

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 06/27/2025
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)
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on observation, interview, and record review the facility failed to administered in a manner that enables it to use its resources effectively and efficiently to attain or main the highest practicable psychosocial well-being for 17 residents.</p> <p>1.</p> <p>The facility failed to ensure calls directed to a centralized staff work area were answered.</p> <p>2.</p> <p>The facility failed to ensure the centralized staff work area had a portable phone available and the portable phone was properly functioning.</p> <p>This failure could place 17 residents on hall 200 with limited resources or other services necessary to provide for the needs of the residents.</p> <p>The findings included:</p> <p>In a confidential interview onn 6/24/2025 at 8:57am revealed the resident referenced in the complaint was discharged from the facility in January 2025. She stated during resident's time at the facility, there was multiple times, particularly during the early morning hours, she contacted the facility via phone and did not receive a response. She stated when she contacted the facility via phone, the phone rung multiple times and was unable to speak with staff. She stated she attempted to contact the facility to discuss concerns regarding the lack of care the resident was receiving.</p> <p>In an interview with Receptionist J on 6/24/2025 at 9:26am revealed the facility had two receptionists that worked Monday- Friday between 8:00am-8:00pm and their responsibility was answering all calls made to the facility. He stated after 8:00pm, all calls were routed to all nurses' stations and any staff could answer calls. He stated there were portable phones at the nurse's station and the portable phones could receive calls and staff could make outgoing calls. He stated to his knowledge the portable phones were properly functioning.</p> <p>Observation of a telephone call made to the facility by the surveyor on 6/26/2025 at 5:00am revealed staff answering the phone.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of a telephone call made to the facility by the surveyor on 6/26/2025 at 6:34am revealed the phone rung continuously and staff did not answer the phone.</p> <p>Observation of a telephone call made to the facility by the surveyor on 6/26/2025 at 6:36am revealed the phone rung continuously and staff did not answer the phone.</p> <p>Observation of the 200 hall nurses' station on 6/26/2025 at 8:48am revealed the portable phone was missing from the phone base.</p> <p>In an interview with ADON A on 6/26/2025 at 8:50am revealed the portable phone was misplaced. She stated the phone has been missing for a while. She stated there was a portable phone at the nurse's station on the 100 hall that was available and functioned properly.</p> <p>Observation of the 100 hall nurses' station on 6/26/2025 at 8:54am revealed a portable phone on the charging base however, the portable phone was not functioning properly due to the phone not being fully charged, and incoming and outgoing calls could not be received or made.</p> <p>Observation of the 300 and 400 hall nurses' station on 6/26/2026 at 9:02am revealed a portable phone on the charging base properly functioning.</p> <p>In an interview with the DON on 6/26/2025 at 11:28am she stated after hours, all incoming calls were routed throughout the facility to all nurses' stations. She stated there were land lines at each nurse's station and a portable phone. She stated the portable phone at 200 hall nurses' station, was misplaced and had been missing for three months. She stated to replace the missing the phone, she would inform the ADM and the ADM would order a new phone. She stated nurses and aides were expected to answer any incoming calls. She stated if staff could not answer an incoming call from the land line or portable phone, the phone would continue to ring, and caller could not leave a message unless the caller knew a direct extension. She stated the caller would have to call back until staff answered the phone. She stated staff was expected to answer the phones after hours. She stated it was important for staff to answer the phones because the caller could be calling regarding the care of a resident and a resident care is always important.</p> <p>In an interview with the ADM on 6/26/2025 at 3:00pm she stated after hours all incoming calls were routed to all nurses' stations. She stated any nurses or aides could answer incoming calls. She stated each nurse's station had a land line and the nurses' stations also had a portable phone. She stated if staff could not answer the land lines or the portable phones the call would continue to ring unless the caller knew an extension. She stated if the caller needed to speak with staff, the caller would have to call back until staff answered the phone. She stated she was informed today, the portable phone at the 200 hall nurses' station was misplaced. She stated it was important for staff to answer incoming calls because the caller could be calling about an emergency and it is important representatives and family to check on their loved ones.</p> <p>Record review of the facility's resident rights policy revised December 2016 reflected Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: F. communication with and access to people and services, both inside and outside the facility.</p>		