

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Methodist Transitional Care Center-Desoto LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 109 Methodist Way Desoto, TX 75115	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure right to reside and receive services in the facility with reasonable accommodation of resident needs for 1 (Resident #13) of 6 residents reviewed for call lights.</p> <p>The facility failed to ensure Resident #13's call button was accessible on 07/15/24.</p> <p>This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency and their needs not being met.</p> <p>Findings included:</p> <p>Record review of Resident #13's face sheet dated 7/15/24 revealed Resident #13 was [AGE] years old with diagnoses of generalized muscle weakness, abnormalities of gait and mobility, mild cognitive impairment, falls, and a history of traumatic brain injury.</p> <p>Record review of Resident #13's Care Plan dated 6/24/24 revealed Resident #13 was at risk for falls and interventions to prevent falls included having the call light within reach.</p> <p>Record review of Resident #13's MDS dated [DATE] revealed Resident #13 had a BIMS score of 11 (suggest moderate cognitive impairment), had a history of falls, and required substantial assistance with transfers.</p> <p>In an interview on 7/15/24 at 10:30 a.m., Resident #13 stated he did not know where his call light was.</p> <p>Observation on 7/15/24 at 10:30 a.m., Resident #13 was in his bed, reached for his call light, but was unable to find it. Call light was at least 6 feet away in a chair across the room.</p> <p>In an interview on 7/15/24 at 10:40 a.m., RN A stated having the call light in place was an intervention to prevent falls for Resident #13.</p> <p>In an interview on 7/15/24 at 1:29 p.m., the DON stated Resident #13 had fallen on 6/28/24 and was sent to the emergency room due to hitting his head. The DON also stated the resident fell again on 7/11/24 but did not sustain any injuries.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 7/15/24 at 2:05 p.m., the DON entered Resident #13's room and removed a fall mat. The resident was sitting in his wheelchair, and his call light was in a chair located behind him not within reach.</p> <p>In an interview on 7/15/24 at 3:03 p.m., CNA A stated fall interventions included ensuring call lights are within reach.</p> <p>Observation on 7/15/24 at 3:10 p.m., Resident #13 was sitting in a chair in his room, with his call light under his buttocks, and dangling behind him on the floor.</p> <p>In an interview on 7/15/24 at 3:15 p.m., LVN A stated Resident #13 can use a call light. LVN A also stated to prevent falls, call lights are placed within reach.</p> <p>In an interview on 7/15/24 at 3:21 p.m., the DON stated Resident #13 can use a call light but does not use it due to being impulsive.</p> <p>In an interview on 7/15/24 at 3:30 p.m., CNA B stated Resident #13 is doing better when using his call light to call for assistance but he is impatient. CNA B also stated Resident #13 walks but is unsteady.</p> <p>Observation on 7/15/24 at 4:18 p.m., Resident #13 was resting in bed and the call light was in a chair across the room not within reach.</p> <p>In an interview on 7/15/24 at 4:40 p.m., the DON stated the expectation is for call lights to be within reach at all times for all residents, and that residents could fall if unable to call for assistance.</p> <p>Record review of the facility's policy titled Answering the Call Light dated March 2012 stated, The purpose of this procedure is to respond to the resident's requests and needs, and when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>