the facility after discharge from the acute care hospital due to concerns about his chosen facility. The Admin. said the resident's chosen physician was not responsive to the urgent messages communicated by the facility regarding Resident #1, and thus the facility felt the physician could not meet the needs of Resident #1. Therefore, they would not readmit Resident #1. Record review of an e-mail dated 10/21/2025 from the ombudsman to the facility reflected information from the TAC 554.1204 and 554.1201 sent to the facility advising them that it was the facility's responsibility to provide physician services 24-hours a day in the event of an emergency, as well as the responsibility to have a back-up physician available in the event that the primary physician was unavailable. The ombudsman asked in the e-mail if this clarifying information would be sufficient to allow readmission of Resident #1, but no response message was included in the file. Record review of Resident #1's hospital discharge records dated 10/24/2025 revealed Resident #1 was discharged from the acute care hospital on [DATE] to a skilled nursing facility. In an interview with Resident #1's family member on 11/20/2025 at 12:08 PM, she said she acted as Resident #1's POA and coordinated his medical care. She said she was not notified by the facility during Resident #1's hospitalization beginning on 10/17/2025, that Resident #1 would not be readmitted to the facility. She said she was not contacted by the Admin. at any time during the hospitalization, and she was notified by the hospital's case manager that the facility was refusing readmission. She said she did not receive any documentation, including e-mails or letters, notifying her of Resident #1's discharge. She said Resident #1 had not severed the patient-doctor relationship with MD B at the facility, and he intended to resume care from MD B upon return to the facility. She said Resident #1 remained under the care of MD B as of the date of the interview. She said she notified the ombudsman that they wanted to appeal the discharge, but Resident #1 was still refused readmission. Due to the unexpected difficulty with finding new placement, Resident #1's family member said the discharge from the acute care hospital was delayed, and Resident #1 experienced anxiety and sadness about remaining in the hospital without a place to discharge. In an interview with the ombudsman on 11/20/2025 at 2:50 PM, he said that when he became aware of the refusal of the facility to readmit Resident #1 during the hospitalization beginning on 10/17/2025, he notified the Admin. that Resident #1 had a right to return to the facility, and that the actions of the facility constituted dumping. He said the Admin. told him that the facility Resident #1 did not have a physician overseeing his care properly, so he could not return. He said he also told the facility that Resident #1 should be issued a notice of discharge, but the facility refused. He notified the facility that Resident #1 was formally appealing the discharge, but the facility informed him that Resident #1 could not return despite the appeal. He felt the facility was refusing to readmit Resident #1 due to conflicts with Resident #1's family member, not the issue regarding Resident #1's physician. In an interview with the Admin. on 11/20/2025 at 2:35 PM, he stated Resident #1 was initially terminated as a patient by the facility's MD, MD A, in August 2025, and the facility's second physician was not accepting new patients. Resident #1 then selected his outpatient physician, MD B, to be his physician at the facility, but he said MD B did not