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	03/27/2023

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interviews and record review the facility failed to ensure 1 of 14 residents reviewed for abuse and neglect (CR #181) were free from abuse, in that: - HA C admitted to snatching CR #181's call light from his pillowcase and placing it out of reach from the resident after the resident pressed it multiple times. - CR #181 was noted to be wheelchair bound and in need of assistance. - CR #181's hospital record documented resident refused to return to the facility because he believed he was abused by staff. This failure caused one resident to experience feelings of fear from abuse and placed all residents who needed assistance and were wheelchair bound at risk of being abused, not having their needs met in a timely manner and experiencing a decrease in quality of care and life. Findings included: Record review of CR #181's face sheet revealed a [AGE] year-old male resident who admitted from a hospital. No diagnoses were listed. Record review of CR #181's nurses notes, dated 01/19/2023 at 3PM, revealed the resident, . admitted to the facility from [Hospital] at 1:30PM via stretcher . Record review of CR #181's nurses notes, dated 01/19/2023 at 11:15PM, LVN J wrote Resident [complaint of] left shoulder pain p being assaulted by staff that snatched call light away from him fracturing his arm or shoulder causing mark on his left arm. Resident refused nurse to complete skin assessment. Nurse observed to BUE scabbed over areas. Resident requested to notify 911 as he wanted to speak [with] police to file assault charges [and] that he can not stay here again. Nurse asked to assess him [and] refused stating that he was not doing a dog [and] pony show for me [and] would not do anything for me. (continued on next page)

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
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #181's nurses notes, dated 01/19/2023 at 11:50PM, LVN J wrote, Resident observed [with] EMT performing ROM to BUE. No signs or symptoms noted of any pain, distress or discomfort during their assessment of the resident. EMT cleared resident in house stating they don't feel that he is needed to go to the ER. As vital signs were good [and] ROM performed effectively. Resident requested to go to hospital to be further evaluated stated chest pain. Resident was transported from facility to ER [with] no marks or bruising noted during EMT's assessment prior to transfer. RP [family member] notified of above. Record review of CR #181's skin assessment, dated 01/19/2023, noted old scab on left and right lower arms. Record review of CR #181 Hospital records, dated 01/20/2023, revealed the resident was a [AGE] year-old patient with, .history of coronary artery disease pacemaker, left hip and right knee replacement who is bedbound and does not ambulate and has been in multiple's SNF facility who had presented to the emergency room initially on 01/21/2022 with complaints of left shoulder pain after EMS had been called for patient to complain that he had been assaulted as she had nursing call bell wrapped around his left forearm and was subsequently pulled by the staff for which he suffered bruising and a tendon laceration. He has been evaluated in the emergency room and and have been subsequently discharged from the emergency room but patient refuses to leave the emergency department to go back to the nursing facility because believes he has been abused [sic] . The hospital record revealed the chief complaint at the ER was of, . Left shoulder pain after call light cord being ripped out from [under] him/ [patient] does report chest pain as well. Bruise and skin tear to [left] arm . CR #181's x-ray result findings revealed, .near complete loss of the subacromial space, consistent chronic rotator tear, similar prior exam [performed 01/21/2022]. Mild-to-moderate degenerative arthritic changes of the acromioclavicular . no acute fracture . In the Medical Screening Exam notes, it stated, . [AGE] year-old male . complaining of left shoulder pain after arguing with the nurse at a nursing facility when hurt his left shoulder and stated that he felt like it came out of joint and popped back in. Patient characterizes pain at an 8 out of 10 with a throbbing sensation . Phone interview with CR #181 was attempted on 3/21/2023 at 10:30AM but surveyor was unsuccessful in reaching the resident. Record review of Corrective Active Form signed 01/19/2023, revealed HA C's discharge date was 01/19/2023 and stated, employee suspended, pending investigation of resident rights. In an interview with HA C on 03/21/2023 at 3:45PM, he stated his role as a hospitality aide was to monitor the residents, answer call lights and take them out for smoke breaks. He stated he went to answer CR #181's call light, after he had already pressed it seven times, and asked if he needed anything. He said CR #181 called him names, such as nig*** faggot and in response, he snatched CR #181's call light that was clipped to the resident's pillow and placed it out of reach on the table, to prevent the resident from pressing the call light again. HA C stated he did so because he felt insulted by what the resident said to him. He stated the call light was never attached to the resident's body and that he never touched CR #181 but the resident lied to LVN J and said I punched him and broke his arm. HA C stated LVN J made him write a report on the incident and he went home because his shift was over soon after the incident. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview with HA C on 03/22/2023 at 2:33PM, HA C said the Administrator told him to stay home the next day after the incident and he did not return until a total of 3 days later, which was the next time he was scheduled to work again. HA C said he took the call light from CR #181 and did not return it to him prior to leaving the room. HA C stated did not know that taking the call light was a human rights issue because the resident was being aggressive and continued to click the call light button. HA C said LVN J came into the room and asked if he took the call light away and he admitted he did and was told by LVN J that it was a form of abuse. HA C said he was trained on abuse during new hire orientation and when he returned to work, the Administrator, the ADON and the Human Resource staff pulled him aside one by one to tell him what he did was wrong. Record review of personnel records revealed HA C received training on abuse upon hire on 06/30/2022. No other records of abuse training after hire and after the incident on 01/19/2023 were provided prior to exit. In an interview with LVN J on 03/22/2023 at 12:20PM, LVN J said at the time of the incident, she was the night supervisor who was called forth by an unknown staff member to tend to CR #181. LVN J stated she kept the alleged perpetrator, HA C, out of the room while she attempted to assess the resident. LVN J stated CR #181 told her he did not want to be at the facility because it was not what he expected. She said the resident accused HA C for breaking his arm but refused LVN J's assessment further for range of motion and bruising and told her he was fine. She stated she called EMS due to resident's complaints of chest pain for EMT to assess him and no X-rays were done in the facility. She said CR #181 also wanted to call the police and press charges on HA C but the police never showed up during her shift. She stated she called and reported the incident to the Administrator who told her to send HA C home and that he would take care of the incident. She said a call light in-service was done. She said the Administrator told her to tell HA C not to come back in. She said she considered the incident as abuse which is why she notified the abuse coordinator. In a follow up interview with LVN J on 03/25/2023 at 8:50AM, she stated she did not witness the incident but was called down to see what CR #181's allegations were. LVN J stated when she came to CR #181's room, HA C was not present in the room, the call light was out of reach hung up on the wall and CR #181 kept saying that HA C broke his arm by pulling the call light from him. LVN J stated HA C told her that he did not touch CR #181 but he did take the call light because CR #181 kept pressing it although he did not want anything. LVN J said she then told HA C to step out and afterwards she attempted to do an assessment which the resident refused. She said the amount of time CR #181 was without his call light was unknown. LVN J stated she considered what HA C did with the call light maybe abuse, but more so neglect because the call light is his lifeline and he needs it for communication. She stated she reported to the Administrator over the phone that CR #181 was accusing HA C of breaking his arm but could not remember if the call light was mentioned in the conversation at that time. She stated before this incident happened, she was unsure whether she was taught what taking a call light from a resident was deemed as. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 03/23/2023 at 3:09PM, the Administrator stated he is the abuse coordinator. He stated on the night of 01/19/2023, LVN J called him and informed him of the incident: that CR #181 was a new admission who was being out of control, who wanted to leave the facility and made accusations against HA C for breaking his arm. He said LVN J told him CR #181 did not allow her to assess him for bruising, but from what she could see, she did not see any obvious bruising. The Administrator stated he never heard about the call light being taken away until surveyors started questioning him about it today. The Administrator said he was not sure if taking the call light was a resident rights issue or abuse issue because he would need to ask HA C what he did and why he did it, but he and LVN J both did not believe HA C would hurt the resident. In an interview with 3/22/2023 at 3:53PM, the Administrator stated he could not find any written statements from staff related to that incident and he could not find any in-service trainings related to abuse that was given to HA C. Record review of forms titled, [Facility Name] with no dates, revealed 22 staff members were asked to document the 7 types of abuse, including involuntary seclusion, who to contact if abuse is witnessed or alleged, and if they knew what happened to CR #181. Of the 22 staff members, HA C was not included. Record review of the facility's policy on Abuse Prohibition Standards of Practice, dated 11/1/2016, stated, . Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property. The following standards of practice will be operationalized in order that residents will not be subject to abuse by anyone, including, but not limited to, facility staff .

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interviews and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse and neglect and to investigate any allegations for 1 of 14 residents reviewed for abuse and neglect (CR #181), in that: - HA C admitted to taking wheelchair bound resident's, CR #181, call light from his pillowcase and placing it out of reach after the resident pressed it multiple times. - CR #181's hospital record documented resident refused to return to the facility because he believed he was abused by staff. - The Administrator failed to in-service HA C on abuse and neglect prior to returning to work. This failure caused one resident to experience feelings of fear from abuse and placed all residents who needed assistance and were wheelchair bound at risk of being abused, not having their needs met in a timely manner and experiencing a decrease in quality of care and life. Findings included: Record review of CR #181's face sheet revealed a [AGE] year-old male resident who admitted from a hospital. No diagnoses were listed. Record review of CR #181's nurses notes, dated 01/19/2023 at 3PM, revealed the resident, . admitted to the facility from [Hospital] at 1:30PM via stretcher . Record review of CR #181's nurses notes, dated 01/19/2023 at 11:15PM, LVN J wrote Resident [complaint of] left shoulder pain p being assaulted by staff that snatched call light away from him fracturing his arm or shoulder causing mark on his left arm. Resident refused nurse to complete skin assessment. Nurse observed to BUE scabbed over areas. Resident requested to notify 911 as he wanted to speak [with] police to file assault charges [and] that he can not stay here again. Nurse asked to assess him [and] refused stating that he was not doing a dog [and] pony show for me [and] would not do anything for me. Record review of CR #181's nurses notes, dated 01/19/2023 at 11:50PM, LVN J wrote, Resident observed [with] EMT performing ROM to BUE. No signs or symptoms noted of any pain, distress or discomfort during their assessment of the resident. EMT cleared resident in house stating they don't feel that he is needed to go to the ER. As vital signs were good [and] ROM performed effectively. Resident requested to go to hospital to be further evaluated stated chest pain. Resident was transported from facility to ER [with] no marks or bruising noted during EMT's assessment prior to transfer. RP [family member] notified of above. Record review of CR #181's skin assessment, dated 01/19/2023, noted old scab on left and right lower arms. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #181 Hospital records, dated 01/20/2023, revealed the resident was a [AGE] year-old patient with, .history of coronary artery disease pacemaker, left hip and right knee replacement who is bedbound and does not ambulate and has been in multiple's SNF facility who had presented to the emergency room initially on 01/21/2022 with complaints of left shoulder pain after EMS had been called for patient to complain that he had been assaulted as she had nursing call bell wrapped around his left forearm and was subsequently pulled by the staff for which he suffered bruising and a tendon laceration. He has been evaluated in the emergency room and and have been subsequently discharged from the emergency room but patient refuses to leave the emergency department to go back to the nursing facility because believes he has been abused [sic] . The hospital record revealed the chief complaint at the ER was of, . Left shoulder pain after call light cord being ripped out from [under] him/ [patient] does report chest pain as well. Bruise and skin tear to [left] arm . CR #181's x-ray result findings revealed, .near complete loss of the subacromial space, consistent chronic rotator tear, similar prior exam [performed 01/21/2022]. Mild-to-moderate degenerative arthritic changes of the acromioclavicular . no acute fracture . In the Medical Screening Exam notes, it stated, . [AGE] year-old male . complaining of left shoulder pain after arguing with the nurse at a nursing facility when hurt his left shoulder and stated that he felt like it came out of joint and popped back in. Patient characterizes pain at an 8 out of 10 with a throbbing sensation . Phone interview with CR #181 was attempted on 3/21/2023 at 10:30AM but surveyor was unsuccessful in reaching the resident. Record review of Corrective Active Form signed 01/19/2023, revealed HA C's discharge date was 01/19/2023 and stated, employee suspended, pending investigation of resident rights. The form was signed by the Administrator and Human Resource Staff. In an interview with HA C on 03/21/2023 at 3:45PM, he stated his role as a hospitality aide was to monitor the residents, answer call lights and take them out for smoke breaks. He stated he went to answer CR #181's call light, after he had already pressed it seven times, and asked if he needed anything. He said CR #181 called him names, such as nig*** faggot and in response, he snatched CR #181's call light that was clipped to the resident's pillow and placed it out of reach on the table, to prevent the resident from pressing the call light again. HA C stated he did so because he felt insulted by what the resident said to him. He stated the call light was never attached to the resident's body and that he never touched CR #181 but the resident lied to LVN J and said I punched him and broke his arm. HA C stated LVN J made him write a report on the incident and he went home because his shift was over soon after the incident. HA C stated he was not suspended as a result of the incident. In a follow up interview with HA C on 03/22/2023 at 2:33PM, HA C said the Administrator told him to stay home the next day after the incident and he did not return until a total of 3 days later, which was the next time he was scheduled to work again. He stated he was never given the Corrective Active Form, dated 01/19/2023, and he did not know it existed. dated HA C said he took the call light from CR #181 and did not return it to him prior to leaving the room. HA C stated did not know that taking the call light was a human rights issue because the resident was being aggressive and continued to click the call light button. HA C said LVN J came into the room and asked if he took the call light away and he admitted he did and was told by LVN J that it was a form of abuse. HA C said he was trained on abuse during new hire orientation and when he returned to work, the Administrator, the ADON and the Human Resource staff pulled him aside one by one to tell him what he did was wrong. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of personnel records revealed HA C received training on abuse upon hire on 06/30/2022. After request for training documents were made on 03/22/2023 at 2:00PM, no other records of abuse training for HA C after the incident on 01/19/2023 were provided prior to exit. In an interview with LVN J on 03/22/2023 at 12:20PM, LVN J said at the time of the incident, she was the night supervisor who was called forth by an unknown staff member to tend to CR #181. LVN J stated she kept the alleged perpetrator, HA C, out of the room while she attempted to assess the resident. LVN J stated CR #181 told her he did not want to be at the facility because it was not what he expected. She said the resident accused HA C for breaking his arm but refused LVN J's assessment further for range of motion and bruising and told her he was fine. She stated she called EMS due to resident's complaints of chest pain for EMT to assess him and no X-rays were done in the facility. She said CR #181 also wanted to call the police and press charges on HA C but the police never showed up during her shift. She stated she called and reported the incident to the Administrator who told her to send HA C home and that he would take care of the incident. She said a call light in-service was done. LVN J said the Administrator told her to tell HA C not to come back in. She said she considered the incident as abuse which is why she notified the abuse coordinator. In a follow up interview with LVN J on 03/25/2023 at 8:50AM, she stated she did not witness the incident but was called down to see what CR #181's allegations were. LVN J stated when she came to CR #181's room, HA C was not present in the room, the call light was out of reach hung up on the wall and CR #181 kept saying that HA C broke his arm by pulling the call light from him. LVN J stated HA C told her that he did not touch CR #181 but he did take the call light because CR #181 kept pressing it although he did not want anything. LVN J said she then told HA C to step out and afterwards she attempted to do an assessment which the resident refused. She said the amount of time CR #181 was without his call light was unknown. LVN J stated she considered what HA C did with the call light maybe abuse, but more so neglect because the call light is his lifeline and he needs it for communication. She stated she reported to the Administrator over the phone that CR #181 was accusing HA C of breaking his arm but could not remember if the call light was mentioned in the conversation at that time. She stated before this incident happened, she was unsure whether she was taught what taking a call light from a resident was deemed as. In an interview with the Administrator on 03/23/2023 at 3:09PM, the Administrator stated he is the abuse coordinator. He stated on the night of 01/19/2023, LVN J called him and informed him of the incident: that CR #181 was a new admission who was being out of control, who wanted to leave the facility and made accusations against HA C for breaking his arm. He said LVN J told him CR #181 did not allow her to assess him for bruising, but from what she could see, she did not see any obvious bruising. The Administrator stated during his investigation he only talked to HA C and LVN J, and he was not sure if there were documented trainings or inservices as a result of the incident. He stated he thought the investigation was very cut and dry with the main allegation being his arm was broken. He stated he reviewed the hospital records and looked at the x-ray results for CR #181's arm which revealed there was no broken arm. The Administrator stated he never heard about the call light being taken away until surveyors started questioning about it today. He said he was not sure if taking the call light was a resident rights issue or abuse issue because he would need to ask HA C what he did and why he did it, but he and LVN J both did not believe HA C would hurt the resident. In an interview with 3/22/2023 at 3:53PM, the administrator stated he could not find any written statements from staff related to that incident and he could not find any inservice trainings related to abuse that was given HA C. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview with the Administrator on 03/23/2023 at 2:00PM, the Administrator stated he, himself, was responsible for conducting the investigation on the allegations made by CR #181 and the purpose of investigations were to find the most probable cause of the issue or to rule out mistreatment. The Administrator explained he had phone call conversations with LVN J and HA C the night of the incident, the following morning, he sent out the Facility Marketer to obtain CR #81's records indicating him arm was not broken, and hospital staff interviews, in which the case manager reported the hospital staff were very familiar with CR #181, who had a pattern of behaviors and making false accusations to leave facilities. He stated from that information, he assumed CR #181 knew what to say to get out of facility right away. He stated during investigations, he did not get statements from the staff that worked at the time of the incident or those involved, but he instead gathered a random sample of staff from all departments, asking if they knew what happened to CR #181. He stated the ADON and he both did most of the inservices together and would usually have staff sign the inservice document. He stated if the alleged perpetrator returned to work, it is because they had been deemed to be safe enough to return, or else, they are terminated or suspended for however long until they were deemed safe, and the alleged perpetrator would have a documented one-on-one inservice with them as well. He stated he deemed HA C safe enough to work because the x-rays showed CR#181 did not acquire a broken arm as he alleged and because HA C stated he never touched the resident. He also said he did not give an inservice on abuse to HA C or to any nursing staff since the incident occurred, outside of the assessment forms, titled |[Facility Name], that was passed out to a random sample of staff. He stated when it came to the necessity of giving inservices he thought of it in terms of the case being solved, so he did not make it a big deal to sit down with HA C and give him an in-service because to him, the allegation was unfounded. The Administrator said at the time, he thought he did a thorough investigation on the CR #181's allegations with focus on the broken arm. He stated he did not know exactly what the abuse policy stated about investigations and today was his first time he read through the investigation instructions listed in the facility policy on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. He stated after reading through the policy, that he did not follow it while investigating this incident. Record review of forms titled, [Facility Name], revealed 22 staff members were asked to document the seven types of abuse, including involuntary seclusion, who to contact if abuse is witnessed or alleged, and if they knew what happened to CR #181. Of the 22 staff members, HA C was not included. Record review of the facility's policy on Abuse Prohibition Standards of Practice, dated 11/1/2016, stated, . Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property. The following standards of practice will be operationalized in order that residents will not be subject to abuse by anyone, including, but not limited to, facility staff . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2021, stated, . 1. All investigations are thoroughly investigated. The administrator initiated investigations . 3. The administrator provide supporting documents and evident related to the alleged incident to the individual off the investigation . 7. The individual conducting the investigation as a minimum: a) reviews the documentation and evidence; b) reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; . d) interviews the person (s) reporting the incident; e) interviews any witness to the incident; f) interviews the resident (as medically appropriate) . h) interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . j) interviews other residents to whom the accused employee provides are or services; k) reviews all events leading up to the alleged incident; and l) documents the investigation completely and thoroughly . 8. d) witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement . The policy also stated corrective actions included, . If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated . 4) If the allegation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to her/her/their/ former position . Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation ofresident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. (continued on next page)

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	675764	A. Building B. Wing	03/27/2023

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. 5. Notices include, as appropriate: a. the resident's name; b. the resident's room number; c. the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); d. the date and time the alleged incident occurred; e. the name(s) of all persons involved in the alleged incident; and f. what immediate action was taken by the facility. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations. 2. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. 3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. a. Any evidence that may be needed for a criminal investigation is sealed, labeled and protected from tampering or destruction. 4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; 1. interviews the resident's roommate, family members, and visitors; J. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and 1. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: a. Each interview is conducted separately and in a private location. b. The purpose and confidentiality of the interview is explained thoroughly to each person involved in the interview process. c. Should a person disclose information that may be self-incriminating, that individual is informed of his/ her rights to terminate the interview until such time as his/her rights are protected (e.g., representation by legal counsel). d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement . The QAPI Team, led by the Administrator, will meet weekly for 3 weeks to discuss coordination of completion of all education, assessments, and interventions are utilized and completed to ensure that appropriate investigation and response to resident allegations and/or incidents requiring investigation are complete per above. The Medical Director was notified of Immediate Jeopardy called on facility on 03/24/2023 and will be part of the QAPI meeting 03/24/2023.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interview and record review the facility failed to have evidence that all alleged violations of abuse, neglect, or mistreatment were thoroughly investigated for 1 of 14 residents reviewed for abuse and neglect (CR #181), in that: - HA C admitted to taking wheelchair bound resident's, CR #181, call light from his pillowcase and placing it out of reach after the resident pressed it multiple times. - CR #181's hospital record documented resident refused to return to the facility because he believed he was abused by staff. - The Administrator failed to obtain documented statements from LVN J and HA C. - The Administrator failed to thoroughly review CR #181's hospital records and LVN J's nurses notes and address the allegation that resident's call light was taken away. This failure caused one resident to experience feelings of fear from abuse and placed all residents at risk of not having instances of abused addressed and thoroughly investigated. Findings included: Record review of CR #181's face sheet revealed a [AGE] year-old male resident who admitted from a hospital. No diagnoses were listed. Record review of CR #181's nurses notes, dated 01/19/2023 at 3PM, revealed the resident, . admitted to the facility from [Hospital] at 1:30PM via stretcher . Record review of CR #181's nurses notes, dated 01/19/2023 at 11:15PM, LVN J wrote Resident [complaint of] left shoulder pain p being assaulted by staff that snatched call light away from him fracturing his arm or shoulder causing mark on his left arm. Resident refused nurse to complete skin assessment. Nurse observed to BUE scabbed over areas. Resident requested to notify 911 as he wanted to speak [with] police to file assault charges [and] that he can not stay here again. Nurse asked to assess him [and] refused stating that he was not doing a dog [and] pony show for me [and] would not do anything for me. Record review of CR #181's nurses notes, dated 01/19/2023 at 11:50PM, LVN J wrote, Resident observed [with] EMT performing ROM to BUE. No signs or symptoms noted of any pain, distress or discomfort during their assessment of the resident. EMT cleared resident in house stating they don't feel that he is needed to go to the ER. As vital signs were good [and] ROM performed effectively. Resident requested to go to hospital to be further evaluated stated chest pain. Resident was transported from facility to ER [with] no marks or bruising noted during EMT's assessment prior to transfer. RP [family member] notified of above. Record review of CR #181's skin assessment, dated 01/19/2023, noted old scab on left and right lower arms. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #181 Hospital records, dated 01/20/2023, revealed the resident was a [AGE] year-old patient with, .history of coronary artery disease pacemaker, left hip and right knee replacement who is bedbound and does not ambulate and has been in multiple's SNF facility who had presented to the emergency room initially on 01/21/2022 with complaints of left shoulder pain after EMS had been called for patient to complain that he had been assaulted as she had nursing call bell wrapped around his left forearm and was subsequently pulled by the staff for which he suffered bruising and a tendon laceration. He has been evaluated in the emergency room and and have been subsequently discharged from the emergency room but patient refuses to leave the emergency department to go back to the nursing facility because believes he has been abused [sic] . The hospital record revealed the chief complaint at the ER was of, . Left shoulder pain after call light cord being ripped out from [under] him/ [patient] does report chest pain as well. Bruise and skin tear to [left] arm . CR #181's x-ray result findings revealed, .near complete loss of the subacromial space, consistent chronic rotator tear, similar prior exam [performed 01/21/2022]. Mild-to-moderate degenerative arthritic changes of the acromioclavicular . no acute fracture . In the Medical Screening Exam notes, it stated, . [AGE] year-old male . complaining of left shoulder pain after arguing with the nurse at a nursing facility when hurt his left shoulder and stated that he felt like it came out of joint and popped back in. Patient characterizes pain at an 8 out of 10 with a throbbing sensation . Phone interview with CR #181 was attempted on 3/21/2023 at 10:30AM but surveyor was unsuccessful in reaching the resident. Record review of Corrective Active Form signed 01/19/2023, revealed HA C's discharge date was 01/19/2023 and stated, employee suspended, pending investigation of resident rights. The form was signed by the Administrator and Human Resource Staff. In an interview with HA C on 03/21/2023 at 3:45PM, he stated his role as a hospitality aide was to monitor the residents, answer call lights and take them out for smoke breaks. He stated he went to answer CR #181's call light, after he had already pressed it seven times, and asked if he needed anything. He said CR #181 called him names, such as nig*** faggot and in response, he snatched CR #181's call light that was clipped to the resident's pillow and placed it out of reach on the table, to prevent the resident from pressing the call light again. HA C stated he did so because he felt insulted by what the resident said to him. He stated the call light was never attached to the resident's body and that he never touched CR #181 but the resident lied to LVN J and said I punched him and broke his arm. HA C stated LVN J made him write a report on the incident and he went home because his shift was over soon after the incident. HA C stated he was not suspended as a result of the incident. In a follow up interview with HA C on 03/22/2023 at 2:33PM, HA C said the Administrator told him to stay home the next day after the incident and he did not return until a total of 3 days later, which was the next time he was scheduled to work again. He stated he was never given the Corrective Active Form, dated 01/19/2023, and he did not know it existed. dated HA C said he took the call light from CR #181 and did not return it to him prior to leaving the room. HA C stated did not know that taking the call light was a human rights issue because the resident was being aggressive and continued to click the call light button. HA C said LVN J came into the room and asked if he took the call light away and he admitted he did and was told by LVN J that it was a form of abuse. HA C said he was trained on abuse during new hire orientation and when he returned to work, the Administrator, the ADON and the Human Resource staff pulled him aside one by one to tell him what he did was wrong. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of personnel records revealed HA C received training on abuse upon hire on 06/30/2022. After request for training documents were made on 03/22/2023 at 2:00PM, no other records of abuse training for HA C after the incident on 01/19/2023 were provided prior to exit. In an interview with LVN J on 03/22/2023 at 12:20PM, LVN J said at the time of the incident, she was the night supervisor who was called forth by an unknown staff member to tend to CR #181. She stated she kept the alleged perpetrator, HA C, out of the room while she attempted to assess the resident. The resident accused HA C for breaking his arm but refused LVN J's assessment further for range of motion and bruising and told her he was fine She said CR #181 also wanted to call the police and press charges on HA C but the police never showed up during her shift. She stated she called and reported the incident to the Administrator who told her to send HA C home and that he would take care of the incident. LVN J said she considered the incident as abuse which is why she notified the abuse coordinator. In a follow up interview with LVN J on 03/25/2023 at 8:50AM, she stated she did not witness the incident but was called down to see what CR #181's allegations were. LVN J stated she considered what HA C did with the call light maybe abuse, but more so neglect because the call light is his lifeline and he needs it for communication. She stated she reported to the Administrator over the phone that CR #181 was accusing HA C of breaking his arm but could not remember if the call light was mentioned in the conversation at that time. She stated before this incident happened, she was unsure if she was taught whether taking a call light from a resident was considered as abuse, neglect or resident rights. In an interview with the Administrator on 03/23/2023 at 3:09PM, the Administrator stated he was the abuse coordinator. He stated on the night of 01/19/2023, LVN J called him and informed him of the incident: that CR #181 was a new admission who was being out of control, who wanted to leave the facility and made accusations against HA C for breaking his arm. The Administrator said LVN J told him CR #181 did not allow her to assess him for bruising, but from what she could see, she did not see any obvious bruising. The Administrator stated he thought the investigation was very cut and dry with the main allegation being his arm was broken. He stated he reviewed the hospital records and looked at the x-ray results for CR #181's arm which revealed there was no broken arm. The Administrator stated he never heard about the call light being taken away until surveyors started questioning about it today. He said he was not sure if taking the call light was a resident rights issue or abuse issue because he would need to ask HA C what he did and why he did it, but he and LVN J both did not believe HA C would hurt the resident. In an interview with 3/22/2023 at 3:53PM, the administrator stated he could not find any written statements from staff related to that incident and he could not find any inservice trainings related to abuse that was given HA C. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview with the Administrator on 03/23/2023 at 2:00PM, the Administrator stated he, himself, was responsible for conducting the investigation on the allegations made by CR #181 and the purpose of investigations were to find the most probable cause of the issue or to rule out mistreatment. The Administrator explained he had phone call conversations with LVN J and HA C the night of the incident, the following morning, he sent out the Facility Marketer to obtain CR #81's records indicating him arm was not broken, and hospital staff interviews, in which the case manager reported the hospital staff were very familiar with CR #181, who had a pattern of behaviors and making false accusations to leave facilities. He stated from that information, he assumed CR #181 knew what to say to get out of facility right away. He stated during investigations, he did not get statements from the staff that worked at the time of the incident or those involved, but he instead gathered a random sample of staff from all departments, asking if they knew what happened to CR #181. He stated if the alleged perpetrator returned to work, it is because they had been deemed to be safe enough to return, or else, they are terminated or suspended for however long until they were deemed safe, and the alleged perpetrator would have a documented one-on-one inservice with them as well. He stated he deemed HA C safe enough to work because the x-rays showed CR#181 did not acquire a broken arm as he alleged and because HA C stated he never touched the resident. The Administrator said at the time, he thought he did a thorough investigation on the CR #181's allegations with focus on the broken arm. He stated he did not know exactly what the abuse policy stated about investigations and today was his first time he read through the investigation instructions listed in the facility policy on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. He stated after reading through the policy, that he did not follow it while investigating this incident. Record review of forms titled, [Facility Name], revealed 22 staff members were asked to document the seven types of abuse, including involuntary seclusion, who to contact if abuse is witnessed or alleged, and if they knew what happened to CR #181. Of the 22 staff members, HA C was not included. Record review of the facility's policy on Abuse Prohibition Standards of Practice, dated 11/1/2016, stated, . Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect and misappropriation of property. The following standards of practice will be operationalized in order that residents will not be subject to abuse by anyone, including, but not limited to, facility staff . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated April 2021, stated, . 1. All investigations are thoroughly investigated. The administrator initiates investigations . 3. The administrator provides supporting documents and evident related to the alleged incident to the individual in charge of the investigation . 7. The individual conducting the investigation as a minimum: a) reviews the documentation and evidence; b) reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; . d) interviews the person (s) reporting the incident; e) interviews any witness to the incident; f) interviews the resident (as medically appropriate) . h) interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . j) interviews other residents to whom the accused employee provides care or services; k) reviews all events leading up to the alleged incident; and l) documents the investigation completely and thoroughly . 8. d) witness statements are obtained in writing, signed and dated. The witness may write his/her statement or the investigator may obtain a statement . The policy also stated corrective actions included, . If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated . 4) If the allegation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to her/her/their/ former position .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on observation, interview and record review, the facility failed to ensure residents were safe from accidents and hazards for 1 of 11 sampled residents (Resident #77), in that: - CNA K was observed transferring Resident #77 by himself using a mechanical lift. This failure places residents at risk of physical harm and injury. Findings included: Record review of Resident #77's face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE], and diagnosed with muscle wasting atrophy, hemiplegia and hemiparesis. Record review of Resident #77's care plan, dated 01/05/2023, reflected ADL function was coded 8 for transfers, meaning transfer activity did not occur. Review of MDS, BIMS, and physician orders Observations on 03/23/23 at 01:12 PM, revealed Resident #77 was being transferred from his bed to the shower table by CNA K, alone, using a mechanical lift. RN U was observed in the room at the time feeding Resident #77's roommate and did not intervene. In an interview with RN U on 03/23/23 at 01:16 PM, RN U stated everyone is trained to do mechanical lift by themselves. In an interview with CNA K on 03/23/23 01:20 PM, CNA K stated that he himself is the muscle and takes it upon himself to do the transfer on his own when he does not have the help nearby, but only sometimes. He stated he had been trained to do it with a second person but still sometimes performs the transfer on his own. In an interview with Resident #77, on 3/23/3023 at 1:21 PM, The resident stated that CNA K usually transfers him using the mechanical lift by himself. In an interview with Unit Manager S on 03/23/23 at 01:24 PM, she stated mechanical lifts require two people to use them. One person was to use the remote to move it up and down while the other one kept the resident stationary to prevent them from hitting their limbs anywhere and acquiring injuries for the resident. She stated, under no circumstance that they would allow one person to do it. She stated to her knowledge, she did not know CNA K to use the mechanical lift alone. She said with only one person on the mechanical light, you could potentially hurt the patient if they fall, and no one would be there to help if things were to go wrong. All CNAs know to use it with 2 people. Unit Manager S said she did not know of any staffing issues and there should always be two people available to use the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 03/23/23 at 02:47 PM, she stated transferring residents by themselves was wrong, and two people were necessary for the safety of the resident's transfer. Record review of inservices on gait belt, dated 02/23/2023 revealed no documented training was provided to aides including procedures for use of the mechanical lift for transfers. Record review of facility's policy on Mechanical Lift Use, dated 01/01/2017, reflected it did not mention the necessity of two staff to safely operate a mechanical lift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47531 Based on observation, interview, and record review, facility failed to provide routine and emergency drugs and biologicals to its residents, or obtain them for 2 of 5 residents review for pharmacy services in that the facility failed to: 1. Remove expired insulins for 3 out of 7 medications on the 3 East medication Cart. 2. Put expiration dates on 2 out of 2 insulins in the 3 east medication room refrigerator. This failure affected 2 residents and placed residents at risk for lower medication efficacy, health complications, and prolonged illness. Findings include: Observation of the 3 East Medication Cart on [DATE] date at 12:01pm time revealed: Humulin R for resident #23 opened on [DATE] and expired on [DATE]. Novolin N for Resident #41 opened on [DATE] and expired on [DATE]. Lantus Solostar for resident #41 opened on [DATE] and expired on [DATE]. Observation of the 3 East Medication Storage Room refrigerator on [DATE] at 12:45pm revealed: Lantus Solostar for resident #41 with an open date of [DATE] with no expiration date on the label. Lantus Solostar for resident #41 with open date of [DATE] with no expiration date on the label. In an interview on [DATE] with LVN H at 12:10 PM she said she did not know the medications were expired, did not know the surveyors were here and this was her first day back at work. In an interview on [DATE] with LVN I at 2:03PM she said when residents receive expired insulin, it will not be effective and will not do what it is supposed to do. She said when insulin expires a resident's blood sugar would elevate and they could get sick. In an interview on [DATE] with the DON at 2:15PM she said they never give expired insulin, and she does not know why the insulin was on the cart. She said residents should not use expired insulin and nurses should only hand expired insulin to her or the unit manager. In an interview on [DATE] with the DON at 12:55PM she said that when insulin is expired, residents should not receive it. She said they have trained staff to visualize the medication before administering it. She said when insulin is expired, it might not be as efficient to treat diabetes and blood sugars could be high. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's medication administration policy titled, Administering Medications, dated 2001, read in part . Check the expiration date on the medication label. When opening a multi-dose container, place the date on the container. Record review of the facility's medication expiration policy titled, Medication Expiration After Opening, no date, read in part . Humulin R, expires in 30 days, Novolin N expires in 42 days, Lantus Insulin expires in 28 days. Record review of the facility's policy titled, Rights of Medication Administration, no date, read in part . Check the medication label.

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	03/27/2023

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview and record review the facility failed to have target behavioral monitoring in place for behaviors associated with the use of psychotropic medications and to ensure residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 6 residents reviewed for unnecessary psychotropic drugs (Resident #61). - The facility failed to obtain consent for Risperdal antipsychotic medication treatment from Resident #61's doctor/facility Medical Director. - The facility failed to obtain psychiatrist referral/ psychiatrist services for the use of antipsychotic medication for Resident #61. - The facility failed to obtain consent for antipsychotic medication treatment from Resident #61's Responsible party. -The facility failed to adequately monitor Resident #61's behaviors and side effects regarding his antipsychotic medication. These failures could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: Record review of Resident #61 face sheet (undated) revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), mood affective disorder (a type of psychiatric disorder) and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). Record review of Resident #61's Comprehensive MDS dated [DATE] revealed Resident #61 had a BIMS score of 03 out of 15, indicating severely impaired cognition. Further review of section N0410, revealed Resident #61 received antipsychotic medication 7 days a week. Record review of Resident #61's care plan initiated 2/28/23 and revised on 3/16/2023 revealed the following: Problem: Potential for medication side effects and adverse reactions due to antidepressant, anti-anxiety and anti-psychotic medication administration required for the management of Depression, Psychosis, Restless and Agitation, Mood Disorder, Anxiety. He has orders for PRN Alprazolam but has not received this medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Resident #61 will be free from medication side effects and / or adverse reaction X 90 days. Approach: Administer medication as ordered: Remeron, Risperidone, PRN Alprazolam Approach: Monitor antipsychotic side effects and effectiveness. Antipsychotic side effects: Dizzy or blurry vision; drowsiness; weight gain; digestive issues; low blood pressure; restlessness; mental fog; loss of motivation; social withdrawal; uncontrolled movements; metabolic syndrome, diabetes Record review of the order summary report dated 02/28/2023 indicated Resident #61 had the following order with start date of 3/01/23 Risperidone tablet; 0.5 mg; amt: 1 tablet; oral Twice A Day 08:00 AM, 04:00 PM for unspecified mood [affective disorder]. The order summary report did not indicate Resident #61 had any behavior or side effect monitoring for the use of antipsychotic medication. Record review of Resident #61's MAR from 3/01/23 to 3/24/23 revealed resident was receiving Risperidone tablet; 0.5 mg; amt: 1 tablet; oral Twice A Day 08:00 AM, 04:00 PM. Record review of Resident #61's Antipsychotic or Neuroleptic Medication Treatment consent revealed Section 1 was not signed by the Health Care Professional proposing treatment or the Delegating physician. Section ll was not signed by the Resident or Resident's Representative. Record review of Resident #61's Antipsychotic or Neuroleptic Medication Treatment consent read in part: Section 1: The following course of therapy with antipsychotic or neuroleptic medication(s) is proposed with the following medication(s), dosage and frequency: Risperdal 0.5 mg-give 1 tab P.O.BID. The consent was not signed by person prescribing medication or person's designee or facility's medical director. Section ll was not signed by the Resident or Resident's Representative. Observation and interview on 3/21/23 at 10:21a.m., with Resident #61 revealed he was resting in bed. He said he did not recall the names of the medications he was taking. Record review and interview on 3/22/23 at 1:33p.m., with the DON, she said there was a behavior monitoring sheet with side effects on there. The DON said this was separate from the MAR and TAR. Sometimes monitoring could be on the MAR. At this time, behavior/side effect monitoring documentation were requested. This Surveyor reviewed Resident #61's consent for Antipsychotic medication treatment, physician orders, and medical chart with the DON. The DON said Resident #61 was cognitively impaired and needed RP to sign the consent for Risperdal use. She said when the resident was on Risperdal the resident needed to be on psych services. She said she did not see in the physical order where the psych referral was ordered. She said his doctor also needed to sign the consent form and if the doctor was not available the Medical Director could also sign the consent. She said she would follow up. In an interview on 3/24/23 at 12:52p.m., with Medication Aide AAA, she said she was responsible for administering routine PO meds to the residents. She said the nurses monitored for the side effects of the antipsychotic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review and interview on 3/24/23 at 9:30a.m., this surveyor reviewed Resident #61's physician order and MAR for the month of March 2023 with LVN AA. LVN AA said antipsychotic medications required family consent if resident was not cognitive enough. She said Resident #61 was cognitively impaired and was unable to sign the consent for Risperdal. She said Risperdal required behavior and side effect monitoring. LVN AA said by not monitoring for behaviors or side effects the resident was at risk for taking something they do not need or having an adverse side effect and staff would be unaware of it. She said Medication aide administered routine medications and if they noticed any behaviors, they were to notify the nurse to document on nurses notes. Record review and interview on 3/24/23 at 9:42a.m., with the DON, Unit Manager A and LVN AA, this Surveyor reviewed Antipsychotic Medication Treatment consents. The DON said a resident receiving antipsychotic medications should have behavior and side effect monitoring as well. Unit Manager A said if they are not monitoring the side effects or the behaviors they will not know when to notify they doctor regarding the need for medication changes. The DON said the Medical Director came once a week to the facility. She said the Medical Director was in the facility on Wednesday 3/22/23 and could have signed the consent. She said the nurse, or the Unit Manager should have gotten the verbal consent from the resident's RP when starting the antipsychotic medication. Unit Manager A said care plan meeting with Resident #61's family was held yesterday (3/23/23) and a verbal consent for Risperdal was received. No behavior/side effect monitoring documentation were provided on exit. Record review of facility's Psychotropic/Psychoactive Drugs policy (7/2009) read in part: .Policy: 2. Qualified staff will monitor the patient/resident for potential undesirable side effects that are associated with the use of the psychotropic drugs according to CMS, state specific rules and regulations, and Facility Practice Guidelines. The policy did not mention consent for Psychotropic/Psychoactive Drugs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41469 Based on observations, interview and record review, the facility failed to distribute and serve food in accordance with professional standards for food service safety for all residents who eat food served by the kitchen, in that: - Low-temperature chemical dishwasher was observed to be used to wash residents' dishware while not reaching required temperature of 120F for wash cycle. This failure placed all residents who eat food served by the facility kitchen using its dishware at risk for foodborne illness. Findings included: Observations of the kitchen on 03/22/2023 at 10:20AM, revealed resident trays and dishware were being washed by Dietary Aide A and the dishwasher temperature was measured at 108F. In interview with Dietary Aide A on 03/22/2023 at 10:20AM, he stated he ran the dishwasher eight times before washing the dishes and he recorded the temperature at 110F prior to washing the dishware. He stated the temperature of the dishwasher is usually around 110F and documented it on the dishwasher temperature log. Record review of the dishwasher temperature log, dated March 2023, revealed the dishwasher temperature was running between 110F and 120F for the past week. In an interview with the Dietary Manager on 03/22/2023 at 10:25AM, she stated she did an in-service for her staff after she noticed the dishwasher temperatures dip down around the month of February 2023. She said she also had maintenance repair the dishwasher twice to fix the issue causing the temperature to be low. She stated the dishwasher temperature is required to be at 120F or above prior to using the dishwasher. She stated running the dishwasher 8 times was not enough to thoroughly wash the dishes and it should have been run until it reached 120F. She stated she did not audit her staff to ensure they are running it enough prior to washing resident dishware. Record review of inservice report, dated 02/13/2023, revealed inservice on the need for dishwasher temp must be done before first wash for breakfast, lunch [and] dinner . report any temps off set to manager and or maintenance . Record review of facility policy on Safe Employee Practices with Equipment, dated 2009, revealed staff should report equipment malfunction to the Nutrition Services Director.