STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676492	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed to immediately notify the Family Member of a significant change in the resident's health status; or a need to alter treatment significantly for 1 (Resident #1) of 3 residents reviewed for parameters to notify the family of a change in condition. 1.The facility failed to notify Resident #1's Family Member after he had an unwitnessed fall and had breakthrough pain on the morning of 02/01/25. The noncompliance was identified as past noncompliance. The facility corrected the noncompliance before the investigation began on 02/04/25. This failure could affect residents by placing them at risk for not having an advocate, delay in medical treatment, or decline in health. Findings included: Record review of Resident #1's electronic face sheet, dated 02/04/25, reflected a [AGE] year-old male, who admitted to the facility initially on 06/15/22, and had a readmitted [DATE]. Resident #1 had a diagnosis of Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (high blood pressure), Dementia (decline in mental abilities), Heart Failure, and History of Falling. Record review of the progress notes on Resident #1's electronic record, dated 02/04/25, reflected the following: 02/01/25 18:17 (6:17 PM) Note Text : late entry: patient was found on floor of room, patient had no skin tears, bp 186/90 p100, patient expressed pain through with consistent yelling ow and help me he also kept grabbing his right hip and refused to lay on that side when being assessed. NP and DON (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

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 02/05/2025
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)

F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

[DON] were notified as well. wife stated patient can take 650mg Tylenol for relief. this nurse administered the 650mg Tylenol and patient

showed relief. NP [NP D] ordered full pelvic x-ray. [DON] ordered tramadol and Tylenol. this nursehas entered orders. patient is in need of

a sitter due to his urge to wander to prevent falls, bed has been in low position since admission on 1/31/2025. plan of care ongoing.

Author: [LVN A]

02/01/25 21:15 (9:15 PM)

While waiting for the X-ray results, the family requested the resident be sent to the emergency room due to pain. A 911 call made,

EMS arrived and transport the resident to [Hospital name]. RP is present, and the administration notified.

Author: [LVN B name]

Record review of Resident #1's hospital document dated 02/04/25, reflected Resident #1 was diagnosed with a right hip fracture that required surgery.

In a telephone interview on 02/04/25 at 12:37 PM, Resident #1's Family Member confirmed that Resident #1 had a hip fracture and had surgery the morning of 02/04/25. The Family Member stated they arrived at the facility around 9:50 AM, and the fall must have occurred before then. The Family Member stated Resident #1 was screaming and yelling in pain when they arrived at the facility to visit. The Family Member stated no one was going into Resident #1's room to assist him. The Family Member stated they requested to speak with the DON, but DON was not there. The Family Member stated the MOD came into the room to talk to them around 10:30-11:00 AM. The MOD informed her that pain medication and x-rays were requested. The Family Member stated the MOD was the one that said Resident #1 had a fall. The Family Member stated LVN A did not call to say Resident #1 had a fall, and when the Family Member arrived at the facility that morning, LVN A still did not mention Resident #1 had a fall.

In a telephone interview on 02/04/25 at 3:22 PM, LVN A stated she did not inform Resident #1's responsible party or any family member about the fall. She stated she did not do it on purpose but failed to tell the family that Resident #1 had fallen earlier.

In an interview on 02/05/25 at 10:43 AM, the DON stated LVN A failed to notify Resident #1's Family Member about the fall. She stated all staff were trained to notify the doctor, nurse management, and the family after a significant change or incident. She stated the risk of not notifying the responsible party after an incident or change in condition was the family not being able to be there for the resident. The DON stated LVN A was terminated.

(continued on next page)

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 02/05/2025
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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/05/25 at 11:08 AM, the Administrator stated LVN A should have notified the family about Resident #1's fall. She stated the risk of not informing family or the responsible party was future issues by not following policy, a failure in customer service, and loss of transparency with family members of residents. In an interview on 02/05/25 at 2:24 PM, RN I stated she worked on the weekend, and she received in-services then. She stated the in-service were over pain management, pain assessments, neuro checks, incident reports, documentation, notification of changes, resident rights, and abuse and neglect. She stated if there was any time of pain management with a resident, all nurses were to follow-up with management. In an interview on 02/05/25 at 2:33 PM, LVN J stated he received in-services this week over abuse and neglect, pain management, fall prevention, documentation, assessments, checks, and notifying the families and the physician. He stated he was told to update the DON with any pain management concerns. He stated he was informed if he worked on the weekends to follow up with the weekend supervisor, ADON, or DON with concerning pain management. In an interview on 02/05/25 at 2:43 PM, ADON F stated she received in-services on Monday regarding pain management, abuse and neglect, resident rights, documentation, fall prevention, chain of command, notification of changes, incidents, and accidents. She stated when there is an incident like a fall, the pain assessments, neuro checks, incident reports, and overall documentation should be available in their electronic system. Record review of a document titled, Emergency Plan of Correction dated 02/03/25, reflected the following: Emergency Plan of Correction Risk Management/ Pain Management 2/3/2025 Problem: Timely Incident Reporting/ Timely Incident Accident Documentation Initiation/ Pain Management Immediate Action: All Nursing Staff In-service, scrubbed risk management documentation, and mass text to notify all staff to call DON and Administrator of any incident/accident immediately Date Completed: 2/2/25 Systemic: DON, ADON, and Administrator will promptly assess documentation for MD and family notification. And assess orders for need for pain regimen and management. Date Completed:2 2/2/25 - ongoing. Monitoring: Daily monitoring of risk management tab and pain assessment. Record review of a document titled, Record of Disciplinary Measure, dated 02/02/25, reflected LVN A did not call the family to notify them or inform the family of the fall when they arrived at the facility for a visit on 02/01/25. (continued on next page)

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 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Change in a Resident's Condition or Status, dated 2001, with a revision date of December 2016, reflected the following: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychosocial status; c. There is a need to change the resident's room assignment; d. A decision has been made to discharge the resident from the facility; and/or e. It is necessary to transfer the resident to a hospital/treatment center.

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 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one resident (Resident #1) of three residents reviewed for change in physical, mental, or psychosocial status. 1. The facility failed to complete routine neuro checks after Resident #1 had a fall on the morning of 02/01/25, and continued to have pain. The noncompliance was identified as past noncompliance. The facility corrected the noncompliance before the investigation began on 02/04/25. This failure could affect residents by placing them at risk for a delay in medical treatment, worsening in condition, or hospitalization . Findings included: Record review of Resident #1's electronic face sheet, dated 02/04/25, reflected a [AGE] year-old male, who admitted to the facility initially on 06/15/22, and had a readmitted [DATE]. Resident #1 had a diagnosis of Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (high blood pressure), Dementia (decline in mental abilities), Heart Failure, and History of Falling. Record review of Resident #1's care plan, dated 06/29/22 was the only care plan listed for the resident from a previous admission. The past care plan did reflect a history of pain due to a past pelvic fracture. The care plan reflected the goal was for Resident #1 to remain free from pain or at a level of discomfort acceptable to the resident. The care plan also reflected a goal of decreased pain within one hour of intervention. The interventions listed on the care plan for pain were to administer pain medications per the physician's orders, given PRN medications for breakthrough as per the physician's orders, note effectiveness, and to report complaints and non-verbal signs. Record review of Resident #1's electronic record reflected no documented pain assessments on 1/31/25 or 02/01/25. Record review of Resident #1's physician's orders dated 02/04/25, reflected the following: Tramadol HCl Tablet 50 MG Give one tablet by mouth every four hours as needed for moderate and severe pain, order date 02/01/25 Tylenol 8-hour Arthritis Pain oral tablet extended release 650 MG (Acetaminophen) Give 1 tablet by mouth three times a day for pain, order date 02/01/25 Monitor pain every shift, order date 01/31/25 Record review of Resident #1's Nurse Administration Record, dated [DATE], reflected the following: (continued on next page)

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 02/05/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor pain every shift, with a start date of 02/01/25 and an end date of 02/03/25. Record review of the progress notes on Resident #1's electronic record, dated 02/04/25, reflected the following: 02/01/25 18:17 (6:17 PM) Note Text : late entry: patient was found on floor of room, patient had no skin tears, bp 186/90 p100, patient expressed pain through with consistent yelling ow and help me he also kept grabbing his right hip and refused to lay on that side when being assessed. NP D and DON [DON] were notified as well. wife stated patient can take 650mg tylenol for relief. this nurse administered the 650mg tylenol and patient showed relief. NP [NP D] ordered full pelvic xray. [DON] ordered tramadol and tylenol. this nursehas entered orders. patient is in need of a sitter due to his urge to wander to prevent falls, bed has been in low position since admission on 1/31/2025. plan of care ongoing. Author: [LVN A] 02/01/25 21:15 (9:15 PM) While waiting for the X-ray results, the family requested the resident be sent to the emergency room due to pain. A 911 call made, EMS arrived and transport the resident to [Hospital name]. RP is present, and the administration notified. Author: [LVN B] Record review of Resident #1's hospital document dated 02/04/25, reflected Resident #1 was diagnosed with a right hip fracture that required surgery. In a telephone interview on 02/04/25 at 12:37 PM, Resident #1' Family Member confirmed that Resident #1 had a hip fracture and had surgery the morning of 02/04/25. The Family Member stated they arrived at the facility around 9:50 AM on 02/01/25, and the fall must have occurred before then. The Family Member stated Resident #1 was screaming and yelling in pain when they arrived at the facility to visit. The Family Member stated no one was going into Resident #1's room to assist or assess him. The Family Member stated they requested to speak with the DON, but the DON was not there. The Family Member stated the MOD came into the room to talk to them around 10:30-11:00 AM. The MOD informed her that pain medication and x-rays were requested. (continued on next page)

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 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON, on 02/04/25 at 12:57 PM, the DON stated Resident #1 fell on [DATE]. The DON stated NP D told her to contact NP C to get the order for pain medication. The DON stated by 11:30 AM, the facility had received the order for the Arthritis Tylenol and the Tramadol. The DON stated she was not sure if Resident #1 had any pain medications between 9:00 AM and 11:30 AM. She stated Resident #1 did not admit to the facility the day before with any pain medication. The DON stated the staff at the facility were immediately in-serviced starting on 02/02/25 regarding pain management, notification of changes, documentation, resident rights, and abuse and neglect. She stated they started reviewing all resident files and medication records to check for any additional concerns. In a telephone interview on 02/04/25 at 3:22 PM, LVN A stated she no longer was working at the facility. She stated she already told everyone what happened. LVN A stated Resident #1 had an unwitnessed fall around breakfast time on 02/01/25. She stated she did not remember the exact time of the fall. She stated she immediately contacted NP D, who gave her orders for x-rays. She stated she had to put the x-ray order into the system to request the x-ray company to come to the facility. LVN A stated the x-ray company arrived at the facility around 5:00 PM that evening, on 02/01/25. She stated she believed she received an order for pain medication around mid-day but did not recall the time. LVN A stated all she knew was Resident #1 received a dose of Tylenol, but she did not remember the time she administered it. She stated she crushed it and put it in applesauce, because the resident was on a pureed diet. LVN A stated Resident #1 did not yell as much after he received the Tylenol. She stated she did not complete the pain assessments or neuro checks, because Resident #1 was not yelling as much as he was that morning. LVN A stated the Tramadol never arrived. She stated she was in-serviced on pain management and fired. LVN A stated that was all she was going to say about the incident and hung up the telephone. In an follow-up interview on 02/05/25 at 10:43 AM, the DON stated LVN A told her she did not document the neuro checks, because she did not complete the neuro checks, because she thought Resident #1 was better. She stated LVN A should have continued to do neuro checks throughout the shift. The DON stated that discrepancy was a reason why LVN A was terminated. The DON stated the risk of not completing the neuro checks was Resident #1 possibly suffered longer. In an interview on 02/05/25 at 11:08 AM, the Administrator stated LVN A and the Weekend Supervisor RN were responsible for following up neuro checks for Resident #1. The Administrator stated after the incident, starting on 02/02/25, the facility completed in-services on abuse and neglect, pain management, incidents, incident reporting, resident rights, notification of changes, assessments, and documentation. The Administrator stated on 02/02/25, the DON started an audit to ensure all nurses complete pain assessments, incident reports, and neuro checks. The Administrator stated she has reviewed and will continue to review and verify during the morning stand up meetings Monday through Friday. The Administrator stated on the weekend, she, the DON, and the weekend supervisors would monitor and review. She stated with pain management, the DON and the ADONs have started doing audits with new admissions as well as current residents. She stated they started a checklist to ensure orders are in place, the DON has started a report on medications ordered. The Administrator stated the DON started daily audits, and she has weekly audits. The administrator stated the DON and ADONs have started monitoring all changes in condition and the managers review during the daily stand-up meeting. The Administrator stated on the weekends, the DON and ADONs would do check-ins. She stated mass text messages were sent to the nurse staff to contact the DON or ADONs on the weekend concerning pain management. (continued on next page)

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 02/05/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 1:56 PM, Caregiver G stated she received in-services on abuse and neglect, resident rights, pain management, notifying a nurse or management if a resident complains about pain, documentation, incident reporting, and fall prevention within the last two days. She stated she was trained to let a nurse know if a resident had an accident or if the resident was in pain. She states she was in-serviced on following up to ensure the nurse checked on the resident. She stated if that resident still complained of pain, she would let the DON know. In an interview on 02/05/25 at 2:11 PM, Medication Assistant H stated she was in-serviced on Monday about abuse and neglect, resident rights, pain management, incident reports, documentation, notifying nurses of incidents, and fall prevention. She stated she was in-serviced about letting a nurse know if a resident was in pain, so the nurses could do pain assessments. She stated she could provide pain medication if it was available and if the resident had not already had pain medications. She stated some medications have to be given by the nurse. In an interview on 02/05/25 at 2:24 PM, RN I stated she worked on the weekend, and she received in-services then. She stated the in-service were over pain management, pain assessments, neuro checks, incident reports, documentation, notification of changes, resident rights, and abuse and neglect. She stated if there was any time of pain management with a resident, all nurses were to follow-up with management. In an interview on 02/05/25 at 2:33 PM, LVN J stated he received in-services this week over abuse and neglect, pain and neuro checks, fall prevention, documentation, assessments, checks, and notifying the families and the physician. He stated he was told to update the DON with any pain management concerns. He stated he was informed if he worked on the weekends to follow up with the weekend supervisor, ADON, or DON with concerning pain management. In an interview on 02/05/25 at 2:43 PM, ADON F stated she received in-services on Monday regarding neuro checks, abuse and neglect, resident rights, documentation, fall prevention, chain of command, notification of changes, incidents, and accidents. She stated when there is an incident like a fall, the pain assessments, neuro checks, incident reports, and overall documentation should be available in their electronic system. Record review of a document titled, Record of Disciplinary Measure, dated 02/02/25, reflected LVN A was disciplined and terminated for resident abuse, neglect, or failure to report such incidents immediately and failure to follow facility rules, policies, and procedures. The document reflected LVN A had a patient under her care who had a fall on 02/01/25 and nurse failed to complete neuro checks/assessments and to monitor Resident #1 after the fall. Record review of an in-service titled, Abuse and Neglect dated 02/02/25, and covered the facility's abuse and neglect policy. All care staff on the employee roster received the in-service. Record review of an in-service titled, incident/accident/neuro checks dated, 02/02/25, and covered accident, incidents, chain of command, and documentation. All care staff on the employee roster received the in-service. (continued on next page)

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 02/05/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an in-service titled, Nurses Falls Witnessed and Unwitnessed, dated 02/02/25, and noted it covered, falls, incidents, pain management, medication orders, x-rays, sending residents out to the hospital, and notifying management, including the DON, as well as the doctor and the family. All care staff on the employee roster received the in-service. Record review of the facility's policy titled, Accepts and Incidents- Reporting and Investigating, and dated 2001 with a revision date of April 2010, reflected the following: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation I. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident fonn: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; I. Follow-up infonnation; m. Other pertinent data as necessary or required

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 3 residents (Resident #1) reviewed for pain management. The facility failed to adequately assess and treat Resident #1's severe breakthrough pain as he was screaming in unrelenting pain. The noncompliance was identified as past noncompliance. The Immediate Jeopardy was identified on 02/05/25 at 1:02 PM and was removed on 02/05/25 at 4:15 PM. The facility corrected the noncompliance before the investigation began on 02/04/25. The Immediate Jeopardy occurred in the past and the facility had already corrected the non-compliance. This failure could place residents at risk for unnecessary pain, discomfort and a decreased quality of life. Findings included: Record review of Resident #1's electronic face sheet, dated 02/04/25, reflected a [AGE] year-old male, who admitted to the facility initially on 06/15/22, and had a readmitted [DATE]. Resident #1 had a diagnosis of Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (high blood pressure), Dementia (decline in mental abilities), Heart Failure, and History of Falling. Record review of Resident #1's care plan, dated 06/29/22 was the only care plan listed for the resident from a previous admission. The past care plan did reflect a history of pain due to a past pelvic fracture. The care plan reflected the goal was for Resident #1 to remain free from pain or at a level of discomfort acceptable to the resident. The care plan also reflected a goal of decreased pain within one hour of intervention. The interventions listed on the care plan for pain were to administer pain medications per the physician's orders, given PRN medications for breakthrough as per the physician's orders, note effectiveness, and to report complaints and non-verbal signs. Record review of Resident #1's electronic record reflected no documented pain assessments on 1/31/25 or 02/01/25. Record review of Resident #1's physician's orders dated 02/04/25, reflected the following: Tramadol HCl Tablet 50 MG Give one tablet by mouth every four hours as needed for moderate and severe pain, order date 02/01/25 Tylenol 8-hour Arthritis Pain oral tablet extended release 650 MG (Acetaminophen) Give 1 tablet by mouth three times a day for pain, order date 02/01/25 Monitor pain every shift, order date 01/31/25 (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Nurse Administration Record, dated [DATE], reflected the following: Monitor pain every shift, with a start date of 02/01/25 and an end date of 02/03/25. Record review of the progress notes on Resident #1's electronic record, dated 02/04/25, reflected the following: 02/01/25 18:17 (6:17 PM) Note Text : late entry: patient was found on floor of room, patient had no skin tears, bp 186/90 p100, patient expressed pain through with consistent yelling ow and help me he also kept grabbing his right hip and refused to lay on that side when being assessed. NP D and DON [DON] were notified as well. wife stated patient can take 650mg tylenol for relief. this nurse administered the 650mg tylenol and patient showed relief. NP [NP D] ordered full pelvic xray. [DON] ordered tramadol and tylenol. this nursehas entered orders. patient is in need of a sitter due to his urge to wander to prevent falls, bed has been in low position since admission on 1/31/2025. plan of care ongoing. Author: [LVN A] 02/01/25 21:15 (9:15 PM) While waiting for the X-ray results, the family requested the resident be sent to the emergency room due to pain. A 911 call made, EMS arrived and transport the resident to [Hospital name]. RP is present, and the administration notified. Author: [LVN B] Record review of Resident #1's hospital document dated 02/04/25, reflected Resident #1 was diagnosed with a right hip fracture that required surgery. In an interview on 02/04/25 at 11:10 AM, NP C stated the facility called her, and let her know Resident #1 was in pain, but did not mention he had a fall. She stated right after the call, she sent the order for tramadol on 02/01/25 at 11:30 AM to the facility staff. (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 02/04/25 at 12:37 PM, Resident #1' Family Member confirmed that Resident #1 had a hip fracture and had surgery the morning of 02/04/25. The Family Member stated they arrived at the facility around 9:50 AM on 02/01/25, and the fall must have occurred before then. The Family Member stated Resident #1 was screaming and yelling in pain when they arrived at the facility to visit. The Family Member stated no one was going into Resident #1's room to assist him. The Family Member stated they requested to speak with the DON, but the DON was not there. The Family Member stated the MOD came into the room to talk to them around 10:30-11:00 AM. The MOD informed her that pain medication and x-rays were requested. In an interview with the DON, on 02/04/25 at 12:57 PM, the DON stated Resident #1 fell on [DATE]. The DON stated it was an unwitnessed fall. She stated LVN A heard Resident #1 yell, and went in to see him on the floor. The DON stated during the admission, the day before, the Family Member of Resident #1 informed the facility that Resident #1 was a little impulsive and moved around often. The DON stated the facility put interventions in place like the bed at the lowest level and placed two fall mats around his bed. The DON stated she was not sure exactly what time the fall occurred, but LVN A sent her a text message around 9:26 AM about Resident #1's fall. The DON stated LVN A contacted NP D and requested x-rays around the same time. The DON stated at 11:26 AM, she spoke with NP D, and NP D informed her she was out of the country, but she was able to provide an order for the x-rays. The DON stated NP D told her to contact NP C to get the order for pain medication. The DON stated by 11:30 AM, the facility had received the order for the Arthritis Tylenol and the Tramadol. The DON stated she was not sure if Resident #1 had any pain medications between 9:00 AM and 11:30 AM. She stated Resident #1 did not admit to the facility the day before with any pain medication. The DON stated the staff at the facility were immediately in-serviced starting on 02/02/25 regarding pain management, notification of changes, documentation, resident rights, and abuse and neglect. She stated they started reviewing all resident files and medication records to check for any additional concerns. In an interview on 02/04/25 at 1:26 PM, the MOD stated she was the manager during that weekend when Resident #1 had the incident. She stated she arrived at the facility around 10:20 AM, made her rounds on the other side of the facility, then made her way to the side where Resident #1's room was, around 11:00 AM or 11:15 AM on 02/01/5. The MOD stated LVN A did not tell her about any incident with Resident #1, but the resident's Family Member was present in the room and informed her that Resident #1 was in pain. She stated she asked the Family Member had Resident #1 received any medication for pain, and the Family Member stated they were not aware of any pain medication given to Resident #1. The MOD stated Resident #1 was laying on his back and did appear to be in pain. The MOD stated she went to his nurse, who was LVN A, and LVN A stated she gave him some pain medication about 30 minutes ago. She stated LVN A stated she had contacted NP D for pain medication, and wife told her he could take Tylenol. The MOD stated after speaking with LVN A, she contacted the DON, because the DON can get orders quicker than the nurses at times. The MOD stated x-rays sometimes took longer on the weekend. She stated she did not check back with the resident or LVN A, because she had not heard anything else about the incident before she left work. The MOD stated they did start in-services on Sunday 02/02/25. She stated she received an in-service on abuse and neglect, pain management, resident rights, notify of changes, documentation, and incidents. The MOD stated she was informed to contact the DON or an ADON immediately if there were concerns with anything at the facility regarding pain management. (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 02/04/25 at 2:05 PM, NP D stated LVN A contacted her around 10:42 AM after the fall happened. She stated LVN A told her he had a fall and was screaming in pain. NP D stated she told LVN A to get x-rays, and LVN A told her Resident #1 had a hip injury in the past and it was normal for him to be in a little pain. She stated she had to repeat to the nurse to get the x-ray. NP D stated she did not receive the x-ray results until the next day. She stated she was informed LVN A was fairly new and called the wrong x-ray company, so it took a little longer than normal. In a follow-up interview on 02/04/25 at 2:20 PM, the DON confirmed LVN A contacted another x-ray company that the facility didn't normally use, so it did take longer to get the results. The DON stated she did not see on the MAR where the Tramadol was given to Resident #1, but she would research a little more. She stated Resident #1 did get Tylenol. She stated she was unsure of what time Resident #1 received Tylenol that morning, because LVN A did not mark the Tylenol as given on the MAR. The DON stated LVN A did leave a progress note around 1:30 PM, stating she administered Tylenol earlier that day. In a telephone interview on 02/04/25 at 3:07 PM, Medication Assistant E stated he was the one that administered the Tylenol to Resident #1 around 2 something in the afternoon on 02/01/25. He stated he remembered giving him the Tylenol, because he crushed his medications. He stated he was not able to swallow pills. He stated no one was present in the room other than he and Resident #1. He stated he did see Resident #1's family member in the facility. Medication Assistant A stated he was told by staff that Resident #1 did fall. He stated Resident #1 kept telling him he was in pain. He stated if Resident #1 had an order for Tramadol, he would not be the staff member to administer that medication. He stated LVN A would have been the one to administer Tramadol. Medication Assistant E stated he was present at the facility when Resident #1 was transported to hospital, but he could not remember what time. He stated it was before he left work, and he left work around 10:00 PM. A telephone interview was attempted with LVN B on 02/04/25 at 3:15 PM, but there was no answer. In a telephone interview on 02/04/25 at 3:22 PM, LVN A stated she no longer was working at the facility. She stated she already told everyone what happened. LVN A stated Resident #1 had an unwitnessed fall around breakfast time on 02/01/25. She stated she did not remember the exact time of the fall. She stated she immediately contacted NP D, who gave her orders for x-rays. She stated she had to put the x-ray order into the system to request the x-ray company to come to the facility. LVN A stated the x-ray company arrived at the facility around 5:00 PM that evening, on 02/01/25. She stated she believed she received an order for pain medication around mid-day but did not recall the time. LVN A stated all she knew was Resident #1 received a dose of Tylenol, but she did not remember the time she administered it. She stated she crushed it and put it in applesauce, because the resident was on a pureed diet. LVN A stated Resident #1 did not yell as much after he received the Tylenol. She stated she did not complete the pain assessments or neuro checks, because Resident #1 was not yelling as much as he was that morning. LVN A stated the Tramadol never arrived. She stated she was in-serviced on pain management and fired. LVN A stated that was all she was going to say about the incident and hung up the telephone. On 02/04/25 at 3:55 PM, Surveyor and the ADON reviewed the medication cart, and Resident #1 did not have any Tramadol on the medication cart. The over-the-counter Tylenol was on the medication cart. The ADON stated she would contact the pharmacy to see if the Tramadol was taken from the e-kit. (continued on next page)

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 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/04/25 at 5:13 PM, via email, the DON stated the Tramadol was never delivered on 02/01/25, because the pharmacy noticed Resident #1 was sent to the hospital. She stated the Tramadol was never pulled from the e-kit either. In an interview on 02/05/25 at 10:03 AM, the Weekend Supervisor RN stated she was aware of the incident with Resident #1 and LVN A. She stated she arrived to work that Saturday, 02/01/25 around 8 something that morning. The Weekend Supervisor RN stated the DON asked her to go check on LVN A around 10:00 AM. She stated the DON stated LVN A may need some help. The Weekend Supervisor RN stated the DON told her LVN A said Resident #1 was demented, that LVN A wanted to send him out to the hospital, and that LVN A felt that Resident #1 was not appropriate for the facility. The Weekend Supervisor RN stated she went to check on LVN A and she stated she could hear Resident #1 screaming. The Weekend Supervisor RN stated LVN A told her he had been screaming all morning. She stated she asked LVN A what was wrong with him, and she told her he had a fall. The Weekend Supervisor RN stated LVN A told her his bed was at the lowest level when he fell on the fall mat. The Weekend Supervisor RN stated she asked if he was given any medication for pain, and LVN A stated he did not have any medication on his chart for pain. The Weekend Supervisor RN stated she did not believe LVN A told the DON that resident had a current fall but just that he had a past hip injury. She stated LVN A told her she had already contacted the nurse practitioner and had requested x-rays. She stated Resident #1's family was at the facility that day, and they had not complained anymore about the pain. She stated she didn't hear him screaming anymore, so she did not know there was still an issue with pain management. The Weekend Supervisor RN stated after the incident, the following day, the staff received in-services on abuse and neglect, pain management, documentation, resident rights, incidents, and notifying the appropriate people. She stated she was informed to contact the DON if there were any future issues with pain management. The Weekend Supervisor RN stated the risk of not following up on pain management is that Resident #1 would continue to be in pain and also the quality of care. In a follow-up interview on 02/05/25 at 10:43 AM, the DON stated LVN A called her around 9:30 AM on 02/01/25, told her that Resident #1 fell . She stated she told LVN A to do an incident report, follow through with the pain assessments, to notify the family and doctor, and asked if pain medications were on board. The DON stated she initially told LVN A to contact NP D, but she also contacted NP D. The DON stated NP D told her to contact NP C for the pain medication. She stated she received the order for x-ray and pain medication and forwarded those orders to LVN A at 11:32 AM on 02/01/25. She stated she was unaware on 02/01/25 that the pain medication, Tramadol, was not received. The DON stated LVN A should have followed through with completing pain assessments throughout the shift. She stated the pharmacy the facility used was in Sulphur Springs, Texas (about 95 miles away). The DON stated the pharmacy had two drop times: 2:00 PM and midnight. She stated LVN A did not follow up with the pharmacy about the Tramadol. She stated if she was aware the Tramadol had not arrived, she could have gotten it from the e-kit. The DON stated the risk of LVN A not following through with pain management or sending the resident to the hospital sooner was Resident #1 might have suffered longer. (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 02/05/25 at 11:08 AM, the Administrator stated LVN A and the Weekend Supervisor RN were responsible for following up on the pain assessments and pain management for Resident #1. She stated there should have been an initiative to get the Tramadol from the e-kit when Resident #1 was still complaining of pain. She stated LVN A should have completed pain asessments throughout the shift. The Administrator stated she felt there was not really a risk since Resident #1 did receive the Tylenol. The Administrator stated after the incident, starting on 02/02/25, the facility completed in-services on abuse and neglect, pain management, incidents, incident reporting, resident rights, notification of changes, pain assessments, and documentation. The Administrator stated on 02/02/25, the DON started an audit to ensure all nurses complete pain assessments, incident reports, and neuro checks. The Administrator stated she has reviewed and will continue to review and verify during the morning stand up meetings Monday through Friday. The Administrator stated on the weekend, she, the DON, and the weekend supervisors would monitor and review. She stated with pain management, the DON and the ADONs have started doing audits with new admissions as well as current residents. She stated they started a checklist to ensure orders are in place, the DON has started a report on medications ordered. The Administrator stated the DON started daily audits, and she has weekly audits. The administrator stated the DON and ADONs have started monitoring all changes in condition and the managers review during the daily stand-up meeting. The Administrator stated on the weekends, the DON and ADONs would do check-ins. She stated mass text messages were sent to the nurse staff to contact the DON or ADONs on the weekend concerning pain management. An Immediate Jeopardy for past non-compliance was identified on 02/05/25. The Administrator was notified of the Immediate Jeopardy for past non-compliance on 02/05/25 at 1:02 PM and were provided with the Immediate Jeopardy Template. The facility was not asked to provide a Plan of Removal, since the Immediate Jeopardy occurred in the past and the facility had already corrected the non-compliance. Record review of a document titled, Emergency Plan of Correction dated 02/03/25, reflected the following: Emergency Plan of Correction Risk Management/ Pain Management 2/3/2025 Problem: Timely Incident Reporting/ Timely Incident Accident Documentation Initiation/ Pain Management Immediate Action: All Nursing Staff In-service, scrubbed risk management documentation, and mass text to notify all staff to call DON and Administrator of any incident/accident immediately Date Completed: 2/2/25 Systemic: DON, ADON, and Administrator will promptly assess documentation for MD and family notification. And assess orders for need for pain regimen and management. Date Completed:2 2/2/25 - ongoing. Monitoring: Daily monitoring of risk management tab and pain assessment. (continued on next page)

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 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 02/05/25 at 1:56 PM, Caregiver G stated she received in-services on abuse and neglect, resident rights, pain management, notifying a nurse or management if a resident complains about pain, documentation, incident reporting, and fall prevention within the last two days. She stated she was trained to let a nurse know if a resident had an accident or if the resident was in pain. She states she was in-serviced on following up to ensure the nurse checked on the resident. She stated if that resident still complained of pain, she would let the DON know. In an interview on 02/05/25 at 2:11 PM, Medication Assistant H stated she was in-serviced on Monday about abuse and neglect, resident rights, pain management, incident reports, documentation, notifying nurses of incidents, and fall prevention. She stated she was in-serviced about letting a nurse know if a resident was in pain, so the nurses could do pain assessments. She stated she could provide pain medication if it was available and if the resident had not already had pain medications. She stated some medications have to be given by the nurse. In an interview on 02/05/25 at 2:24 PM, RN I stated she worked on the weekend, and she received in-services then. She stated the in-service were over pain management, pain assessments, neuro checks, incident reports, documentation, notification of changes, resident rights, and abuse and neglect. She stated if there was any time of pain management with a resident, all nurses were to follow-up with management. In an interview on 02/05/25 at 2:33 PM, LVN J stated he received in-services this week over abuse and neglect, pain management, fall prevention, documentation, assessments, checks, and notifying the families and the physician. He stated he was told to update the DON with any pain management concerns. He stated he was informed if he worked on the weekends to follow up with the weekend supervisor, ADON, or DON with concerning pain management. In an interview on 02/05/25 at 2:43 PM, ADON F stated she received in-services on Monday regarding pain management, abuse and neglect, resident rights, documentation, fall prevention, chain of command, notification of changes, incidents, and accidents. She stated when there is an incident like a fall, the pain assessments, neuro checks, incident reports, and overall documentation should be available in their electronic system. Record review of a document titled, Record of Disciplinary Measure, dated 02/02/25, reflected LVN A was disciplined and terminated for resident abuse, neglect, or failure to report such incidents immediately and failure to follow facility rules, policies, and procedures. The document reflected LVN A had a patient under her care who had a fall on 02/01/25 and nurse failed to complete neuro checks/assessments and to monitor Resident #1 after the fall. Record review of an in-service titled, Abuse and Neglect dated 02/02/25, and covered the facility's abuse and neglect policy. All care staff on the employee roster received the in-service. Record review of an in-service titled, incident/accident/neuro checks dated, 02/02/25, and covered accident, incidents, chain of command, and documentation. All care staff on the employee roster received the in-service. (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an in-service titled, Nurses Falls Witnessed and Unwitnessed, dated 02/02/25, and noted it covered, falls, incidents, pain management, medication orders, x-rays, sending residents out to the hospital, and notifying management, including the DON, as well as the doctor and the family. All care staff on the employee roster received the in-service. Record review of the facility's policy titled, Pain Management, dated 2001, with a revision date of April 2009, reflected the following: The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. 1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain. b. Effectively recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. Recognizing Pain: I. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain. Possible Behavioral Signs of Pain: a. Verbal expressions such as groaning, crying, screaming; b. Facial expressions such as grimacing, frowning, clenching of the jaw, etc.; c. Changes in gait, skin color and vital signs; (continued on next page)

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 02/05/2025
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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Behavior such as resisting care, irritability, depression, decreased participation in usual activities; e. Limitations in his or her level of activity due to the presence of pain; f. Guarding, rubbing or favoring a particular part of the body;

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 02/05/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 (Resident #1) of 3 residents reviewed for accuracy of medical records in that: 1. LVN A did not document the administration of Tylenol Arthritis 650 MG on the Medication Administration Record during the morning shift on 02/01/25 for Resident #1 and failed to document the time of the Tylenol Arthritis 650 MG administration on the progress notes in Resident #1's file. 2. LVN A failed to document any pain assessments or neuro checks for Resident #1 after he had a fall on the morning of 02/01/25. The noncompliance was identified as past noncompliance. The facility corrected the noncompliance before the investigation began on 02/04/25. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. Findings included: Record review of Resident #1's electronic face sheet, dated 02/04/25, reflected a [AGE] year-old male, who admitted to the facility initially on 06/15/22, and had a readmitted [DATE]. Resident #1 had a diagnosis of Type 2 Diabetes (body does not use insulin effectively or does not produce enough insulin), Essential Hypertension (high blood pressure), Dementia (decline in mental abilities), Heart Failure, and History of Falling. Record review of the February Medication Administration Record for Resident #1, dated 02/04/25, reflected no documentation of Resident #1 receiving the Tylenol on the morning of 02/01/25. Record review of Resident #1's physician's orders dated 02/04/25, reflected the following: Tramadol HCl Tablet 50 MG Give one tablet by mouth every four hours as needed for moderate and severe pain, order date 02/01/25 Tylenol 8-hour Arthritis Pain oral tablet extended release 650 MG (Acetaminophen) Give 1 tablet by mouth three times a day for pain, order date 02/01/25 Monitor pain every shift, order date 01/31/25 Record review of Resident #1's Nurse Administration Record, dated [DATE], reflected the following: Monitor pain every shift, with a start date of 02/01/25 and an end date of 02/03/25. (continued on next page)

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 02/05/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the progress notes on Resident #1's electronic record, dated 02/04/25, reflected the following: 02/01/25 18:17 (6:17 PM) Note Text : late entry: patient was found on floor of room, patient had no skin tears, bp 186/90 p100, patient expressed pain through with consistent yelling ow and help me he also kept grabbing his right hip and refused to lay on that side when being assessed. NP and DON [DON name] were notified as well. wife stated patient can take 650mg Tylenol for relief. this nurse administered the 650mg Tylenol and patient showed relief. NP [NP name] ordered full pelvic x-ray. [DON name] ordered tramadol and Tylenol. this nursehas entered orders. patient is in need of a sitter due to his urge to wander to prevent falls, bed has been in low position since admission on 1/31/2025. plan of care ongoing. Author: [LVN A name] Record review of a document titled, Record of Disciplinary Measure dated 02/02/25, reflected LVN A was disciplined and terminated for resident abuse, neglect, or failure to report such incidents immediately and failure to follow facility rules, policies, and procedures. The document reflected LVN A had a patient under her care who had a fall on 02/01/25 and nurse failed to complete neuro checks/assessments and to monitor Resident #1 after the fall. Record review of Resident #1's electronic medical records reflected there were no neuro checks documented, and there were no pain assessments documented on 02/01/25. In a telephone interview on 02/04/25 at 3:22 PM, LVN A stated she gave Resident #1 Tylenol after his fall on 02/01/25. She stated she did not remember the time she administered the Tylenol. LVN A stated she did not know why she did not document the Tylenol was given on the Medication Administration Record. She stated she documented it on a late entry in the progress notes. LVN A stated she assessed him right after his unwitnessed fall. LVN A stated she did not complete neuro checks or pain assessments throughout her shift on 02/01/25, because Resident #1 was not yelling as much as he was that morning. In an interview on 02/05/25 at 10:43 AM, the DON stated LVN A should have documented the administration of the Tylenol on the Medication Administration Record if it was given. The DON stated LVN A documented it on the progress notes, but LVN A did not document the time the medication was given. The DON stated LVN A should have completed and documented neuro checks and pain assessments throughout her shift. She stated she failed to document those checks and assessments. The DON stated LVN A did not complete the incident report until Sunday, 02/02/25. She stated if she would have completed the incident report timely, the incident report would have prompted her to do all of the assessments and checks. The DON stated the risk of not documenting any of that was a visit from the state, a lawsuit, or putting the corporation or resident at risk. The DON stated documentation was very vital. (continued on next page)

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 02/05/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 11:08 AM, the Administrator stated LVN A failed to document the medication as given on the Medication Administration Record, and she failed to complete and document neuro checks and pain assessments during her shift. The Administrator stated the risk of LVN A not documenting was the resident not getting a good assessment. Record review of a document titled, Emergency Plan of Correction dated 02/03/25, reflected the following: Emergency Plan of Correction Risk Management/ Pain Management 2/3/2025 Problem: Timely Incident Reporting/ Timely Incident Accident Documentation Initiation/ Pain Management Immediate Action: All Nursing Staff In-service, scrubbed risk management documentation, and mass text to notify all staff to call DON and Administrator of any incident/accident immediately Date Completed: 2/2/25 Systemic: DON, ADON, and Administrator will promptly assess documentation for MD and family notification. And assess orders for need for pain regimen and management. Date Completed:2 2/2/25 - ongoing. Monitoring: Daily monitoring of risk management tab and pain assessment. In an interview on 02/05/25 at 1:56 PM, Caregiver G stated she received in-services on abuse and neglect, resident rights, pain management, notifying a nurse or management if a resident complains about pain, documentation, incident reporting, and fall prevention within the last two days. She stated she was trained to let a nurse know if a resident had an accident or if the resident was in pain. She states she was in-serviced on following up to ensure the nurse checked on the resident. She stated if that resident still complained of pain, she would let the DON know. In an interview on 02/05/25 at 2:11 PM, Medication Assistant H stated she was in-serviced on Monday about abuse and neglect, resident rights, pain management, incident reports, documentation, notifying nurses of incidents, and fall prevention. She stated she was in-serviced about letting a nurse know if a resident was in pain, so the nurses could do pain assessments. She stated she could provide pain medication if it was available and if the resident had not already had pain medications. She stated some medications have to be given by the nurse. In an interview on 02/05/25 at 2:24 PM, RN I stated she worked on the weekend, and she received in-services then. She stated the in-service were over pain management, pain assessments, neuro checks, incident reports, documentation, notification of changes, resident rights, and abuse and neglect. She stated if there was any time of pain management with a resident, all nurses were to follow-up with management. (continued on next page)

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 02/05/2025
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/05/25 at 2:33 PM, LVN J stated he received in-services this week over abuse and neglect, pain management, fall prevention, documentation, assessments, checks, and notifying the families and the physician. He stated he was told to update the DON with any pain management concerns. He stated he was informed if he worked on the weekends to follow up with the weekend supervisor, ADON, or DON with concerning pain management. In an interview on 02/05/25 at 2:43 PM, ADON F stated she received in-services on Monday regarding pain management, abuse and neglect, resident rights, documentation, fall prevention, chain of command, notification of changes, incidents, and accidents. She stated when there is an incident like a fall, the pain assessments, neuro checks, incident reports, and overall documentation should be available in their electronic system. Record review of a document titled, Record of Disciplinary Measure, dated 02/02/25, reflected LVN A was disciplined and terminated for resident abuse, neglect, or failure to report such incidents immediately and failure to follow facility rules, policies, and procedures. The document reflected LVN A had a patient under her care who had a fall on 02/01/25 and nurse failed to complete neuro checks/assessments and to monitor Resident #1 after the fall. Record review of an in-service titled, Abuse and Neglect dated 02/02/25, and covered the facility's abuse and neglect policy. All care staff on the employee roster received the in-service. Record review of an in-service titled, incident/accident/neuro checks dated, 02/02/25, and covered accident, incidents, chain of command, and documentation. All care staff on the employee roster received the in-service. Record review of an in-service titled, Nurses Falls Witnessed and Unwitnessed, dated 02/02/25, and noted it covered, falls, incidents, pain management, medication orders, x-rays, sending residents out to the hospital, and notifying management, including the DON, as well as the doctor and the family. All care staff on the employee roster received the in-service. Record review of the facility's policy titled, Pain Assessment and Management, dated 2001, with a revision date of April 2009, reflected the following: Documentation l. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record. The facility's Medication Administration policy was requested on 02/04/25 at 9:50 AM from the DON but not received.