STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675764	A. Building B. Wing	07/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Branch Transitional Care Center	1615 Hillendahl Rd Houston, TX 77055

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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review the facility failed to ensure each resident had the right to be free from involuntary seclusion for 2 of 7 residents (CR #1 and Resident #1) reviewed for involuntary seclusion in that: -CR #1 and Resident #1 were placed in the secured unit without documentation of the clinical criteria for placement in the secured unit by the resident's Physician, along with information provided by members of the interdisciplinary team. - CR#1 was scared and terrified by being placed in the secure unit. -Resident #1 felt scared placed in the secure unit. -The facility was using the secure unit for newly admitted resident's who did not qualify to be on the secure unit. CR#1 and Resident #1were kept on the secure unit until a bed was available in the non-secure unit. -The facility failed to demonstrate they had an understanding of being unable to unlawfully restrict a resident to a secure unit against their will. -The facility failed to train staff and put procedures into place that ensured that residents were not placed on secured unit unless behaviors warrant or physician orders. An Immediate Jeopardy (IJ) was identified on [DATE] at 4:44p.m.,while the IJ was removed on [DATE] , the facility remained out of compliance at a severity level of actual harm that is not Immediate Jeopardy and a scope of isolated as the facility continued to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at risk of unnecessary isolation, leading to a decreased quality of life, low self-esteem, and distrust of staff. Findings include: CR #1 (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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the admission sheet for CR # 1 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included acute respiratory disease, unspecified mood affective disorder and nutritional deficiency. CR#1 was discharged on [DATE]. CR#1 was listed as his own RP. Record review of CR #1's admission doctor's orders dated [DATE] revealed no orders to place the resident on the secured unit. Record review of Social Worker notes dated [DATE] read in part: .CR#1 stated that he is ready to go home and he didn't know why he was still in the hospital. SW informed the resident that he is in a nursing home. The resident stated that he did not understand why he was in a nursing home . Record review of CR#1's room change notification dated [DATE] read in part: .Resident completed 14 day mandatory quarantine for covid precaution. Comments- aware of room transfer-very alert and agreeable to change at this time good I was wondering when I can get out of here . The form was not signed by the Resident or the RP. The form did not indicate that 3rd floor was a secure unit. Record review of CR#1's room change notification dated [DATE] read in part: .from room [ROOM NUMBER]B to room [ROOM NUMBER]B . The form was not signed by the Resident/RP or staff representative. The form did not indicate that 3rd floor was a secure unit. Record review of CR #1's admission agreement revealed it was signed and dated [DATE] by CR #1. Record review of CR #1's Quarterly MDS dated [DATE] revealed his BIMS was 13 out of 15 indicating intact cognitively. He required supervision for dressing, toilet use, and personal hygiene. Further review of the MDS Section E0200. Behavior symptom-Presence & Frequency was coded as behavior not exhibited. (physical, verbal, other behavioral symptoms not directed toward others). E0900. Wandering-Presence & Frequency was coded as behavior not exhibited. Record review of the CR #1's care plan dated [DATE] and revised on [DATE] revealed no documentation about being placed on the secured unit, exit seeking, eloping or behaviors. Record review of CR#1's room change notification dated [DATE] read in part: .Resident complain about room and wanted to change room. From room [ROOM NUMBER]A to room [ROOM NUMBER]B . The form was not signed by the Resident or the RP. Record review of the nurse's notes for CR #1 dated [DATE] read in part: .Resident complained that he was uncomfortable with is roommate. He stated that his roommate made threat against him. I informed him that I can move him to another room being that he stated he did not want to go into the room again. The roommate denied saying anything to CR#1. CR#1 was offered a private room on 3 [NAME] where he would not have to worry about having a roommate. He stated that he will not move and that he needed a lawyer before he will move. The Social Worker came and spoke with him but he is refusing to move and stated that he will sleep on the floor . Record review of CR#1's nurse's note dated [DATE] read in part: .CR#1 was spotted hitting another resident on the arm because the follow resident was trying to take his items away in the dining area . (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's nurse's note dated [DATE] read in part: .0900, Resident is AAOX3. He is able to make decision for himself. He refused all morning medications. Nurse attempted x 4 and he got really agitated and aggressive . Record review of psychiatric evaluation for CR#1 dated [DATE] read in part: .Pt is seen in the hallway and he appears irritable and he reports that one of other staff did not take him out for fresh air and states that the staff always has something against him . Record review of Social Worker notes for CR#1 dated [DATE] read in part: .APS worker stated the resident did say that he is being held against his will at (facility's name). APS worker stated the resident appears to be in his right mind and he is capable of making his own decision . Record review of CR#1's nurse's note dated [DATE] read in part: .care plan meeting held today regarding resident requesting to go home. All concerns were addressed with DON, Administrator, myself, Social Worker, CR#1, Ombudsman and CR#1's friend over the telephone. Resident insisted that he was going to be going home. Even when it was explained to him that it would not be a safe discharge being that he was going to a hotel and leaving AMA. Resident decided to leave anyway . In a telephone interview on [DATE] at 2:14p.m., with the Ombudsman, he said he had concerns about the facility. He said he had spoken to the Administrator concerning residents being on the secured unit due to lack of availability of beds on other units. They were moving newly admitted residents to the secure unit after they were done with 10 days quarantine because facility did not have beds available on the 2nd floor. He said CR#1 was held in the facility in the secure unit against his will. He said they had a meeting on [DATE] in which he told the facility that CR#1 was his own RP and they could not keep him against his will. Facility refused to discharge him to a hotel, so CR#1 signed AMA paperwork and left the same day. In a telephone interview on [DATE] at 4:09p.m., with CR#1's friend, she said CR #1 was scared on the locked unit and did not want to be on the secured unit. The facility refused to discharge CR #1 back to the hotel where he had lived previously so he signed himself out of the facility. CR #1's friend said he is safe now. He was scared to death. They had him locked up in the secure unit. Therefore, she involved the Ombudsman and finally they had a care plan meeting on [DATE] where CR#1 had no choice but to sign AMA paperwork so he could be out of the secure unit. She said they took his cell phone away and she would have to talk to him at the nurse's station where the nurses could hear their conversation. She said she had brought it up to Unit Manager B and she told her, do not worry nobody was listening to you. She said they violated his rights in so many ways. She said, magically his cell phone was brought by the Social Worker in the care plan meeting. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 4:49p.m., with CR#1 he said he was scared and terrified by this experience. He said he was discharged from the hospital to this facility to be treated for chest pain. He said he was on the 2nd floor and then moved to a locked unit. He said he was not told before the room change that he would be locked up. He said he spoke numerous times to the Social worker I wanted out. The Social Worker would always say I will look into it. He said he would continuously ask staff to take him out to go and get fresh air. He said they would take him out with the smokers for about 5 minutes per day. He said, I have heart problems I don't need to be inhaling all that secondhand smoke. He said, that was their way of punishment for getting only 5 minutes of fresh air. He said they took his cell phone away so he could not communicate with anybody outside in private. He said it was horrible, he could not take it. He said he had to fight to be released from there. He said he never wanted to go back to the facility. He said they violated his right. In an interview on [DATE] at 9:07a.m., with the Administrator, he said CR#1 was a COVID patient admitted on their warm unit and later transferred to 3rd floor secure unit because of no male bed availability. He said they were working on safe discharge for him to move to a care home because CR#1 wanted to go and live in a hotel. He said the Social Worker was working on his transfer. They got APS involved because they did not know where CR#1 checks were going. He said CR#1 was resistant, he did not want to go to personal care home. He said they were working on dementia diagnosis. The staff would explain him, he would acknowledge and after 1 or 2 minutes later he would not recall anything. In an interview on [DATE] at 9:20a.m., with the DON, she said CR#1 was admitted on their warm unit to do regular quarantine. When it was time for him to move out of the warm unit, he was moved on the 3rd floor because they had open beds on the secure unit. She said due to COVID everything was disorganized they were moving residents based on availability She said 3rd floor was a secure unit. The DON said the criteria for a resident to be in secure unit was risk for elopement, exit seeking, wandering or behaviors. She said CR#1 did not have good communication skills and had outburst. She said in his mind he thought he was not treated well. He always had conflicts with his roommates on the secure unit. He was not an elopement risk. She said they offered him a private room in the secure unit. But CR#1 said he should not be the one to move. Someone else should move. Surveyor reviewed nurse's notes with the DON where CR#1 was offered to move from 3 east to 3 [NAME] when he had conflict with his roommate. But the room change was offered on the secure unit and not the 2nd floor non-secure unit. The DON did not answer. The DON said CR#1 was allowed to go to the smoking area. She said due to COVID only 2 residents per 1 staff were allowed to go out at the same time. She said he wanted to stay longer to get fresh air for 15 to 30 minutes sometime even longer. She said they could not do that because there were other smokers that staff needed to bring down. She said he wanted to go AMA and that his friend set up transportation for him. In an interview on [DATE] at 9:48a.m., with the Social worker, he said CR#1 did not need to be on a secure unit. CR#1 had mentioned to him that he wanted to leave the facility but, he did not mention to him anything about him being on the secure unit. He said CR#1 wanted to live in a hotel but that would be an unsafe discharge, because he required 24 hours nursing care due to his chest pains. So, he found a personal health care home instead of another nursing home. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:39a.m., with LVN A, she said CR#1 was alert and oriented x3. She said he was the only resident on the secure unit that could hold a conversation. She said he would continuously ask to go out to get some fresh air. She said CR#1 did not smoke. She said due to COVID only 2 residents could go out at a time with staff. She said there were many smokers in the secure unit. Therefore, residents would stay out for a limited time for about 5 to 10 minutes. She said CR#1 would get upset at that and had outburst. In a telephone interview on [DATE] at 12:06p.m., with the Emergency Responsible party, she said she was not aware he was on the secure unit. She said CR#1 told her he did not wanted to stay at that facility. She said she spoke to the Social Worker about CR#1 wanting to be discharged . She said social worker told her that they were unable to discharge CR#1 to the hotel because it would be an unsafe discharge. She said she told Social Worker that CR#1 was his own RP therefore hecould go wherever he wanted to go and live. She said that CR#1 was living in the hotel before. She said SW kept telling her that it was an unsafe discharge. In a record review and interview on [DATE] at 12:16p.m., with the DON, Surveyor reviewed CR#1's room notifications forms with the DON. The DON said CR#1 was initially admitted on [DATE] and was placed on 10 days quarantine then transferred to 3rd floor secure unit on [DATE]. CR #1 went to the hospital for chest pains and returned on [DATE] to the secure unit. CR #1 discharged to the hospital again and readmitted on [DATE] and was on quarantine for 10 days then was sent again to the secure unit on [DATE]. DON said he was sent three different times to the secure unit because they had no male bed available and he was already established on the secure unit. In an interview on [DATE] at 12:42p.m., with the DON andUnit Manger A, the DON said the criteria for a resident to be in secure unit was risk for elopement, exit seeking, wandering and behaviors. She said all newly admitted residents were admitted to their warm unit (2 west) for 10 days to be quarantined and then moved out based on availability of the bed. She said they only had beds available in the secure unit (3rd and 4th floor). She said facility could not let resident stay more than 10 days in the warm unit because it was at risk for them catching something and getting sick. She said CR#1 was his own RP. In an interview on [DATE] at 1:12p.m., with DON, Unit Manger A, Unit Manger B and CR#1's Emergency Responsible party (on phone). Emergency Responsible party said nobody contacted her from the facility till late January. Unit Manger B said she remembered talking to Emergency Responsible party and letting her know CR#1 was moved to 3rd floor secure unit. Unit Manager B said she notified emergency responsible party because she was listed on CR#1's face sheet. The DON explained CR#1 was his own responsible party. In an interview on [DATE] at 1:38p.m., with the MDS Nurse, she said CR#1 was not care planned about being placed on the secured unit, exit seeking, eloping or behaviors because he was not supposed to be in the secure unit. He ended up on the secure unit because there was no bed available on the non-secure unit. Resident #1 Record review of the admission sheet for Resident # 1 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hyperlipidemia, anxiety disorder, dysarthria following cerebral infarction. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Resident #1's baseline care plan, dated [DATE] revealed no documentation about being placed on the secured unit, exit seeking or eloping. Resident was bedbound. Record review of the Resident #1's Comprehensive Plan of Care dated [DATE] revealed no documentation about being placed on the secured unit, exit seeking or eloping. Record review of Resident #1's admission doctor's orders dated [DATE] revealed no orders to place the resident on the secured unit. Record review of Resident #1's admission MDS, dated [DATE] revealed her staff assessment for mental status was conducted due to the resident was unable to complete the brief interview for mental status questions. She was assessed as having short term memory problems, long term memory problems, and cognitive skills for daily decision making was severely impaired never/rarely made decision. She was totally dependent on one person physical assist for dressing, toilet use, and personal hygiene. She was always incontinent of bowel and bladder. Further MDS revealed Section E0200. Behavior symptom-Presence & Frequency was coded as behavior not exhibited. (physical, verbal, other behavioral symptoms not directed toward others). E0900. Wandering-Presence & Frequency was coded as behavior not exhibited. Record review of the Resident #1's Acute care plan dated [DATE] read in part: .Problem-Temporary room change. Short term goal-Resident will be moved to floor or choice/appropriate as soon as room is available. Will continue to provide high quality care while on 3rd floor. Approach/interventions- Will room resident off the 3rd floor and move back to another unit on 2nd floor when possible . Record Review of Resident #'s 1 room change notification dated [DATE], not signed by Resident or RP, read in part: .Resident and RP aware of room change. [Marketer A] in admission spoke with them because of limited English-both are ok with change until room is available on 2nd floor . The form did not indicate that the room was on the secure locked unit. In an interview on [DATE] at 10:59a.m., with Unit Manager A, she said she was in charge of the Warm unit. She said once the residents completed their 10 day of quarantine, they would be moved out of the warm unit depending on their level of needs. She said residents with risk of elopement/wanders and behaviors would be moved to 3rd/4th secure unit. She said Resident #1 did not have any behaviors. Resident #1 was moved to secure unit because they needed a bed in the warm unit for the new admission. In an interview on [DATE] at 2:10p.m., with the DON and Unit Manager A, the DON said Resident #1 was a new admit and she did not exhibit any psych behaviors. The DON said Resident #1 did not met the criteria for the secured unit. The DON said Resident #1 was sent to secure unit because they did not have a female bed available on the 2nd floor. She said they all reviewed room roster together and they only had 2 male beds available on the 2nd floor at that time. The DON said they could not keep residents pass 10 days in the warm unit as it was risk for them catching infections. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on ,d+[DATE] at 2:27p.m., with Resident #1, her RP and Physical Therapist A. Resident #1 said Manager A told them that she would be on 3rd floor for 2 to 3 days only. She said today was day 5. She said she had a stroke and was unable to mover her right side of the body. She said she wanted to go back to 2nd floor. She said 2 to 3 people came in her room and tried to take her purse away. She was grabbing on to her purse with her left hand. She said she was scared. They would take her purse. She pointed to her head and said they are crazy people. RP said they were told only 2 to 3 days they would have to be on 3rd floor. He said they wanted to go to 2nd floor again. Physical Therapist A said he had been working with Resident #1 for the past 2 weeks. He said Resident#1 had been on 3rd floor for couple of days. In an interview on [DATE] at 2:29p.m., with CNA A and CNA B, CNA A said Resident #1 required total care. She said Resident was bedbound. CNA B said Resident #1 had been on 3rd floor for couple of days. CNA A said Resident #1 did not have any behaviors. In an interview on [DATE] at 2:38p.m., with the DON, Surveyor shared her interview from Resident #1 that the resident was scared to be in the secure unit. DON said there was no female bed available. She said 2nd floor had large Korean population that has been there for years and would not like the move. Therefore, they could not move residents around on 2nd floor. She said once a bed became available, they would move Resident #1 from the secure unit. The DON said the criteria for a resident to be in secure unit was risk for elopement, exit seeking, wandering or behaviors. In an interview on [DATE] at 3:01p.m., with the Administrator and the DON, when asked if they were aware that it would be considered involuntary seclusion by moving residents to secure unit that did not meet the criteria. The Administrator said they had no choice. The Administrator said they had no beds available on the 2nd floor (2 east) so they had to move residents to the secure unit (3rd and 4th) until bed became available on the 2nd floor (2 East). In an interview on [DATE] at 3:02p.m., with the Business Coordinator, she said she was responsible for initial admissions, get clinical reviewed and arrange the admission for the resident in the facility. She said fully vaccinated would be admitted with general population. Partial or non-vaccinated would be placed in the warm unit before they were placed in their permanent room. She said for any new admission she would look to see if they had space for them. She said non vaccinated would go in their warm unit and fully vaccinated would be placed in the non-secure unit. She said if there was no bed available, she would ask the hospital to hold the patient and if they could not hold, they facility could not admit that patient. She said she was not aware that the facility was moving residents to a secure unit due to no bed availability on the non-secure unit. She said she admitted CR#1 to the warm unit and was not aware he was later moved to a secure unit. She said they should not be doing that if they did not belong in the secure unit. She said nursing was responsible for in house transfer. She said Marketer A admitted Resident #1 to the facility. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:18p.m., with Unit Manager A, she said she miscalculated the days. She said Resident #1 was admitted on [DATE] her 10 days would have ended on Saturday [DATE]. She said Resident #1 would have to stay in the warm unit till Monday because managers did not work on the weekends and she did not want Resident #1 to get exposed with new people coming in. She said they needed a bed for new admission so she transferred Resident #1 to 3rd floor. She said she knew Resident #1 did not meet the criteria to be in the secure unit but there was no female bed available on the 2nd floor. She said mangers were transferring resident in house but DON and the Administrator were aware of those changes. In an interview on [DATE] at 4:27p.m., with HHSC Telephonic Interpreter, Resident#1, Resident #1's RP and Unit Manager C, the interpreter said Resident #1 told her that she was just moved to 2nd floor on ([DATE]). Resident #1 said she used to be on the 2nd floor but on the other side. Resident #1said she felt safe now and that she was scared on the 3rd floor. Resident #1 said she was paralyzed and could not move her right side of the body. Resident #1 said 2 to 3 people came to her room at different times of the day and would try to take her purse. She said one day while her family member was coming to visit her, he caught one of the female resident's taking her purse and he grabbed it from the other resident's hand. Resident #1 said she could not move and defend herself. Resident #1 said she was scared on that floor. She said she was told she would only be there for 2 to 3 days, but they moved her today. Record review of facility's Policy and Procedures on Secure Units (not dated) read in part: .Policy-To provide a safe environment for all residents living on the secure care unit. To prevent accidents related to wandering and elopement. Procedures-1. All residents with potential for admission to the secure unit will have an elopement assessment prior to admission as well as a consent signed by the resident representative and a doctors order for admission to the secure unit. 2. A care plan with interventions to maintain a resident safety based on their elopement risk will be completed. 3. All exit doors are alarmed and code locked and remain on 24 hours per day. 4. Door codes will be changed as needed. Staff and visitors are instructed to ensure the door is closed tightly after entering or exiting the secured area. 5. In the event that a resident exits the building or cannot be readily located the policy and procedure for missing resident will be followed. 6. All staff are trained to respond to the alarms in orientation. Maintenance staff check all secure unit doors daily. Definition: Elopement-exiting the facility unsupervised. Involuntary seclusion- separation of a resident from others or confinement to their room against the resident's will or the will of the residents representative. Secure unit- part of a building that's access in through a coded door . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675764	A. Building B. Wing	07/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Branch Transitional Care Center	1615 Hillendahl Rd Houston, TX 77055

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's Resident Rights policy (revision: ,d+[DATE]) read in part: .policy: to assure that the patient's/resident's personal dignity, well being, and self determination is maintained and to educate patients/residents with respect to their rights and responsibilities in accordance with state and federal regulations. The [NAME] of Rights and Responsibilities of the patients/residents will be communicated to the patients/residents in a language and/or by means of communication that ensures that the patient/resident understands these rights and will be recognized and supported by all Facility staff members at all times. Staff will document that the information was provided to the patient/resident/legal representative. The facility must promote the rights of each patient admitted to provide for a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. All residents have the same rights and freedom as any other citizen of the United States with fear of discrimination. Abuse/Neglect: Types of Abuse-Mental Abuse (to cause mental anguish to another with intent to harm such as humiliation, harassment, threats of punishment or deprivation). 20. Discharge yourself from the facility unless you have been adjudicated mentally incompetent . Record review of facility's Reporting Abuse to Facility Management (not dated) read in part: .Policy Interpretation and Implementation: 1. Our facility does not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. d. Involuntary seclusion is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommate) against the resident's will, or the will of the resident's legal representative (sponsor). Emotional or Psychological Abuse- Emotional or psychological abuse is defined ass the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse include but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment. In addition, isolating an elderly person from his/her family, friends, or regular activities; giving an older person the silent treatment, and enforced social isolation are examples of emotional/psychological abuse. Signs and symptoms of emotional/psychological abuse include but are not limited to: being emotionally upset or agitated; being extremely withdrawn and non communicative or non responsive; unusual behavior usually attributed to dementia . On [DATE] at 4:44pm the Administrator was notified of the IJ. The IJ template was left with the Administrator and a plan of removal (POR) was requested at that time. After several revisions, the POR was accepted on [DATE] at 10:55am. The POR revealed: [facility name] Plan of Removal [DATE] v2, [DATE] v3 4:58 1) The admission policy has been reviewed and revised to address bed availability after quarantine status as of [DATE]. Admission staff has been inserviced on the new process as of [DATE]. 2) All residents on the secured units are being re-assessed to determine if they are an elopement risk using appropriate elopement risk assessment form. This task is being completed by Nurse Unit Managers and Social Workers on [DATE]. Residents that are inappropriately placed will be moved to the appropriate level. Accommodations will be made based on their personal choices such as giving them the code to the door, taking them off the unit frequently, or referring to a sister facility. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) Admission policies have been revised with regards to admissions onto the quarantine unit and where they move to upon meeting their time. Residents will only be admitted for short stays if there is not an appropriate place for them t [TRUNCATED]

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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** 40249 Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections COVID-19 for 1 of 5 newly admitted Residents (Resident #1) reviewed for infection control monitoring: The facility did not implement a 10-day quarantine to monitor for COVID-19 for Resident #1 after she was admitted from the hospital. Resident #1 was moved out of the qurantine unit after day 9. This failure placed residents, staff and visitors at risk of transmission of communicable diseases and infections, including COVID-19. Finding included: Record review of the admission sheet for Resident # 1 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hyperlipidemia, anxiety disorder, dysarthria following cerebral infarction. Record review of Resident #1's admission MDS, dated [DATE] revealed her staff assessment for mental status was conducted due to the resident was unable to complete the brief interview for mental status questions. She was assessed as having short term memory problems, long term memory problems, and cognitive skills for daily decision making was severely impaired never/rarely made decision. She was totally dependent on one person physical assist for dressing, toilet use, and personal hygiene. She was always incontinent of bowel and bladder. Record review of Resident #1's physician orders dated 6/17/21 revealed there was no doctor's order for her to be in quarantine for 10 days. Record review of the Resident #1's Comprehensive Plan of Care dated 6/17/21 revealed no documentation about Resident #1 to be in quarantine for 10 days. In an interview on 6/30/21 at 10:59a.m., with Unit Manager A, she said she was in charge of the Warm unit. She said once the residents completed their 10 day of quarantine, they would be moved out of the warm unit depending on their level of needs. She said residents with risk of elopement/wanders and behaviors would be moved to 3rd/4th secure unit. She said Resident #1 did not have any behaviors. Resident #1 was moved to secure unit because they needed a bed in the warm unit for the new admission. She said she was aware Resident #1 did not complete her 10 days of quarantine. Observation and interview on 6/30/21 at 2:27p.m., with Resident #1, her RP and Physical Therapist A. Observation of Resident #1 revealed that she was out of the warm unit and in the secure unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 7/1/21 at 3:26p.m., with Marketer A, he said his responsibility was to admit Korean patients into the facility. He said he admitted Resident #1. He said Resident #1 was not vaccinated so he explained to her that she would have to go to their warm unit for 10 days quarantine. He said last week Unit Manager A from 2 [NAME] sent Resident #1 to 3rd floor secure unit. He said he was very upset because Resident #1 had not completed her 10 days. Resident #1 was moved on Friday instead of Monday. He said they had to follow rules and regulations for quarantining residents. He said Unit Manager A told him that they needed a bed for new admission therefore, she had to move Resident #1 to 3rd floor secure unit. He said he spoke to Resident#1's RP and explained that it was a temporary move. In an interview on 7/1/21 at 4:02p.m., with Unit Manager A, Unit Manger B and Unit Manger C, Unit Manager A said Resident #1 was moved from warm unit to secure unit on 6/25/21. Unit Manager B said Resident #1 came to her unit on Friday 6/25/21 because there was no female bed available on the 2nd floor. In an interview on 7/1/21 at 4:18p.m., with Unit Manager A, she said she miscalculated the days. She said Resident #1 was admitted on [DATE] her 10 days would have ended on Saturday 6/26/21. She said Resident #1 would have had to stay in the warm unit till Monday (6/28/21) because managers did not work on the weekends and she did not want Resident #1 to get exposed with new people coming in. She said they needed a bed for new admission so she transferred Resident #1 to 3rd floor. She said she knew Resident #1 did not meet the criteria to be in the secure unit but there was no female bed available on the 2nd floor. She said mangers were transferring resident in house but DON and the Administrator were aware of those changes. In an interview on 7/2/21 at 10:42a.m., with the DON, she said Resident#1 was transferred before ten days. She said Resident #1 was supposed to be completed with her ten days the next day (6/26/21). She had no symptoms. She said, We had some people coming in and needed the bed. She was a few hours away from completion of the ten days. Said the policy was 10 days of quarantine. In an interview on 07/03/21 at 9:51a.m., with the DON, she said that she checked for updates to the COVID-19 response plan at least every week. She said that the facility was using COVID-19 Response for NF Version 3.9, dated 04/06/21. Record review of HHS COVID-19 Response for Nursing Facilities dated 4/06/2021 read in part: All residents with unknown COVID-19 status must be quarantined per CDC guidance. [Residents who are fully vaccinated, asymptomatic and have not had prolonged close exposure to someone with COVID-19, do not have to quarantine]. The CDC continues to endorse quarantine for up to 14 days. However, new CDC guidance offers two additional options for people without symptoms to be able to shorten their quarantine. New admissions, readmissions, and residents who have spent one or more nights away from the facility are all considered residents with unknown COVID-19 status. All residents with unknown COVID-19 status must be quarantined per the CDC guidance .