STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676369	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollymead	4101 Long Prairie Road Flower Mound, TX 75028

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to appropriately discharge for 1 (Resident #1) of 7 residents reviewed for transfer/discharge. The facility failed to ensure Resident #1 was not discharged home without Home Health services to assist with ongoing care needs. This failure could place residents at risk of being discharged inappropriately causing a disruption in their care and services and potential decline in health. Findings included:Record review of Resident #1's face sheet, dated 06/12/26, reflected that Resident #1 was an [AGE] year-old male resident who was admitted to the facility on [DATE] and discharged on 06/10/2026 with the diagnoses of Hepatic Encephalopathy (a nervous system disorder caused by severe liver disease), Hypertensive Heart Disease with Heart Failure (condition where chronic high blood pressure forces the heart to work too hard over time), Alcoholic Polyneuropathy (nerve damage caused by heavy alcohol consumption), and Alcoholic Cirrhosis of Liver without Ascites (destruction of normal liver tissue). Record review of Resident #1's MDS, dated [DATE], reflected that Resident#1 had a BIMS score of 10, which indicates Resident #1 had moderate cognitive impairment. MDS indicated Resident #1 was admitted for Inpatient Rehabilitation Facility. MDS indicated in Section Q Participation in Assessment and Goal Planning:Is active discharge planning already occurring for the resident to return to the community? 1. YesHas a referral been made to the Local Contact Agency (LCA)? 0.NoIndicate Reason why referral to LCA was not made. 4. discharge date 3 or fewer months away Record review of Resident #1's care plan, not dated, reflected the following: FocusRisk for Wandering/Elopement Identified, resident exit seeks.GoalThe Resident's safety will be maintained.Interventions1 to 1 supervision, Engage Resident is purposeful activity, identify if there is a pattern and purpose if wandering, Provide clear, simple instructions. FocusThe resident has risk for impaired cognitive function/impaired thought processes diagnoses hepatic encephalopathy.GoalThe resident will improve current level of cognitive function through the review date.InterventionAdminister medications as ordered. Monitor and document for side effects and effectiveness, Ask yes/no questions to determine the resident's needs, Monitor/document/report PRN any changes in cognitive function, specifically changes in decision making, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Care Plan did not indicate information regarding discharge planning. Record review of a text message that was sent to Family Member from the SW number on 06/08/26 reflected Hi this is SW at [Facility]. Resident #1 is going to need to discharge today. The Administrator is asking for a family member to come get him. Please contact me at your earliest convenience. He is still a danger for exit seeking. We provided a sitter through the weekend. The Administrator is no longer willing to cover the cost. Record review of a letter from Resident #1's external doctor dated 06/10/26, reflected To whom it concerns: As you know Resident #1 suffers from chronic alcoholism that has led to cirrhosis, hepatic encephalopathy, neuropathy causing balance disorder, anemia and cognitive impairment. It is my medical opinion that he not live unsupervised or be allowed to drive due to his cognitive impairment. Family Member is currently in the process of trying to find a permanent living facility. Please allow him to continue to stay at your rehabilitation facility a (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	bit longer so Family Member can find a permanent facility. During a phone call on 06/15/26 at 12:55 PM, the Family Member stated when Resident #1 was at the hospital the doctor informed her that they did not recommend Resident #1 to go home. Family Member stated when she went to the facility on [DATE] they were supposed to have a care plan meeting, but the care plan meeting turned into a discharge meeting. The Family Member stated she told the [Facility] it would be an unsafe discharge due to Resident #1 living alone and he had cognitive issues. The Family Member stated the [facility] told her Resident #1 did not have any cognitive issues. The Family Member stated when she told the administrator that if they discharged Resident #1 it would be unsafe the administrator told her, They were just going to get the DON and the physician to clear Resident #1 so they could move forward with the discharge. The Family Member stated that she requested the facility to notify her the day that Resident #1 was going to see the Physician because she wanted to be present due to having some questions, but she was never notified. The Family Member stated that is when she reached out to the doctor from the [Hospital] to get a letter to give to the [facility] letting them know that the [Hospital] did not recommend letting Resident #1 discharge, but she stated by the time she received the letter from the hospital they were already letting Resident #1 discharge. The Family Member stated she was never notified that he was being discharged the day Resident #1 left the [Facility] and she did not even know how he had gotten home. Family Member stated she was going to send the POA paperwork, but surveyor never received it. During a phone call on 06/15/26 at 1:40 PM, the SW stated Resident #1 was discharged due to continuously requesting to be discharged . The SW stated Resident #1 was confused when he first admitted to the facility and she stated that he thought he was in an Anonymous Alcohol center. The SW stated that Resident #1 knew he was in a treatment center and he just did not know it was skilled nursing facility. The SW stated Resident #1 became increasingly agitated about wanting to go home. The SW stated Resident #1 did not remember signing any kind of POA paperwork. SW stated the family member was the POA, but she did not submit the POA paperwork to them until the day before the Resident was being discharged on 06/09/26. The SW stated the family member did not understand resident right's when she was told the resident was going to be discharged due to wanting to go home. The SW stated that Resident #1 stated he did not want to go to a group home. The SW stated that the family member was unhappy about the discharge and stated if they discharged Resident #1 it would be an unsafe discharge because he lived alone. The SW stated the family member became very mad about the discharge and cussed her out. The SW stated she made a report to APS to go and inspect Resident #1's home to determine if his home was a safe environment due to Resident #1 living home alone. SW stated when APS reported back to her that Resident #1's home was a safe environment and there were no hazards. When asking the SW who did she speak with from APS and if she had their contact number she stated that she was unsure of the person's name and she did not have that information in front of her at that moment. SW stated she then made the referral on 06/08/26 for home health care services to go out to the Resident #1's home after he was discharged . The SW stated she then attempted to notify the family member that Resident #1 would be discharged but she stated the Family Member did not answer the phone. The SW stated they discharged Resident #1 and then arranged an Uber ride for Resident #1 to be transported home on [DATE]. The SW stated she followed up with home health care to find out if they went to Resident#1's home, but she stated that she was told they were still in the process of verification and she stated she was unsure who she spoke with. The SW stated she was unsure of the dates that she reached out to home healthcare. The SW stated she made no other follow-ups with home health care to see if they went to the Resident's home She stated she was unsure about what else was discussed due to the incident being so long ago and she stated she was not in front of her computer to look at her notes. The SW stated the risk of discharging a resident inappropriately was that the resident could be put at risk to be sent back to the hospital, or the resident could be injured if no one was checking on him. During an interview on 06/15/26 at 2:34 PM, the DOR stated Resident #1 could walk and on the first day they had trouble finding him in the facility. The DOR stated Resident (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 could walk 500 feet with stand-by assistance. The DOR stated Resident #1 was in his room at first and the next minute they could not find him. The DOR stated Resident #1 needed supervision because of his cognitive impairments and confusion. The DOR stated when Resident #1 was admitted he had some confusion and he was a little better by the time he discharged but he was still slightly confused. The DOR stated during the time Resident #1 was in the facility he had to be redirected quite a few times and she had to educate him that he was confused and it was unsafe for a confused person to leave the facility. The DOR stated that Resident #1 tried to go out of one of the side exit doors, but a staff member was able to redirect him as soon as he opened the door on 06/03/26. The DOR stated when they redirected Resident#1 it only lasted about 15 minutes sporadically and then he would be in the hallway again just looking around trying to see where he was going. The DOR stated Resident #1's was not oriented to the task at times. The DOR stated that Resident #1 would sit in the dining room and he would look around in confusion as if he was lost in his thoughts. The DOR stated in in Resident #1's case he was diagnosed with alcoholic cirrhosis of the liver without ascites, and he also had Hepatic encephalopathy which caused his confusion and the reason he needed supervision. The DOR stated she believed Resident #1 would be safe if he lived with someone at home, but if he lived by himself-there was a chance he could open the door and walk out because that was what he had been trying to do during his time at the facility. The DOR stated she did have some concerns about Resident #1 being discharged due to his cognitive decline and she asked the ADON why he was being discharged and she had told her that it was due to Resident #1 persistently wanting to go home. The DOR stated the risk of inappropriately discharging Resident #1 was that he could make some unsafe decisions that would compromise his health. During an interview on 06/15/26 at 2:58 PM, CNA A stated Resident #1 was a sweet person and from the moment he was admitted he would always say he wanted to go home. CNA stated Resident #1 thought that he was in an anonymous alcohol center. CNA A stated some days Resident #1 would be calm and other days he would say he wanted to go home and he would try to leave the facility. CNA A stated the family member would go to the facility and attempted to convince Resident #1 to stay in the facility but then other times he would feel like the family member was not listening to him and he would become aggressive. CNA A stated Resident #1 would then pack up his belongings and then say that he was leaving. CNA A stated Resident #1 was cognitive enough because he was able to tell her how to get to his home. CNA A stated that Resident #1 told her that he ordered his own groceries. CNA A stated when Resident #1 found out he was in FM he had told her that he did not live too far from the facility and he could walk home. CNA A stated the only time Resident #1 was confused was during the first night he was admitted when they could not find him in his room and then found him sitting in the chapel. CNA A stated Resident #1 was not confused any other time, and he took care of himself, so he had been trying to go home. CNA A stated the risk of discharging a resident inappropriately is that the Resident could be harmed and they should not discharge any residents who they feel would not be suitable for discharge. During a phone call on 06/15/26 at 3:30 PM, Admissions at [Home Health Care] stated they just received the referral for Resident #1 around 3:00 PM on 06/15/26. During an interview on 06/15/26 at 3:37 PM, LVN B stated Resident #1 was in his hall and from the first time he saw him he was always packing his belongings. LVN B stated Resident #1 was always confused and he always had to redirect him. LVN B stated Resident #1 did not understand he was in a nursing facility and thought he was in a hotel. LVN B stated that Resident #1 was not aware of what he was doing due to his acute condition that caused him to be confused. LVN B stated that Resident #1 would think that his truck was parked outside and he could just go and drive it out of the parking lot. LVN B stated he thought that the receptionist had his keys, and he would go to the front and ask for his keys. LVN B stated he did not work with Resident #1 too often he just took his vital signs; made sure he was stable and he would give Resident #1 his medication. LVN B stated Resident #1 would not be safe to discharge himself and he did not give him the impression that he could take care of himself. LVN B stated a risk of a resident being inappropriately discharged was that they could harm themselves. During an interview on (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/15/26 at 3:49 PM, the Physician stated the last time she saw Resident #1 was on 06/08/26 and he appeared very anxious and he wanted to go home. The Physician stated Resident #1 kept telling her someone was going to pick him up. The physician stated during the day she visited Resident #1 the facility still had him under supervision 1 to 1. The Physician stated the facility was worried about an elopement and he kept asking to go home. The physician stated she couldn't remember the day that the SW called her, but she stated she received a call and the SW told her Resident #1 was cleared from therapy and that he seemed to be oriented and that he physically did not need to be in the facility any longer and he could go home. The physician stated that Resident #1 told them he had a friend that could check on him often and so the SW set up his home healthcare services. The Physician stated Resident #1 was admitted with Hepatic Encephalopathy and that's why they did not discharge him immediately. During an interview on 06/15/26 at 4:00 PM, the ADON stated Resident #1 was admitted from the hospital due to him suffering from alcohol abuse. The ADON stated when Resident #1 was admitted he did not agree to be at the facility. The ADON stated Resident #1's Family Member put him at the facility, and the resident wanted to go home. The ADON stated on 06/02/26 when the resident was admitted , they realized Resident #1 was not in his room. The ADON stated the resident was found in the front of the building by the library area, and she called the Administrator. The ADON stated since they did not know the resident too well, they agreed to place him on one in one monitoring to make sure he did not try to leave. The ADON stated the resident did not have exit seeking behavior, but they looked at him as an elopement risk. The ADON stated on 06/03/26 the resident kept saying he wanted to leave, and he did not want to be at the facility. The ADON stated the family member went to the facility and spoke with her directly. The ADON stated she informed the family member that if Resident #1 kept saying he wanted to leave they would need to discharge him and they could not keep him there because they did not have a locked unit. The ADON stated he remained on one-to-one supervision until 06/09/26 when he packed his bags and put them in his wheelchair and said he was leaving. The ADON stated she called the family member to notify of the Resident #1's behavior, and the family member responded, What do you want me to do? The ADON stated the family member said to let Resident #1 go outside and once Resident #1 realized he could not go anywhere he would go back into the facility. The ADON stated she then informed the Family Member they could not do that. The ADON stated on 06/09/26 they had a care plan meeting with Resident #1 and the family member. During the meeting, the Family Member was asked where Resident #1 lived. The ADON stated the family member reported that the resident lived alone and that if he were discharged it would be an unsafe discharge. The ADON stated Resident #1 then stated in the care plan meeting that he wanted to go home again. The ADON stated that the family member cussed out the SW and told the administrator that she did not want to hear anything else from him because she was upset that they were going to discharge Resident #1. The ADON stated the SW then setup a discharge date and made an APS report so they could go and view Resident#1's home to see if the home environment was safe. The ADON stated APS reported back and said the home would be safe and that it would not be an unsafe discharge. The ADON stated they did not plan on discharging Resident #1 but once he said he wanted to leave he was able to go after therapy cleared him and the physician said he could go. The ADON stated that once he was discharged on 06/10/26 he went home and called from a neighbor's phone and let the facility know he had made it home, he was doing well, and that his neighbor said he would check on him. The ADON stated she had set up home health care to visit to go to Resident #1's home. The ADON stated the risk of discharging a resident inappropriately could be catastrophic and a resident could fall, be disoriented, or go back to the hospital and not be able to take care of themselves. During a phone call on 06/15/26 at 4:45 PM, the Physician stated she did not know if the surveyor was still at the facility, but she had just left and she wanted to call to clarify. The Physician stated she spoke with the DOR, and she was unaware that therapy had concerns regarding Resident #1 being able to discharge. The Physician stated she questioned therapy about not notifying her of their concerns. The Physician stated when the SW (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called her and told her that Resident #1 was cleared from therapy and that APS went out to Resident #1's home and confirmed his environment would be safe she stated she told her okay he could discharge. The physician stated she typically just trusts them when they say a resident is cleared to go home. The physician stated at the time when she spoke with the SW about the discharge, she was also unaware that the Family Member felt the discharged would have been unsafe. The Physician stated had she would have known that the Family Member had concerns about the discharge she would have told them to have a meeting with the Family Member to discuss the concerns. The Physician stated the risk of a resident being discharged inappropriately was that the resident would not get the care they needed. During an interview on 06/16/26 at 9:45 AM, the Administrator stated he and the Regional Director went to visit Resident #1 at his home. The Administrator stated the resident appeared to be fine. During an interview on 06/16/26 at 10:20 AM, the Speech Therapist stated he only worked with Resident#1 for two sessions of therapy and from the times he worked with him his cognitive status was pretty low. The Speech Therapist stated his problem-solving abilities were severe, and it only improved to moderate by the time he left. The Speech Therapist stated he was not sure about the discharge process, and they only told him when a resident was being discharged . The Speech Therapist stated his day-to-day recall was not all the way there. He stated Resident #1 was able to tell him about something that happened a couple of months ago, but he could not remember the details. The Speech Therapist stated on another occasion Resident #1 asked him if the facility was an anonymous alcohol center, and he told him that it was a skilled nursing and facility. He stated the next day the resident did not remember that conversation and asked him if the facility was an anonymous alcohol center again. The Speech Therapist stated that he did not know much about the discharge, so he would not know what the risk of discharging a resident inappropriately would be. During a phone call on 06/16/26 at 3:35 PM, Resident #1 gave the surveyor consent to go to his house to check on him. During a phone call on 06/16/26 at 3:40 PM, Family Member stated she received a call from the RD on 06/15/26 and he told her that they were going to go to Resident #1's house to check on him and she stated she told him not to go to Resident #1's house. The Family member stated The Administrator and the RD still went to Resident #1's home and she said Resident #1 said that he was scared because he said, he did not know who they were and he thought they were trying to take him back to the [Facility]. Family member stated she would meet surveyor at Resident #1 house because she did not want him to be scared when the surveyor went to visit him. During an interview with Resident #1 and the family member on 06/17/26 at 4:15 PM, when trying to ask Resident #1 about the [Facility] he stated, which one is [Facility] is that the one in [NAME]? The family member informed Resident #1 that he was never in a facility in A. When trying to ask Resident #1 questions about what happened when he discharged from [Facility], Resident #1 then stated, where is [Facility] again. Resident #1 stated so I was never in [NAME], and the family member answered, no. Resident #1 stated it is clearly something wrong with my memory. When attempting a third time to ask the residents questions about [Facility] he stated, that's not the one in [NAME]. The family member then told Resident #1 it's the one you think that is in [NAME]. The family member stated the [Facility] is the one where the two guys came to visit with you yesterday. Resident #1 stated oh that's who came to the house yesterday, he stated there were two guys and one stood back and the other one stood at the door and he stated they did not have on any professional clothes. Resident #1 stated they scared him and he started not to open his door. Resident #1 then stated all he remembered was that the driver that brought him home was nice and he stated he did not remember who the transport was, but it could have possibly been transportation that the facility uses all the time. Resident #1 stated he had his walker when he left the facility and remembered falling 5 times. Resident #1 had no visible injuries during the visit on 06/16/26. Resident #1 stated that he did not remember if the [Facility] told him why he was at the facility.Resident #1 stated you have to remember it has been 8 weeks of being in two different facilities. The family member then informed Resident #1 that it had not been 8 weeks at all and that he was only at the [Hospital] and the (continued on next page)

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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	had been disoriented when she assessed him, she would not have let him be discharged and she would have kept him the facility. The DON stated the risk of discharging a resident inappropriately was that the resident could be at risk of returning to the hospital, they could fall or even have some medication issues. During an interview on 06/17/26 at 4:13 PM, the Administrator stated when Resident #1 was first admitted he received a call Resident #1 was not in his room and he told staff to do a search of the building. The Administrator stated he guessed Resident #1 did not know he had to stay in his room. The Administrator stated they decided to move Resident # ?1's room closer to the nurse's station because he was new and they did not know if he would try to leave the building. The Administrator stated at first they were going to put him one-to-one supervision for the first couple of days and then they decided to get a sitter for Resident #1 and continue one-on-one supervision. The Administrator stated on 06/09/26 the day before Resident #1 was discharged he packed all his stuff and said that he wanted to go home. The Administrator stated when they had the meeting with the family member to notify her that they were going to let Resident #1 discharge, and he stated the family member started using profanities toward him and he told her he was not going to continue to speak to her any longer due to her not having a civilized conversation. The Administrator stated the family member told them that it would be an unsafe discharge due to Resident #1 living by himself. The Administrator stated that is when the SW set up for APS to go visit Resident #1's home and then had Resident #1 assessed and the SW set up home health care services for Resident #1. He stated that he had heard that home health care did not receive the referral, and he asked the SW about it, but the SW said she set it up on 06/08/26 and that's all he could go off of. The Administrator stated the DON and the physician stated he was safe to discharge. The Administrator stated Resident #1 was alert and oriented when he was discharged . The Administrator stated Resident #1 knew his exact address and where he wanted to go. The Administrator stated the expectation of staff were to notify the physician, family, and set up appropriate post discharge services like home health care or hospice. The Administrator the risk of discharging a resident inappropriately was that the resident would not get the appropriate services or equipment needed for their health and they could possibly not get their medications. Record Review of facility policy titled Transfer and Discharge (including AMA), undated, reflected the following in part:Policy: It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.Policy Explanation and Compliance Guidelines:The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's needs. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.The health of individuals in the facility would otherwise be endangered.Anticipated Discharge to the CommunityFacility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care.A member of the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following:A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.A final summary of the resident's status.Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or discharge will be provided and d