

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 12/10/2025
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving mistreatment, neglect, abuse or misappropriation of resident property were reported immediately, but not later than 2 hours if the alleged violation involved abuse or resulted in serious bodily injury, to other officials (including to the State Agency) for one (Resident #1) of six residents reviewed for abuse. The Administrator, who is the Abuse Coordinator, failed to immediately report (within 2 hours) an allegation of abuse made by Resident #1 on 11/19/25. The failure could affect 72 residents and could result in undetected abuse and/or decline in feelings of safety and well-being. Findings include: Record review of Resident #1's face sheet dated 12/10/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with primary diagnosis of gastrostomy malfunction (this a feeding tube that malfunctions or was replaced). Her secondary diagnoses included COPD (a lung disease that blocks airflow and makes it difficult to breathe), type 2 diabetes Mellitus (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels), unspecified dementia (Brain disease that alters brain function and causes a cognitive decline) and cellulitis of the abdominal wall (infection in the stomach wall which appears as redness on the stomach area). Record review of Resident#1's admission MDS dated [DATE] and discharge MDS dated [DATE] did not reflect a BIMS score. Record review of Resident #1's hospital record dated 11/17/25 reflected Resident #1's mental status assessment was Alert and Oriented to person [she knew who she was, (name, birthday, age)], Place [she knew where she was], and time [she knew what time it was]. Record review of Resident #1's physician order summary for December 2025 reflected-crush/dissolve medication and give with food or fluid three times a day. Ordered 11/18/25 Record review of facility grievance log dated 11/19/25 revealed Resident #1 had reported to DON that on morning of 11/19/25 on the 6am-6pm shift, the staff member passing medication pinched her mouth together and placed medication in her mouth after she had refused the medication because of the taste. The grievance reflected Resident #1's family was present at the time the allegation was made. The grievance revealed medication aide was placed on suspension pending investigation and life satisfaction surveys for Abuse and Neglect were completed. In a phone interview with Resident #1's family on 12/09/25 at 3:40 PM, she stated Resident #1 was in the hospital. She said on 11/19/25 around 3:00 pm, she arrived to visit Resident #1 at the facility. Resident #1 reported to her that earlier that morning, a Medication Technician (name unknown) grabbed her by her mouth and tried to force her to take medication (medication name unknown). The family stated Resident#1 told the Medication Technician that she did not want the medication because she did not like the taste of it crushed. In an interview with DON on 12/10/25 at 1:59 PM, she stated LVN D reported to her that Resident #1's family wanted to speak with her. DON said that family was upset that Resident #1 had alleged that a Medication Aide had forced Resident #1 to take medication. DON said that she filed the grievance, reported the incident to the abuse coordinator (the Administrator) and called corporate office to report the incident. DON said that they did an internal investigation and determined that the allegations were unfounded. She said she was advised by corporate that it was not a reportable incident because Med Tech had LVN D as a witness during the exchange and the following day, Resident #1's family apologized for her outburst and the cursing she had done the day before. DON said Resident #1's family told her that Resident #1 had dementia and may have been confused. DON stated with that information and confirmation from corporate office, they did not feel they needed to report the incident to State office. In an interview with Medication Technician on 12/10/25 at 2:04 PM, she stated Resident #1 was new to the facility and she had an order to crush her medication before oral administration. She said when she went into Resident #1's room to administer medication, Resident #1 who refused to take the medication stated that she took her pills whole (not crushed). Med Tech said she then left Resident #1 and went to confirm with LVN D. She said together with LVN D, they went to talk to Resident #1 about the physician order to crush medications before administration. Med Tech stated at that point Resident #1 was agreeable to take medication as LVN D walked out of the room. Med Tech said after just taking a small bite of the crushed medication Resident #1 refused saying that she did not like the taste. Med Tech said at that point, she walked out and gave the medications to LVN D and reported that Resident #1 refused her medications. Med Tech stated she did not grab Resident#1's mouth or force her to take the medication. She said when she refused, she went and reported it to the nurse and that was it. She said that she would not force a resident to take medication as that was abuse and a resident had a right to</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate services to prevent complications of enteral feeding for four of six residents (Residents #1, #3, #4, and #5) observed for gastrostomy tube feeding. 1. The facility failed to ensure Residents #1, #3, and #4's G-tube dressings were changed and dated. 2. The facility failed to make sure that formula tubing was sealed with a cap to prevent exposure and contamination during downtime for Resident #1 and #5. These failures could place residents at risk of contamination and communicable infectious diseases. Findings included: Resident #1 Record review of Resident #1's face sheet dated 12/10/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with primary diagnosis of gastrostomy malfunction (this a feeding tube that malfunctions or was replaced). Her secondary diagnoses were COPD (a lung disease that blocks airflow and makes it difficult to breathe), type 2 diabetes Mellitus (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels), unspecified dementia (Brain disease that alters brain function and causes a cognitive decline) and cellulitis of the abdominal wall (infection in the stomach wall which appears as redness on the stomach area). Record review of Resident#1's admission MDS dated [DATE] did not reflect a BIMS score. Record review of Resident#1's discharge MDS dated [DATE] revealed Resident #1 had a feeding tube. The MDS did not indicate how much nutritional calories or fluid were obtained using tube feeding. Record review of Resident #1's physician order summary for December 2025 reflected-GT: Pump give [brand name of diabetic feeding] at 40 cc/hr per g-tube for 20 hours every shift. Ordered 11/18/25-GT: Cleanse peg [other name of g-tube] site with normal saline, pat dry and apply dressing daily or as needed every shift. Ordered 11/18/25. Record review of Resident #1's care plan initiated on 11/24/25 revealed Resident #1 had cellulitis of the abdominal wall. The goal was for Resident #1 to have no complications resulting from the cellulitis through the review date. The interventions were to observe/document/report to MD the following symptoms of Cellulitis: Red, Swollen, tender Skin, reddened area begins to spread, small red spots that appear on the reddened skin, small blisters which may form and burst, swollen lymph glands. Further review of the care plan indicated Resident #1 required tube feeding related to dysphagia (difficulty swallowing). The goal was for Resident #1 to maintain adequate nutritional and hydration status as evidenced by weight stability, no signs and symptoms of malnutrition or dehydration. Interventions included Document/report to MD PRN: aspiration, fever, Shortness of breath, tube dislodged, infection at tube site, self-extubation [pulling g-tube out], tube malfunction, abnormal breath/lung sound, abdominal pain, distention, tenderness, diarrhea, nausea and vomiting. In a phone interview with Resident #1's family on 12/09/25 at 3:40 PM, she stated Resident #1 was currently in the hospital. She said she had gone to the facility to visit Resident # 1, on 11/19/25, 11/20/25, and 11/21/25. She said Resident #1 was not connected to her feeding tube on 11/20/25, and 11/21/25, and the tube feeding end was hanging from the IV pole uncapped and dirty. She said the same tube feeding from 11/19 was still hanging on the pole. She stated on 11/20/25, Resident #1's Peg tube dressing had a foul odor coming from it so she removed it and cleaned the site the best she could. Record Review of Resident #1's photos provided by family via email revealed a photo dated 11/19/25 at 5:40 pm of the uncapped feeding tubing with brown substance that was dry on the end of the tube and another photo dated 11/20/25 taken at 12:54 PM, revealed a soiled gauze dressing with brown and red discharge on it. The g-tube dressing was undated. Record review of Resident #1's MAR revealed cleanse peg site with normal saline, pat dry and apply dressing daily or as needed every shift. It was documented as completed on the 6 am-6pm shift on 11/19/25 by LVN D and on 11/20 and 11/21/25 it was documented as completed by LVN E On 12/10/25 at 2:57 PM, an attempt was made to contact LVN D. A message with a return number was left. There has been no return call from the nurse. In a phone interview with LVN E on 12/10/25 at 4:51 PM, she stated she worked the overnight 6pm-6 am shift. She said she changed Resident #1's g-tube dressing change, the new feeding tubing and water and the syringe for g-tube. She said it was done overnight by her and other assigned nurses with patients who had g-tubes. She said when she worked with residents who had g-tubes, she made sure that the feeding was new. She said she also labeled the feeding bag, the syringe and the g-tube dressing. She said the potential risk of not completing these tasks was infection. Resident #3 Record Review of Resident #3's face sheet dated 12/10/25 revealed a [AGE] year-old male with an initial admission to the facility of 06/03/21 and readmitted on [DATE] with a primary diagnosis of nontraumatic intracerebral hemorrhage in hemisphere. Subcortical (this is a</p>		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for 1 of 1 resident (Resident #2) reviewed for peripheral intravenous care. The facility failed to ensure physician orders for Resident #2 were followed to change PICC line dressing every 7 days as ordered. This failure could affect residents by placing them at risk of infection. Findings included: Record review of Resident #2's face sheet dated 12/10/25 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of other mechanical complication of internal fixation device of bone of right lower leg, subsequent encounter (this is an active infection that was caused by the hardware in the right lower leg). Record review of Resident #2's admission MDS dated [DATE] did not indicate Resident #2 had a BIMS score. Record review of Resident #2s Physician order summary for December 2025 reflected -LUE DL PICC IV: Change IV dressing Q TUE days and PRN. Ordered on 12/03/25.-Monitor IV insertion site for s/s of infection/infiltration every shift. Ordered 12/02/25. Record review of Resident #2's care plan initiated on 12/03/25 indicated Resident #2 was on IV antibiotic therapy related to pin site osteomyelitis (bone infection) infection. The goal was for Resident #2's infection to resolve without complications. The interventions were to administer medication as ordered. The care plan also revealed that Resident #2 had a surgical incision related to fracture repair. The goal was for the surgical wound to heal without complications by the review date. Interventions included Monitor for signs of infection (redness, warmth, excessive drainage) and report changes to MD. Observation and interview with Resident #2 on 12/10/25 at 10:00 AM revealed Resident #2 was attached to an IV pole with IV antibiotic being infused. Resident #2 said that she received antibiotics twice a day. Resident #2 extended her left arm and revealed a PICC line with two ports. One of the ports was covered with a green cap and the other port was being used for the infusion. The dressing was coming off on the left outer side. The dressing was dated 11/26/25 with time print 17:55 [5:55PM]. The inner insertion site had a gel covering of PICC line and dressing around the immediate proximity was intact and clean. Resident #2 said she did not know how often the IV dressing is changed. In an interview with LVN A on 12/10/25 at 10:29 AM, she stated this was the first time that she was assigned to work with Resident #2 and she wanted to give at least one antibiotic before changing the IV dressing. She said she noticed that the PICC line needed to be changed but she did not change it until the first antibiotic was completed. She said that she had assessed the PICC line before medication administration to make sure there were no signs and symptoms of infection such as redness, swelling, pain, or any discoloration. She said she knew that all PICC line dressings were changed every Tuesdays or weekly. She said that the risk of not changing IV dressing was infection. In an interview with RN F on 12/10/25 at 1:45 PM, she stated she was the infection control preventionist. She said nurses were responsible for putting orders in for dressing changes and the unit managers monitored that orders are accurate. She said she is supposed to monitor that staff are following the infection control procedures. She said that she was not aware that a resident had a PICC line dressing that was overdue. She said the risk of not changing the dressing when it is due is infection. An interview with the DON on 12/10/25 at 1:59 PM revealed that nurses were responsible for completing dressing changes as ordered weekly on Tuesdays and charge nurse were responsible for monitoring completion of tasks. She said LVN B was supposed to change Resident #2's PICC line dressing yesterday on Tuesday (12/09/25). DON stated LVN B told her that she became busy with admission and discharge and forgot to complete the dressing change. She said that LVN B should have communicated with the oncoming nurse that she had not completed the dressing change. She said she did not know how the IV dressing change was missed between 12/03/25 until 12/10/25 but that on Monday 12/08/25, Resident #2 was gone to an appointment. She said if the IV dressing did not get changed as ordered, then there was potential for infection. In an interview with LVN B on 12/10/25 at 4:00 PM, it was revealed she had been employed to the facility for about four months. She said, honestly it slipped my mind. She said she was very busy on Tuesday with admission and discharge and forgot to change Resident #2's PICC line dressing. She said she also forgot to communicate with on coming nurse about the IV dressing change. She said she needed a better time management strategy. She said she had been trained to assess and change IV dressings. She said that she monitored PICC for signs and symptoms of infection. She said failure to change PICC line dressing put the resident at risk for an infection. In an interview with the Administrator on 12/10/25 at 05:09 PM she said the</p>		