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	06/27/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide the Resident Council Group a private space for monthly resident council meetings for the facility's only resident council. 1. The facility failed to ensure resident council meetings were held in a private meeting space. Staff continued to enter the activities room while the resident council meeting was being held. This failure could place residents at risk of not disclosing concerns or issues, which could lead to emotional turmoil and distress. Findings included: Observation of the resident council meeting on 6/25/2025 at 1:30pm revealed five residents located in the facility's activities room for the resident group meeting. The activities room was in an open area with no doors to the room. Five care staff and providers continued to enter the activities room and interrupt the group meeting. In an interview with the AD on 06/25/2025 at 1:37pm she stated resident council meetings were held in the activities room or in the dining room. She stated the conference room is a private area, but the conference room was unavailable because the nurse managers used the conference room as a workspace. In a confidential group interview on 06/25/2025 at 1:50pm revealed resident council meetings were held in the activities room and staff frequently came in and out of the activities room during resident council meetings and used the vending machines. In an interview with the ADM on 06/25/2025 at 3:00pm she stated resident council meetings were held in the activities room or the classroom. She stated if the facility was not conducting orientation during the resident council meeting, the meeting could take place in the classroom. She stated not ensuring resident council meetings were held in a private area could violate the privacy of the residents. (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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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Resident Rights policy revised 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: t. privacy and confidentiality.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming for 1 of 6 residents (Resident #18) reviewed for quality of care. The facility failed to ensure Resident #18 call lights were answered in a timely manner. This deficient practice could affect Resident #18's feelings of dissatisfaction or poor self-esteem. Findings included: Review of Resident #18 admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included appendicitis (inflammation of the appendix), muscle weakness, abnormalities of gait and mobility (any deviations from a typical walking pattern), lack of coordination, cognitive communication deficit, anemia (not enough red blood cells), type 2 diabetes (body doesn't produce enough insulin), hyperlipidemia (abnormally high levels of fatty substances in the blood), hypertension (the force of blood against your artery walls is consistently too high), paroxysmal atrial fibrillation (episodes of an irregular heartbeat stop on their own), gastro-esophageal reflux disease without esophagitis (esophagus doesn't show signs of inflammation or damage despite the presence of reflux), end stage renal disease (kidneys are functioning at a very low level, requiring dialysis or kidney transplant for survival), chronic kidney disease (kidneys cannot filter blood as well as they should, dependence on renal dialysis (kidneys are no longer able to adequately filter waste and excess fluid from the blood, requiring regular dialysis treatments to sustain life. Record review of Resident #18's quarterly MDS assessment, dated 10/16/24, reflected Resident #18 had a BIMS score of 15, indicating intact cognition. Attempted interview with Resident #18 on 06/26 /25 at 12:35 PM but did not receive a return call. During a confidential interview on 06/23/25 at 2:36 PM, Resident #18 revealed to her that she had a bowel movement the night before and pressed her call light and staff came in and turned the light off and refused to change her until the morning. Interview on 06/27/25 at 6:15 PM, CNA K revealed she had to answer a coworker's call light due to light being on for 15 minutes and felt that was to long for the resident to go without care. CNA K stated that residents have reported that when she was not at work they were hesitant to hit their call light cause they didn't want to bother the staff, because staff will come in and turn off the light and not provide care to the resident, which could lead to issues such as skin breakdown if they were left wet or they could be left in extreme pain if the request was for pain medication. Interview on 06/27/25 at 7:02 PM, CNA L revealed resident have complained that staff turned their call light off and did not provide care and stated that could be bad for residents, because it could have been a serious problem like for example, they fell and had an injury, so best practice is to go answer the call light as soon as you can. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/28/25 at 1:39 PM, the DON revealed residents have complained to staff about call light response time, staff has been reeducated that anyone can answer a call light and if that staff member is unable to provide care, to leave the light on and go get the staff member who could assist, because if they turn the light off and the can't find the proper person they would forget and the resident care needs weren't provided. The DON stated that the facility conducted ambassador rounds Monday through Friday and hired an evening shift manager that leaves at 10 PM because she realized that unfortunately when staff was not monitored, they may not do what they were supposed to, so the Administrator and the DON have popped up overnight to ensure staff did their job. Interview on 06/28/25 at 3:01 PM, the ADM revealed that the expectation to answer call lights was as soon as possible, but no longer than 15 minutes and that all staff were able to answer call lights, and if unable to provide service to the resident, leave the call light on, go inform the appropriate staff member so they could go address residents' concerns. Additionally, there was no overnight manger on duty, so the DON and ADM conduct monthly spot checks, where they will come into the facility at random times throughout the night to ensure resident care was provided. The Administrator stated it was important to respond to call lights as it could lead to harm of the resident depending on what the call light was on for. Record review of Grievance/Complaint Report dated 10/21/2024, reflected resident stated that she placed her call light on for assistance related to incontinent episode and staff CNA with blue on came in the room told her that she would return and never returned was reported to the DON and Interpreter for Resident #18. Facility follow-up stated that in-serve on call light answering and providing service in a timely manner to provide care was given. Resolution of grievance/complaint stated patient stated that care needs were provided in the next 72 hours in and timely manner. Record review of the facility's policy Answering the Call Light, revised October 2010, reflected Answer the resident's call light as soon as possible.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown and infection for one (Resident #12) of four residents reviewed for pressure ulcers (open wound on the skin caused by prolonged pressure to bony prominences). The facility failed to ensure that Resident #12's negative pressure wound device had settings per physician order on 06/25/2025, and 06/26/2025. This failure could place the residents with pressure ulcers at risk for worsening of existing pressure ulcers and infection. Findings included: Record review of Resident #12 Face Sheet dated 06/26/2025 revealed she was a [AGE] year-old female admitted from an acute care hospital for long term care on 03/13/2025. Relevant diagnoses included heart failure (heart unable to pump enough blood to meet the body's needs,) pyelonephritis (kidney infection,) and dementia (group of symptoms affecting memory, thinking, and social abilities.) Record review of Resident #12's Quarterly MDS dated [DATE] revealed she had moderate cognitive impairment with a BIMS score of 11. She was dependent upon staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. She was incontinent of bowel and bladder. She was admitted with a total of two stage IV pressure ulcer/injuries. Record review of Resident #12's Physician Orders revealed Wound Vac continuously at 125 mgm hg to Sacrum . every day shift for wound care . Start date 06/21/2025. In an observation and interview of Resident #12 on 06/25/2025 at 10:25 AM, her negative pressure wound device was turned on and the setting was observed at 150 mmHg . In interview, Resident #12 revealed she was not aware of the physician orders for her device settings nor when it was last changed. In an observation of Resident #12 on 06/26/2025 at 10:45 AM, her negative pressure wound device was turned on and the setting was observed at 150 mmHg. In an interview with Resident #12's nurse for the day, LVN H, on 06/26/2025 at 10:47 AM, she stated she was not certain about Resident #12's negative pressure wound device settings and would defer to Treatment Nurse C for more clarification. In an interview and observation with facility's Treatment Nurse C on 06/26/2025 at 10:50 AM, she stated Resident #12's negative pressure wound device settings should be 125 mmHg, stated it was currently at 150 mmHg, and was observed to reset the device to 125 mmHg. She stated the potential outcome was nothing, as [Resident #12] has a lot of drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with facility's DON on 06/26/2025 at 1:08 PM, she stated her expectations were for all nursing staff at the facility to ensure residents with negative pressure wound devices have the settings set according to physician orders. She stated if the settings were not correct, it was a medication error that could cause harm to the residents at the facility. She stated it was Treatment Nurse C's responsibility to ensure the settings were correct each day. In an interview with Administrator on 06/26/2025 at 3:00 PM, she stated she would defer to her clinical team for wound care expectations. Record review of facility policy, Negative Pressure Wound Therapy, rev. 02/2014, revealed Preparation . 1. Verify that there is order for this procedure .13. Turn on pump: a. Initiate negative pressure setting on the pump as ordered .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety. 1. The facility failed to ensure all foods stored in the refrigerator were covered, labeled, and dated. 2. The facility failed to ensure dented cans were placed in a separate storage area. 3. The facility failed to discard open items in the dry storage that were not sealed. These failures could place residents at risk for food-borne illness and cross contamination. Findings Included: Observation of the refrigerator on 6/24/2025 at 8:02am revealed the following: -1 tray of 13 drinks dated 6/24/2025 not labeled. -1 tray of 8 fruit cups not labeled or dated. Observation of the dry storage on 6/24/2025 at 8:10am revealed the following: -1 5.31 lbs jug of mashed potatoes dated 6/18/2025 was opened and exposed to the air. -1 6.56 lbs can of marinara sauce dated 6/14/2025 was dented on bottom right. In an interview with the DM on 06/25/2025 at 9:44am she stated it was the kitchen aides' responsibility to ensure all food and drinks were labeled, dated, and sealed appropriately. She stated failing to properly label, date, and seal food and drinks could cause residents to be sick, vomit, or have food borne illness. She stated it was all the kitchen staff responsibility to check for dented cans and remove any dented cans. She stated dented cans could cause the residents to become sick. In an interview with DA I on 6/25/2025 at 9:50am he stated it was his responsibility to make sure all food and drinks were labeled, dated, and sealed correctly. He stated food and drinks labeled and dated correctly can prevent expired food and drinks served to residents. He stated expired food or drinks could make residents sick. He stated all kitchen staff were responsible for checking for dented cans and placing dented cans in a separate area. He stated dented cans could make residents sick.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Residents #123 and #124) of twenty residents reviewed for Infection Control. 1. The facility failed to ensure MA G sanitized the blood pressure cuff while administering medications and checking vital signs of Residents #123 and #124 on 06/24/2025. 2. The facility failed to ensure MA G performed hand hygiene prior to resident contact and care for Resident #124 on 06/24/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings include: Record review of Resident #123's Face Sheet dated 06/26/2025 revealed he was a [AGE] year-old male admitted from an acute care hospital on [DATE]. Relevant diagnoses included encephalopathy (disease that affects the brain's function or structure,) cerebral infarction (obstruction of flow of blood to the brain resulting in brain cell death) resulting in left side deficits, pneumonia (infection that inflames the air sacs in one or both lungs,) and diabetes mellitus type II (insulin resistance.) Record review of Resident 124's Face Sheet dated 06/26/2025 revealed she was an [AGE] year-old female admitted from a rehabilitation hospital for extended rehabilitative therapy on 06/05/2025. Relevant diagnoses included femur (leg) fracture and diabetes mellitus type II (insulin resistance.) During an observation of MA G with Resident #123 on 06/24/2025 at 8:08 AM, she obtained a blood pressure device from an unattended medication cart in the hallway, performed hand hygiene in resident's sink, and obtained his blood pressure with his left upper arm. MA G failed to sanitize the blood pressure cuff and device prior to use on Resident #123. During an observation of MA G with Resident #124 on 06/24/2025 at 8:38 AM, MA G entered the resident room and obtained Resident #124's blood pressure with her right upper arm. MA G failed to perform hand hygiene prior to resident contact and sanitize the blood pressure cuff and device prior to use on Resident #124. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with MA G on 06/24/2025 at 8:56 AM, she stated did not recall if she performed hand hygiene prior to contact with Resident #124. She stated it was important to complete hand hygiene before and after all resident contact for infection control purposes. MA G stated she obtained the blood pressure cuff and device off the nurse's cart in the hall and assumed it was [sanitized] before use with Resident #123. She later stated she should have sanitized it prior to use with Resident #123 and prior to use with Resident #124. She stated, it should have been done, and it was an infection control issue. MA G stated she has received in-services on the topics and it was her responsibility to ensure these tasks were completed. In an interview with DON on 06/26/2025 at 1:08 PM, she stated she expected her staff to perform hand hygiene between resident care and contact for infection control purposes. Additionally, she stated she expected her staff to sanitize shared use equipment between resident contact and use for infection control purposes. She stated it was ultimately her responsibility to ensure this was completed and provided in-services for review. In an interview with Administrator on 06/26/2025 at 3:00 PM, she stated she expected her staff to perform hand hygiene and sanitize shared use equipment between resident contact and use for infection control purposes. Record review of facility policy, Handwashing/Hand hygiene, rev. 08/2015, revealed This facility considers hand hygiene the primary means to prevent the spread of infections . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap and water for the following situations: . before or after direct contact with residents; i. After contact with a resident's intact skin . Record review of facility policy, Cleaning and Disinfection of Resident-Care Items and Equipment, rev. 07/2014 revealed Resident-care equipment, including reusable items . will be cleaned and disinfected . 1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care: d. Reusable items are cleaned and disinfected or sterilized between residents . Record review of facility in-service, Cleaning and Disinfecting Resident Care Items, dated 04/09/2025 revealed, Remember to clean and disinfect shared items before, in between, and after use to prevent the spread of infection . MA G was listed as in attendance on the signature list. Record review of facility in-service, Handwashing and Hand Sanitizing, dated 04/25/2025 revealed Handwashing is the first line of defense to control the spread of infection . Hand sanitizing should be performed between each patient contact . MA G was listed as in attendance on the signature list.