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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	109 Methodist Way Desoto, TX 75115

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review the facility failed to ensure that each resident who experiences a significant change in status is comprehensively assessed within 14 days for 1 of 3 residents (Residents #1) reviewed for significant change. The facility failed to ensure Resident # 1 had a Significant Change Assessment completed after she had a change in altered mental status. This failure could contribute to providing an inaccurate assessment of resident's most current medical condition and could lead to failure to not provide necessary care. Findings included: Record review of Resident #1's face sheet, dated 04/11/2025, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. DX included: unspecified dementia (cognitive decline) and Cognitive communication deficit (difficulties in communication skills from cognitive impairments, attention, memory.). Record review of Resident #1's discharge MDS assessment, dated 03/31/2025, reflected the resident had a BIMS score of 8, indicating she was moderately impaired cognitively. Record review of Resident #1's care plan, dated 03/13/2025, reflected that Resident #1's had a potential for ADL Self-care Performance Deficit r/t Dementia. Resident required assistance from staff for toileting, bathing, personal hygiene, and dressing. Resident #1 required supervision and cuing for bed mobility and transfers. Resident had impaired cognitive function/impaired thought process r/t dementia .intervention Observe/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Record review of progress note dated 03/28/2025 at 2:48 PM by NP reflected Assessment and Plan: Pt currently will benefit from continuous 24hr care for medication, skin care, education, and reinforcement in therapies along with psychiatric medical care/recommendations for ongoing medical issues. Will need to include family education/training and possible DME assessment -Precautions: Acute Metabolic Encephalopathy [a brain dysfunction caused by a sudden imbalance in the body's metabolism, leading to changes in brain function, such as confusion, disorientation, or memory loss.] oriented X3, baseline dementia. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note dated 3/31/2025 at 9:29 PM, NP reflected suspected progressive dementia - supportive care. Record review of Resident #1's MD orders dated 03/26/2025 reflected the following: Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth every 8 hours as needed for Anxiety . Hydroxyzine Tablet 25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety. During a phone interview with ADON T on 04/11/2025 at 11:35 AM she stated that Resident #1 was observed during her stay (03/12/2025 to 03/31/2025) with increased impaired cognition, confusion, and altered mental status, t herefore, required more assistance with care and should not be discharged home alone to care for herself. During a phone interview with ADON N on 04/25/2025 at 12:35 PM she reported that this was the second admission for Resident #1. In her first admission she was cognitively alert and oriented, however her readmission on 03/12/2025 she had been observed with increased confusion, memory loss, and required more supervision for care needs during her stay (03/12/2025 to 03/31/2025P. During a phone interview with NP on 04/25/2025 at 10:45 AM she stated that Resident #1's confusion and cognition was progressive, and she required supervision if discharged home. During an interview on 04/26/2025 at 5:05 PM the DON stated her expectation was a Significant Change Assessment should have been completed within after 14 days of Resident #1 having an altered mental status related to dementia. The DON stated the MDS nurse was responsible to complete the Significant Change and nursing was responsible to notify MDS with the change. The DON stated the effect on residents could have received incorrect services and supervision at discharge. During an interview on 04/26/2025 at 3:59 PM with MDS R nurse she was responsible to complete the Significant Change Assessment. The nurse working with Resident #1 and IDT team should have triggered for a Significant Change Assessment to be completed and should have been completed when the resident was diagnosed with dementia, confusion, and decline in cognition and ADL's. The MDS R stated the MDS nurse was responsible to complete the MDS and the DON reviews, audits and signs the completed assessment. MDS R stated the effect on residents could have been plan of care not being updated . MDS Coordinator R said a MDS for significant change should be completed when a resident had changes in altered mental status, dx, medications, medical history . Review of CMS 'S State Operations Manual-Appendix PP February 24, 2025, revealed: INTENT S483.20(b)(2)(ii) To ensure that each resident who experiences a significant change in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DEFINITIONS S483.20(b)(2)(ii) Significant Change is a major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered self-limiting (NOTE: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan .Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline . GUIDANCE S483.20(b)(2)(ii) . The facility should document in the medical record when the determination is made that the resident meets the criteria for a Significant Change in Status Assessment Examples of Decline include, but are not limited to o Resident's decision-making ability has changed; Record review of facility policy dated December 2016 titled Change in a Resident's Condition or Status Policy Statement 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.). Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); .Impacts more than one area of the resident's health status; . Requires interdisciplinary review and/or revision to the care plan; .Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form . There is a significant change in the resident's physical, mental, or psychosocial status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review the facility failed to develop and implement a person-centered comprehensive care plan to include measurable objectives and timeframes to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being for 4 of 10 (Resident #1, #6, #7, and #8) residents reviewed for comprehensive care plans in that: 1.The facility failed to ensure Resident #1's care plan addressed her anxiety and discharge goals, objectives, and interventions. 2. The facility failed to ensure Resident #6, #7, and #8's care plan addressed their discharge goals, objectives, and interventions. Findings included: Record review of Resident #1's face sheet dated 04/11/2025 Revealed she was a 73- year-old female admitted to the facility on [DATE] and discharged on [DATE]. DX included: Acute kidney failure (failing kidney function), unspecified dementia (cognitive decline), abnormalities of the gait, unsteadiness on fee, Lack of coordination, Cognitive communication deficit (difficulties in communication skills from cognitive impairments, attention, memory .), hypokalemia (low potassium levels). Record review of Resident #1's discharge MDS assessment, dated 03/31/2025, reflected the resident had a BIMS score of 8, indicating she was moderately impaired cognitively. The MDS assessment reflected section GG for resident functional abilities were left empty, indicating she was not assessed at discharge on 03/31/2025. The discharge MDS was not signed by authorized personnel. Record review of Resident #1's care plan, dated 03/13/2025, reflected that Resident #1's has a potential for ADL Self-care Performance Deficit r/t Dementia. Resident requires assistant from staff for toileting, bathing, personal hygiene, and dressing. Resident #1 requires supervision and cuing for bed mobility and transfers. Resident has impaired cognitive function/impaired thought process r/t dementia .intervention Observe/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status .resident was at risk of falls r/t tunable gate, dementia. Resident #1's care plan did not address discharge goals, objectives, and interventions. During an interview with Resident #1 on 04/25/2025 at 10:00 AM she was interviewable, confused and could not recall daily routines, where she lived, nor her discharge home details. She has lost her ID card, purse, and cell phone. She can't recall the last time she used the items. Resident # 6 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's face sheet dated 04/14/2025 reflected he was an [AGE] year-old male that was admitted on [DATE]. Resident's current DX: muscle wasting and atrophy, multiple sites (age related loss of muscles), Malignant neoplasm prostate (cancerous tumor in the prostate gland), DM 2 (irregular blood sugar levels), abnormal gait. Record review of Resident #6 's entry MDS revealed entry date 04/03/2025 from hospital to facility for skilled care. Record review of Resident # 6's BIMS assessment dated [DATE] was a score of 15, indicating he was cognitively intact. Record review of Resident # 6 's Care Plan dated 04/03/2025 reflected Resident has a skin tear and is at risk for skin tears due to Fragile skin .resident is on Anticoagulant therapy r/t Atrial fibrillation (irregular heartbeat resident has the potential for s/sx of complications of cardiac problems due to coronary artery disease (heart disease) r/t atrial fibrillation, hypercholesterolemia (abnormal high levels of cholesterol in blood), hypertension (high blood pressure) .resident has an ostomy and is At risk for complications including but not limited to stoma (surgical opening in abdomen), irritation, bleeding and ischemia (reduced blood supply to areas of the body). Cancer (uncontrolled growth of cells), Bowel obstruction, Trauma, ileus (intestine stop moving properly), Hernia (condition of part of an organ is displaced), Sigmoid volvulus (condition where the lower part of the large intestine, twist, and cause bowel obstruction) Resident has disorder/diagnosis uses antidepressant medication. At risk for side effects. Depression. Resident #6's care plan did not address his discharge goals, objectives, and interventions. During an observation and interview with Resident #6 on 04/14/25 at 11:04 AM revealed the resident lying in bed with no concerns with hygiene or room hazards. His call light was within reach, ostomy bag, and interviewable. Resident #6 stated he was at the facility for a short-term staff for therapy. He had no concerns with care, services, or treatment. Resident stated staff are responding and treating him with respect and dignity. Resident #7 Record review of Resident #7's face sheet dated 04/25/2025 reflected he was a [AGE] year-old male that was admitted on [DATE]. Resident's current DX: single subsegmental thrombotic pulmonary embolism (blood clot in pulmonary artery) w/o acute Cor pulmonale (enlarge abnormal heart), sickle cell, emphysema (disorder affecting the tiny air sacs of the lungs), COPD (chronic obstructive pulmonary disease (damage to the airways or other parts of the lung), End stage renal disease (severely damaged kidneys unable to function properly) dependence on dialysis medical procedure that filters the blood, removes waste products). Record review of Resident #7 's quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating he was cognitively intact. Health conditions of shortness of breath with, continuous oxygen and dialysis addressed and active discharge planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Care plan dated 03/31/2025 reflected [Resident] is on PO Antibiotic therapy r/t infection [Resident]Enhanced Barrier Precautions - [Resident] At risk for infection r/t Wounds, [Resident] Indwelling medical device . [Resident] is at risk for Ineffective Airway Clearance d/t COPD . [Resident] has the potential for s/sx of Congestive Heart Failure . [Resident] has Oxygen Therapy r/t COPD and Emphysema .at risk for falls r/t impaired balance unaware of safety needs. Resident #7's care plan did not address his discharge goals, objectives, and interventions. During an observation and interview with Resident #7 on 4/25/25 at 11:08 AM, he was in the hallway in his wheelchair with a NC with no concerns with hygiene or care. His ankles and feet were observed swollen and he denied pain. He stated that he would be discharging home soon with his sisters and they would transport. Resident #8 Record review of Resident #8's face sheet dated 04/14/2025 reflected he was a [AGE] year-old male that was admitted on [DATE]Resident's current DX: anemia (limited red blood cells) , hyperlipidemia (high cholesterol), depression (feeling down), hypertension (high blood pressure) chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle doesn't pump blood effectively, leading to a reduced ejection fraction.), seizure, atrial fibrillation, cerebral infarction (stroke) without residual deficits, hemiplegia and hemiparesis (impaired movement on one side, but hemiplegia is a more severe condition with a complete lack of motor function.), following cerebral infarction affecting left dominant side, muscle weakness, other lack of coordination, cognitive communication deficit (difficulty communicating) acute respiratory failure with hypoxia (respiratory can't deliver oxygen effectively). Record review of Resident #8 's admission MDS dated [DATE] reflected a BIMS score of 12 indicating he was moderately impaired cognitively. Resident #8 required staff supervision and assistance for ADLS and eating. Record review of Resident # 8's Care Plan dated 03/26/2025 revealed: The resident has surgical incision to . resident is Moderate risk for falls r/t impaired mobility, left sided hemiparesis, HX of CVA the (Left Chest) r/t Pacemaker surgery .resident uses antidepressant medication. At risk for side effects. Depression .resident has pain related to impaired mobility . Resident #8's Depression. Resident #8's care plan did not address discharge, goals, objectives, and interventions. During an interview with Resident #8 on 04/11/2025 at 10:55 AM revealed he would be discharged home with his wife and family soon and they would provide transportation. He was not sure if additional services would be ordered for aftercare at this time. During an interview with ADON N on 04/26/25 at 12:35 PM she said all care plans should be completed timely and accurately to guide the resident's care needs while at a skilled facility and address the plan of discharge. Failure to complete and document discharge plans in the care plan could lead to goals for aftercare not being met. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 04/26/2025 at 5:05 PM revealed she was responsible along with the nurses to monitor and update resident care plans for changes and goals while at the facility. She stated that care plans were not updated for discharge information as the discharge assessment plan conducted by the nurses provided this information. Discharge planning addressees the plan along with other disciplines (SW/CM) During an interview with the ADM on 04/25/2025 at 5:25 PM revealed she expects the staff to complete the care plans timely and accurately to address the residents' needs. ADM said resident's goals for treatment should include discharge planning. She stated the discharge planning will address the resident needs once the discharge was planned. The policy for the care plan was requested on 04/11/2025 and was not provided. Review of federal guidelines for care plans. S483.21(b) Comprehensive Care Plans S483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under S483.24, S483.25 or S483.40; and (ii) Any services that would otherwise be required under S483.24, S483.25 or S483.40 but are not provided due to the resident's exercise of rights under S483.10, including the right to refuse treatment under S483.10(c)(6). (iv)In consultation with the resident and the resident's representative(s)-(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. S483. 21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally competent and trauma-informed.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable well-being of each resident reviewed for one (Resident #1) of four residents reviewed for Administration. The ADM and DON failed to ensure residents discharged home were provided the appropriate supervision and care before returning home. The ADM directed staff to discharge Resident #1 home without knowing she was diagnosed with dementia, confusion, altered mental status, and no POA. The IDT failed to notify the NP/MD of Resident #1's discharge home alone without services. The ADM, DON, and CM T returned Resident #1 to an unsafe home environment without investigating and following up prior to sending her home in an Uber (ride share). An Immediate Jeopardy (IJ) situation was identified on 05/08/2025 at 11:00 AM after an administrative review determined that the noncompliance would be elevated to an IJ. The ADM was provided an IJ template and told that the current POR (Plan of Removal) that was accepted on 04/26/2025 at 1:22 PM was sufficient. While the IJ was removed on 04/26/2025 at 5:45 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility was still monitoring the effectiveness of their Plan of Removal (POR). This failure placed residents at risk of not receiving the appropriate care and services to maintain their highest practicable well-being and at risk of a diminished quality of life and supervision for safety. The findings included: Record review of Resident #1's face sheet, dated 04/11/2025, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. DX reflected unspecified dementia (cognitive decline), Lack of coordination, Cognitive communication deficit (difficulties in communication skills from cognitive impairments, attention, memory .), hypokalemia (low potassium levels). The face sheet did not list a POA or RP, only emergency contact #1 (FM S) and the name and phone number of FM J. Record review of Resident #1's entry MDS assessment, dated 03/12/2025 reflected entry date of 03/12/2025 from the hospital to a skilled nursing facility. Record review of Resident #1's discharge MDS assessment, dated 03/31/2025, reflected the resident had a BIMS score of 8, indicating she was moderately impaired cognitively. The MDS assessment reflected Resident #1 had no history of wandering; section GG for resident functional abilities was left empty, indicating she was not assessed at discharge on 03/31/2025. Section N - Medications reflected the resident was not taking any high-risk medications. The discharge MDS was not signed by authorized personnel. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated 03/13/2025, reflected that Resident #1's has a potential for ADL Self-care Performance Deficit r/t Dementia. Resident requires assistant from staff for toileting, bathing, personal hygiene, and dressing. Resident #1 requires supervision and cuing for bed mobility and transfers. Resident has impaired cognitive function/impaired thought process r/t dementia .intervention Observe/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Resident #1 was at risk of falls. Record review of Resident #1's MD orders dated 03/12/2025 reflected the following: Hypoglycemic Protocol: Follow Hypoglycemic Protocol if blood sugar is less than 70 mg/dl (a unit of volume equal to one-tenth of a liter.) Assessment tab when protocol is required every shift -Start Date- 03/12/2025 6:00 PM -DC Date-04/01/2025 3:54 PM 03/12/2025 HS snacks .Monitor resident for abnormal bruising and/or bleeding from nose, gums, blood in urine or stool Q Shift every shift .order dated 03/26/2025 reflected .Melatonin Oral Tablet 3 MG (Melatonin) Give 1 tablet by mouth every 8 hours as needed for Anxiety . Hydroxyzine Tablet 25 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety. Record review of Resident #1's progress note dated 03/28/2025 at 12:49 PM by RN G resident is A &O x 1 (alert and oriented times) indicating that she knew her name but not where they are, what time it is or what is happening, with confusion. cont. to require assist with ADL. Record review of Resident #1's progress note dated 03/28/2025 at 2:48 PM by the NP reflected Assessment and Plan: Impaired mobility and gait worsened state since PTA, continue rehabilitation efforts with multidisciplinary approach including PT for gait, OT for self-care skills and transfers. - Pt currently will benefit from continuous 24 hr care for medication, skin care, education, and reinforcement in therapies along with psychiatric medical care/recommendations for ongoing medical issues. Record review of Resident #1's progress note dated 3/31/2025 at 9:29 PM, by the NP reflected suspected progressive dementia - supportive care. Record review of Resident #1's insurance dated 03/30/2025 titled Medicare coverage of current skilled nursing services will end on 03/30/2025. Verbal notification given patient or RP on 03/27/2025. Additional information reason unable to sign cognitive impairment NOMNC given to [FM] via telephone the beneficiary's last day of coverage 03/30/2025 and the date when the beneficiary liability is expected to begin 03/31/2025 informed [FM] that appeal must be done as soon as possible, but no later than 12:00 noon of the day before the last covered day [FM] plans to take member to home on 03/31/2025. Record review of Resident #1's Physician discharge summary completed by NP RB dated 03/31/2025 reflected provisional diagnosis: Acute Kidney Failure, unspecified Condition at discharge stable .Discharge Diagnosis: aftercare acute kidney failure unspecified Prognosis: Fair. Disposition: home by uber. [name] home health. DME - NA signed by NP RB. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's ADON N Discharge Plan of Care dated 04/04/2025 reflected Resident # 1 was being discharged to home with family, nursing needs: wheelchair .transportation: family transported. Scheduled appointments: f/u with PCP .CM explained care/support to resident caregiver, yes no special instructions for diet .treatment reviewed with resident/caregiver, yes .APS referral made with resident discharge home d/t cognitive decline. This note was added after the resident discharged by CM T as a late entry. During an interview with Resident #1 on 04/25/2025 at 10:00 AM at the hospital revealed she was interviewable, confused and could not recall daily routines, where she lived, nor her discharge home details. She had lost her ID card, purse, and cell phone. She couldn't recall the last time she used the items. During a phone interview with FM S on 04/11/2025 at 10:20 AM revealed that she did not attend any meetings as an RP during Resident #1's stays at the facility. FM S told the ADM that the home did not have electricity and that Resident #1 would be living in the home alone. FM S said that the facility did not ensure home health services were scheduled prior to discharging Resident #1 home alone. FM S said she did not agree with the ADM goal to discharge Resident #1 home, because Resident #1 was confused, and no services were set up prior to her return home. FM S said the ADM proceeded to discharge Resident #1 home despite her concerns. FM S said there were additional kinship relations of FM J (RK K and RK C), however, they were not contacted nor informed about the discharge planning and return home. FM S said that Resident #1 did not have a walker or wheelchair when she arrived at the apartment, only personal belongings. FM S said she was waiting in her car at Resident #1's apartment when the driver left her at the apartment complex. FM S asked the [NAME] to bring Resident #1 to her apartment and allow entrance, because she did not have a key. FM S said once [NAME] escorted Resident #1 in her apartment and departed in a golf cart. During an interview with the ADM on 04/11/2025 at 9:40 AM, revealed Resident #1's was discharged on [DATE] at 3:40 PM. ADM said FM S was aware of the discharge home, and home health had been contacted. ADM said it was the RP's responsibility to call HHS and schedule a visit to the home for an assessment. ADM said FM S had reservations closer to the discharge date stating she was afraid of Resident #1, Resident #1 can't live with her, the home was not safe due to the electric power being disconnected. ADM stated that she did not contact the apartment manager for information on Resident #1's home environment prior to discharge. ADM told FM S she would have Resident #1 transported to the apartments via Uber (transportation business). ADM said she did not attempt to search for other family prior to discharge. ADM said Resident #1 discharged home on a previous stay, and this was the discharge plan at the time of admission on 03/12/2025. She denied behaviors of cognitive loss and confusion. She said the resident was capable of returning home to care for herself. She notified APS of the home condition allegations from FM S as an alternate plan for Resident #1 when she left the faciity on [DATE]. During an interview on 04/11/2025 at 6:40 PM with KR K she stated that she was not related to Resident #1. KR K reported that FM S have excluded her from the rehabilitation contact, therefore she was not aware that Resident #1 had been discharged on [DATE]. On 03/31/2025 (time unknown) KR K said Resident #1 was somewhat confused at times. KR K said resident lived alone and was discharged home from the facility in 12/2024. KR K said the facility staff did not contact her during Resident #1's stays 03/12/2025. KR K said the hospital placement was temporary and a means for getting assistance with another placement. (continued on next page)

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	676492	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Transitional Care Center-Desoto LLC	109 Methodist Way Desoto, TX 75115

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility CM T on 04/14/2025 at 11:00 AM she stated that Resident #1 was sent home after a NOMNC discharge for insurance payment ending. The ADM directed CM T to complete the discharge summary on 03/27/2025 (see record review for discharge plan). CM T and ADM called FM S to transport Resident #1 home; however, FM S refused and did not want to be responsible for the care of Resident #1. CM T said the ADM notified the FM that Resident #1 would be discharged home today via paid public transportation, because FM S agreed to the discharge home in the NOMNC via phone. FM S told the ADM that the resident would be living alone, the apartment electric power was disconnected, the apartment was soiled with cat feces and urine, and the environment was not safe for the resident to live. CM T stated that she had notified the HHS of the resident discharge home and the need for an assessment of after care services. During an interview with the DON on 04/14/2025 at 2:30 PM revealed Resident #1's FM agreed to the courtesy transport, and she would be waiting at the complex for Resident #1, then called and stated the home was not safe and sanitary for Resident #1 to live in due to the utilities not working. DON said the FM told the ADM that the home was not safe prior to sending her home via uber. The DON and the ADM were notified after the discharge that the FM was not present to receive the resident at the home location. the ADM and DON stated that the resident payment insurance days had ended, and the FM knew the plan to discharge the resident home at the time of admission. The DON said the resident did not have an identifying information to pursue Medicaid or an additional placement at the time of the discharge. The ADM told the FM she would contact APS to for a report regarding the unsafe home environment. During a phone interview with NP on 04/25/2025 at 10:45 AM she stated that Resident #1's confusion and cognition was progressive, and she required supervision if discharged home. During an interview with the DON on 04/26/2025 at 5:05 PM she stated that in the future residents would no longer be transported via courtesy transportation at the expense of the facility. The DON said she would ensure the MD was included in the discharge planning in the IDT meeting, seek additional clinical guidance from members prior to discharge to ensure resident safety. The DON said she would report all concerns involving RP and POA's to the ADM. During a second interview with the ADM 04/25/25 at 5:25 PM she stated that changes to the facility discharge included no courtesy transports from the facility for discharged residents. She would notify the ombudsman and leadership of a resident's changes in condition, the need for a responsible representative and additional resources before sending an impaired cognitive resident home to live alone. The ADM said that the ADM, DON, ADON, CM, SW, MD, MDS, and DOR was a part of the IDT. During an interview with LSW on 04/25/2025 at 6:25 PM she stated that discharge planning should be coordinated with all disciplines to ensure safety. She stated that residents without a confirmed RP or POA would remain at the facility until a safe discharge plan was confirmed to ensure, resident's safety. She said cognitively impaired residents should not be sent home to live alone. She stated that CM T was under the social services department, however she was not consulted on Resident #1's discharge 03/31/2025, because CM T discharged residents that were here for short term skilled services. LSW said she will contact the HHC, DME and other services for aftercare to ensure scheduling of the services and equipment prior to discharging from the facility. She said failing to follow up with services could result in the resident not having the aftercare and needed equipment to function at home. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/06/2025 at 2:42 PM with KR K revealed the hospital was discharging the resident home, since the family did not want a referral for services in a nursing home. She will consult with them to request more time before discharging the resident home. During an interview on 05/12025 at 840 AM with KR K she stated Resident # 1 was discharged home. She stated that the apartment has been cleaned, and she and KR C are visiting daily until HHS or other aftercare services were provided. KR K said the barrier to placement and services were limited insurance benefits. An Immediate Jeopardy (IJ) situation was identified on 05/08/2025 at 11:00 AM after an administrative review determined that the noncompliance would be elevated to an IJ. The ADM was provided an IJ template and told that the current POR (Plan of Removal) that was accepted on 04/26/2025 at 1:22 PM was sufficient. While the IJ was removed on 04/26/2025 at 5:45 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility was still monitoring the effectiveness of their Plan of Removal (POR). The following Plan of Removal was accepted on 04/26/2025 at 1:22 PM for immediate actions to ensure residents were not in jeopardy of harm. The POR reflected the following: The Plan of Removal reflected the following: Plan of Removal - F 835 submits the following Plan of Removal for the alleged failure to develop an effective discharge planning process. By submitting this plan of removal covered the non-compliance. does not admit to the accuracy of the alleged deficient practice. What corrective actions have been implemented for the identified residents? 1. The following plan was implemented to ensure the discharge planning is effective immediately on 4/25/2025 for all upcoming discharges: a. Residents and family members will be instructed to provide their own transportation upon discharge. Courtesy transportation will no longer be provided. b. Discharge paperwork will be presented to the power of attorney, responsible party, and or resident if they are their own RP with intact cognition to be reviewed and signed upon discharge. c. A discharge summary/plan of care will be provided to the cognitively intact resident, responsible party, and/or power of attorney. d. Post discharge services such as home health will be set up prior to discharge. e. Physicians and NP's will be notified of discharges to address resident's needs. f. Resident #1 no longer resides at the facility was at the hospital How were other residents at risk to be affected by this deficient practice identified? (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service training report dated 04/11/2025 by the RD with the ADM, time unknown, reflected Appropriate discharge planning include the following steps: Discharge summary completion, communication of discharge orders, confirmation of home health orders information of on discharge transportation, Notification of discharge to RP/POA and resident if cognitive. The ADM's signature was observed on page 2 confirming attendance. Record review of a facility in-service titled discharge date d 04/11/2025, time unknown, by the ADM, reflected to ensure appropriate discharge planning of residents and to ensure safe discharge time following items have been completed: 1. Family members of RP will be required to pick up residents. 2. We will no longer provide courtesy transportation. 3. RP will sign discharge. 4. Discharge will only be signed by a cognitive party/resident and or family member. Signatures of staff that participated in the in-service revealed CM T, LSW, MDS D, LVN M, RN H, RN G, LVN S, LVN R, LVN O, LVN A, LVN B. Record review of facility Inservice titled Discharge Plan of Care Completion UDA's department managers dated 04/2025 time unknown by ADM reflected Please ensure that the discharge plan of care UDA's (User defined assessments) are completed within 48 hours of discharge. Discharge summaries are to be completed within 48 hours of discharge. Ensure that the physician and NP assigned to the resident is notified of the upcoming discharge to address any additional resident needs. The facility will ensure that discharge paperwork will be signed by only cognitively intact residents and/or responsible party on power of attorney. Signatures of staff that participated in the in-service, CM T, LSW, ADON, LVN E, DON, LVN K, and MDS R. the date of the in-service was not dated at the top or bottom of the in-service. Record review of in-service titled dated April 25, 2025, by ADM for the dual services department/ social services titled discharge planning reflected to ensure residents safely discharge back their prior settings, Family members will be required to provide their own transportation. Family members will be required to sign discharge paperwork. Staff signatures LSW P and CM T. LSW and CM T signature was observed on page 2 confirming attendance. Record review on 04/26/2025 of Residents #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, and #31 were reviewed for residents with discharged planning completion from the facility on or after 04/08/2025. The charts indicated appropriate notifications were made and the resident's discharges were safe. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews were conducted on 04/26/2025 from 4:15 PM to 5:30 PM, with ADM, DON, ADON N, MDS R, LSW, CM T, RN G (1st shift), RN H (2nd shift), LVN S (2nd shift), LVN O (2nd shift), LVN L (1st shift), LVN J (1st shift) RN U (1st shift) regarding training on discharge planning for residents included: ensure that nursing/social services staff follow up with aftercare services and MD/PCP to confirm resident client service status; ensure who and where the resident will be living and if supervision was needed or left alone; ensure cognitively impaired residents are not transported via public transportation; ensure all assessments, care plan, and MDS are completed prior to discharging the resident, and ensure the NP and MD were notified prior to discharge of date, plan, and time of discharge in order to obtain additional services and approvals for the resident to discharge. The staff said that follow up calls would be conducted to confirm follow up appointments and services for aftercare. Ensure the POA/RP have the correct contact information of the pharmacy and MD/PCP are provided to pick up RX's and for the follow up appointment in two weeks; ensure the POA/RP have knowledge of the delivery timeframe for DME and expectations of billing; ensure the resident's POA/RP were present at discharge to transport from the facility. In an interview with the ADM and DON on 04/26/2025 at 5:48 PM, both stated that ongoing monitoring and auditing by the IDT, DON, ADON, and LSW will completed for accuracy of resident assessments, discharge planning, discharge summary's, resident cognitive and functional abilities, referral and notification of resident's after care services, follow up calls to after care service providers within 24 to 48 hours to ensure residents service implementation and resident safety. Record review of the facility policy untitled and undated reflected in part Policy Statement.: A licensed Administrator is responsible for the day-to-day functions of the facility Policy interpretation and implementation: he is governing board of this facility has appointed an Administrator who is duly licensed in accordance with current federal and state requirements. The Administrator is responsible for, but not limited to: Managing the day-to-day functions of the facility .Ensuring that each resident's right to fair and equitable treatment, self. determination, individuality, privacy, confidentiality of information, property, and civil rights, including the right to lodge a complaint, are strictly enforced .Implementing established resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities. Delegation of authority/chain of command: In the absence of the Administrator, the Assistant Administrator or Director of Nursing Services is authorized to act in the Administrator's behalf. Should both the Administrator and the Assistant Administrator or Director of Nursing Services be absent, the chain of command as established by this facility shall be followed. A complete outline of the Administrator's duties and responsibilities is contained in his/her job description. The Administrator was informed the Immediate Jeopardy was removed on 05/26/2025 at 5:45 PM. The facility remained out of compliance at a severity level of potential for more than minimal harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to monitor the implementation of the plan of removal.