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	12/05/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676492	A. Building B. Wing	12/05/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure the resident had access to a private form of communication. 1) The facility removed the landline telephone from the resident's room.2) The facility refused to provide a telephone to the resident when he requested to use one. This failure could cause psychosocial harm to the residents by not allowing them to communicate with people outside of the facility when desired.During the off-site preparation for the investigation, an interview was conducted with the complainant on 09/25/25 at 6:15 PM. The complainant stated [Family Member] demanded the facility not provide Resident #1 access to a telephone to prevent him from communicating with other members of the family. Complainant further stated Resident #1 had been diagnosed with dementia (an umbrella term for a group of symptoms characterized by a decline in mental ability that impacts daily life, including memory, thinking, and behavior). While interviewing Resident #1 on 09/26/25 at 9:45 AM, Resident #1 was able to communicate in a well articulated manner and appeared to be of sound mind. Resident #1 stated he was in the facility due to being involved in a serious vehicle collision and was in the process of recovering. Resident #1 was able to describe to me how the vehicle collision occurred and recount a correct timeline of the collision and his ensuing hospital stays and medical procedures since being hospitalized . While speaking to Resident #1, complainant and [Family Member] arrived to visit. In person interview conducted with complainant and [Family Member] on 09/26/25 at 10:38 AM. Complainant and [Family Member] stated Resident #1 had been diagnosed with Sun Downers (a set of symptoms-including confusion, anxiety, aggression, and agitation-that typically begin in the late afternoon and evening in individuals with dementia.) 2-3 years ago by his personal Doctor. The complainant further stated she and [Family Member] had Resident #1's personal Doctor complete a CME on 08/29/25. The complainant continued to state she and [Family Member] have Medical POA for Resident #1. [Family Member] stated during the interview, he instructed the facility to remove and deny Resident #1 all forms of communication to prevent him from communicating with other members of the family without their knowledge. Complainant and [Family Member] stated they did not have a court order showing Resident #1 had been ruled incompetent. Complainant provided copies of the CME and Medical POA. During an interview with Resident #1's personal Doctor, on 09/26/25 at 1:40 PM, he stated he has not diagnosed Resident #1 with dementia or Sun Downers and stated those diagnoses were given to Resident #1 by [Family Member]. He further advised he did complete the CME at [Family Member] request and stated he wrote on the CME Resident #1 had not been diagnosed with dementia. Resident #1's personal Doctor continued to state [Family Member] was quite insistent on completing the CME indicating Resident #1 had dementia. Resident #1's personal Doctor continued to state he advised [Family Member] he had not seen Resident #1 in some time and could not diagnosis him with dementia. Resident #1's personal Doctor said he completed the CME to appease [Family Member] and completed the CME in such a manner that indicated if there were any mental deficiency, it would be due to the vehicle accident and not dementia, and most likely be temporary. During an interview with DON on 09/26/25 at 2:05 PM, she stated [Family Member] demanded Resident #1 not have access to a telephone to communicate with other family members. DON stated the facility complied with [Family Member] request and removed the phone from Resident #1's room and denied him access to any other forms of communication. DON further stated the facility does have the ability to provide a form of private communication for the resident but has not done so due to the request of [Family Member]. DON stated there are no medical records, diagnostic records, or diagnosis indicating Resident #1 has dementia. Durning a re-interview of Resident #1 on 09/26/25 at 3:10 PM he stated his personal cell phone was taken from him by [Family Member] shortly after being admitted . Resident #1 further stated he had been allowed to use the phone only once when he first arrived to the facility. Resident #1 continued to state he asks to use a phone several times a day and is denied by staff. Resident #1 said no one will tell him why he can't use the phone. Resident #1 stated he missed speaking to his wife and daughter and has not been able to speak to them since being admitted to the facility. While speaking to Resident #1, Med Aid entered to provide care and stated she was instructed to not provide a phone to Resident #1 if he asked. Med Aid further confirmed Resident #1 had asked for a phone every day he has been in the facility to call his wife. During an interview with the Administrator on 09/26/25 at 3:56 PM, she stated there were no records indicating Resident #1 was unable to make decisions for himself. The Administrator said she had instructed Resident #1 not have access to a form of communication at the

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	12/05/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one of three (Medication Cart #1) medication carts reviewed for pharmacy services.The facility failed to ensure Medication Cart #1 was locked when unattended, in the 300 Hall, on 09/26/25.This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversioFindings included:In an observation and interview on 09/26/25 at 9:28 AM, Medication Cart #1 was observed unlocked and unattended as it set outside room [ROOM NUMBER], across from the nurses' station. There were no staff at the nurses' station. There were no staff in the immediate area. Medication Tech A was observed about 4 rooms down as she passed medication. The DON was observed as she came down the hall and locked the medication cart. The DON stated she was not sure who was responsible for the unlocked medication cart. The DON asked Medication Tech A who last attended the medication cart, and Medication Tech A stated she was the last one that used the unlocked medication cart. The DON told Medication Tech A that all medication carts should be locked when unattended to prevent drug diversion.In an interview on 09/26/25 at 12:02 PM, Medication Tech A stated she was responsible for two medication carts today. She stated she used the medication carts for 300 and 400 halls, and she stated she forgot to lock the other cart when she switched to a different cart. She stated she never left medication carts unlocked and was upset about it. Medication Tech A stated the risk of an unlocked medication cart was a patient could get in it and get stuff. Medication Tech A stated she was trained to always lock the medication carts. In an interview on 09/26/25 at 4:05 PM, the Administrator stated she was informed about the unlocked medication cart that was the responsibility of Medication Tech A. She stated the staff received in-services routinely on medication administration and locked medication. The Administrator stated the risk of an unlocked medication cart was anyone would have access to the medications.A policy on locked medication was requested on 09/26/25 at 11:50 AM and at 3:35 PM but not received.