

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Mansfield Medical Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 301 N Miller Rd Mansfield, TX 76063	
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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on interview and record review the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the resident failed, after reasonable and appropriate notice, to pay for a stay at the facility for 1 of 6 residents (Resident #1) reviewed for transfer and discharged rights. The BOM failed to submit Resident #1's Long Term (Medicaid) application and provided bank statements when she and her family expressed interest in applying for Medicaid prior to her discharge from the facility on 09/12/24. This deficient practice could place residents at risk of not being able to remain at the facility, resulting in violation of their rights. The findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE], Resident #1 had diagnoses which included muscle wasting and atrophy, cognitive communication deficit, dysphagia, type 2 diabetes mellitus with hypoglycemia, congestive heart failure, unspecified dementia, other viral pneumonia, chronic kidney disease, and essential hypertension. Record review of Resident #1's care plan, initiated on 08/16/24, reflected the following: Focus: Admit to SNF D/T self-care deficit: Resident requires 24-hour nursing care and has no plans to discharge at this time. Resident will remain long term for nursing services. Record review of the physician order tab of Resident #1's electronic health record reflected the following physician order created on 09/11/24: May discharge home with all medications and personal belongings. Home Health to eval and treat for PT OT ST and nursing. DME as indicated Record review of the progress notes tab of Resident #1's electronic health record reflected the following note, created on 09/19/24 by the SSA: D/C home 9/12/24, transported by [the facility].; [home health agency and contact information]. Wheelchair and 3-1 commode from [DME Company and contact information]. Family will make follow up appt (per clinic request). D/C all meds and personal belongings. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676143	Facility ID: 676143 If continuation sheet Page 1 of 6

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the financial notes tab of Resident #1's electronic health record reflected the following notes made by the BOMA: - a note dated 08/23/24, Spoke with [family member] over MCP if they are wanting LTC, stated [the family member] needed to speak with [family members] to discuss if it will be the right decision. I told [family member] we are on a time crunch to see if she would meet eligibility as we still have not seen any financials and since we have a CC on file she will continue to make the weekly payments for 150 for the copays she is in. [The family member] stated they understood and hopefully by next week and will have a decision. - a note on 09/09/24, spoke with [family member] again over LTC and BO hasn't received any financials to determine eligibility. [Family Member] stated they weren't followed up with by the BO still wanting financials. I told him was he not seeking LTC for [Resident #1] as discussed and [family member] stated yes. I told him we have yet to receive any financial information and BO is needing ASAP, as [Resident #1] will be receiving a NOMNC this week and will have to be DC. [Family member] was upset and stated they would try to get everything in by the end of the week. In an interview on 09/20/24 at 8:26 AM, Resident #1's family member stated Resident #1 was discharged abruptly from the facility on 09/12/24. The family member stated they had been in communication with the facility regarding Resident #1's stay. The family member stated they received a call on 09/09/24 or 09/10/24 from the BOMA stating Resident #1's stay at the facility would no longer be covered. The family member stated they discussed payment options for Resident #1's copays and applying for long term Medicaid. The family member stated after speaking with the family, it was decided to apply for Medicaid for Resident #1. The family member stated they provided the application and bank statements to the facility's business office. The family member stated he received a call from the facility and was told Resident #1 should be seen by her physician before her Medicaid application was processed, as it could help her eligibility. The family member stated they could not recall who they spoke to. The family member stated roughly a week after that call, they received an additional call requesting additional financial information regarding property, life insurance policies and vehicles. The family member stated they notified the facility they would try to get the additional information in and gave verbal payout amounts for the life insurance policy. The family member stated the facility advised him Resident #1 would not qualify for Medicaid and her discharge would continue as planned. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/24 at 3:09 PM, the BOM stated when the facility received a NOMNC for a resident, the resident and their representative and notified of their right of an appeal. The BOM stated if the resident was seeking long term care, they would assist in the application process. The BOM stated if financials were not provided to accompany the Medicaid application, the facility would continue with the discharge especially if the resident was given a NOMNC. The BOM stated if a Medicaid application was filed, the resident could not be discharged until a decision was made. The BOM stated a 30-day notice would be required to discharge a resident after a Medicaid application was submitted. The BOM stated Resident #1 was issued a NOMNC on 09/09/24, with the last covered service date being 09/12/24. The BOM stated Resident #1 appealed the NOMNC and lost the appeal on 09/10/24. The BOM stated Resident #1 and her family were notified they could request a 2nd level appeal, which would take roughly 2 weeks and they would have to pay out of pocket until an appeal decision was made. The BOM stated the family was unable to afford the required payments but did express interest in applying for Medicaid. The BOM stated the family submitted the resident bank statements and she was found to have a few properties, life insurance policies and vehicles in her name. The BOM stated she received a verbal payout figure of the life insurance policy from Resident #1's family member and advised the family member Resident #1 would not qualify after referencing the Medicaid income and resource limits. The BOM stated she had not submitted the Medicaid application because she generally did not submit Medicaid applications she did not believe they would qualify. In an interview on 09/25/24 at 12:10 PM, the BOMA stated discharges were planned at admission. The BOMA stated when residents were issued a NOMNC, they were told of their right to appeal, the facility's payment policies and if the resident wanted to apply for Medicaid, they were assisted. The BOMA stated she believed Resident #1 did not get approved for Medicaid due to the properties in her name and life insurance policies. The BOMA stated the facility would submit Medicaid applications with all supporting documents to determine their eligibility. The BOMA stated they would submit the application to the case worker and if additional documentation was received. The BOMA stated if additional documentation was needed the case worker would let the facility know and give the resident 10 days or so to submit the documentation. The BOMA stated she was uncertain if Resident #1's application was submitted but she could recall the resident had a life insurance policy that was over the resource limit and had properties in her name. In an interview on 09/25/24 at 4:30 PM, the ADMIN stated Medicaid applications were handled by the facility on a case-by-case basis. He stated the facility went by Medicaid guidelines to determine eligibility. The ADMIN stated if the resident did not provide all required documentation, the resident would become a private pay resident. The ADMIN stated the responsibility to submit Medicaid applications fell on the resident and their families, so he was not aware Resident #1's Medicaid application was not submitted, and he believed the BOM misspoke when she stated Medicaid applications were not submitted if they believed they would not be approved. The ADMIN stated he believed the facility did all they could do to assist Resident #1 in applying for Medicaid but the family failed to provide the required documentation to the business office. The ADMIN could not recall when the financial documentation was requested from Resident #1's family. When asked if the BOM should have submitted Resident #1's Medicaid application, the ADMIN stated nursing facilities were a business first and he did not believe Medicaid applications that they know would not be approved should be submitted by the facility. The ADMIN stated when their business office manager and lawyers review the documentation and they find the resident would not qualify, the resident was discharged and referred to independent lawyers to help residents apply for Medicaid. The ADMIN stated he would speak with the BOM about the submission of Medicaid applications in the future. (continued on next page)		

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A related facility policy was requested from BOM and ADMIN on 09/20/24 at 3:09 pm and on 09/25/24 at 4:30 pm but was not provided upon exit.		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 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 failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for one of four residents (Resident #1) and one of one month (August 2024) reviewed for transfer and discharge. 1. The facility failed to send a transfer or discharge notice in writing to the facility's Ombudsman as soon as practicable when Resident #1 was discharged home on 09/12/24. 2. The facility failed to ensure the facility's Ombudsman was notified, at least 30 days in advance of the discharge, or as soon as practicable before transfer or discharge for all discharges during the month of August 2024. These failures could place residents at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes. The findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses which included muscle wasting and atrophy, cognitive communication deficit, dysphagia, type 2 diabetes mellitus with hypoglycemia, congestive heart failure, unspecified dementia, other viral pneumonia, chronic kidney disease, and essential hypertension. Record review of Resident #1's care plan, initiated on 08/16/24, reflected the following: Focus: Admit to SNF D/T self-care deficit: Resident requires 24-hour nursing care and has no plans to discharge at this time. Resident will remain long term for nursing services. Record review of the physician order tab of Resident #1's electronic health record reflected the following physician order created on 09/11/24: May discharge home with all medications and personal belongings. Home health to eval and treat for PT OT ST and nursing. DME as indicated Record review of the progress notes tab of Resident #1's electronic health record reflected the following note, created on 09/19/24 by the SSA: D/C home 9/12/24, transported by[the facility].; [home health agency and contact information]. Wheelchair and 3-1 commode from [DME Company and contact information]. Family will make follow up appt (per clinic request). D/C all meds and personal belongings. Record review of the facility's discharge logs from 06/01/24 to 09/20/24, indicated there were 24 residents who discharged from the facility in the month of August 2024. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 09/25/24 at 10:02 AM, the Ombudsman stated she typically received notification of the facility's discharges by email. The Ombudsman stated she would receive monthly emails which listed the residents who were discharged from the facility. The Ombudsman stated she had no report of Resident #1's discharge and she believed she was last notified of discharges in July 2024. In an interview on 09/25/24 at 11:56 AM, the DON stated the facility hired a new social worker in July 2024. The DON stated the previous social worker did not notify the Ombudsman of the facility's discharges for the Month of August and neither did the facility's current social worker. The DON stated she attempted to call the Ombudsman to confirm the last month of discharges she was notified, but her call was unsuccessful. The DON stated the current social worker would email Augusts discharged to the Ombudsman immediately. In an interview on 09/25/24 at 12:52 PM, the SW stated she had been the facility's social worker for roughly 8 weeks. The SW stated she was still learning the facility's procedures and she did not know she had to notify the Ombudsman of the facility's discharges, but she would notify the Ombudsman of the facility's discharges. In an interview on 09/25/24 at 4:30 PM, the ADMIN stated he was not aware the Ombudsman was not notified of resident discharges since July 2024. The ADMIN stated the SW was solely responsible for notifying the Ombudsman of the facility's discharges. The ADMIN stated discharges should be reported to the Ombudsman monthly, unless a 30-day notice was issued, and a copy of the notice was sent to the Ombudsman the same day the notice was provided to the resident. The ADMIN stated he was unsure of what the Ombudsman did with the discharge notifications, so he was uncertain of how not receiving a discharge notification could affect the residents being discharged . The ADMIN stated he would in-service the SW and monitor discharge notifications to ensure the Ombudsman was notified appropriately in the future. A related policy was requested from the DON and ADMIN on 09/25/24 at 11:56 am and 4:30 pm but was not provided upon exit. t.		