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	02/28/2022

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 4 of 8 residents reviewed for ADLs (Residents #3 #8, #9 and #11). The facility failed to timely turn and reposition Resident #3 for 3.5 hours. The facility did not provide Resident #8, #9, and #11 with timely incontinent care. This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs. Findings included: Resident #3 Record review of R#3's face sheet indicated a [AGE] year-old-male who admitted to the facility on [DATE] and discharged to the hospital on 2/17/22. His diagnoses included schizoaffective disorder (mental disorder), Atherosclerosis of native arteries with gangrene in bilateral legs (narrowed arteries in the legs), cellulitis (bacterial infection), and osteomyelitis (infection of the skin). Record review of R#3's admission MDS dated [DATE] indicated a BIMS of 10, indicating moderately impaired cognition. Further review of the MDS indicated R#3 required total assistance with two persons for ADLS. Record review of R#3's care plan with a date of 1/28/22 indicated R#3 is at risk for skin breakdown related to cellulitis. Interventions include monitor for incontinence every 2 hours and PRN, change promptly and turn and reposition PRN. The care plan indicated he required total dependence for ADLS. Record review of R#3's physicians order dated 1/28/22 read in part, hair clean and combed to promote dignity, resident dressed in manner to promote dignity . Record review of R#3's weekly skin assessment dated [DATE] indicated wounds to bilateral lower legs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation made on 2/8/22 at 10:29 AM, R#3 was lying in bed, head of bed elevated, he was on an air mattress facing towards the door. Attempted interview but R#3 was sleeping. In an interview on 2/8/22 at 10:57 AM, LVN K stated R#3 is in the room by himself and requires assistance with ADLS. She stated he is a fairly new resident that she is still learning about. Observation of R#3 made on 2/8/22 at 11:22 AM, R#3 was lying in bed, facing towards the door. Observation made on 2/8/22 at 1:00 PM, R#3 was lying in the bed, head of bed still elevated, lying in the same position from initial observation at 10:29 AM. Wounds observed on residents' toes. Call light at the end of bed, out of reach. In an interview on 2/8/22 at 1:05 PM, CNA H stated she was getting ready to assist R#3 with eating. She stated she was not sure when the resident was last turned and repositioned as he was not her resident and the CNA assigned to him was assisting another resident. She stated residents are to be turned and repositioned every two hours to avoid skin breakdown. In an interview on 2/8/22 at 1:15 PM, LVN K she stated R#3 had gangrene to his lower extremities and admitted to the facility with it. She stated it is often hard for them to turn and reposition him due to him being in pain. LVN K stated she is still learning how to care for R#3 due to him being slim and fragile to her. In an interview on 2/8/22 at 1:20 PM, R#3 stated he was not sure the last time he was turned but would let the staff reposition him. Resident #8 Record review of R#8's face sheet indicated an [AGE] year-old-male who admitted to the facility on [DATE]. His diagnoses included Anxiety disorder, Hypertension (elevated blood pressure), Dementia, Acute Kidney Failure (reduction in kidneys abilities) and Hyperlipidemia (elevated lipid levels). Record review of Resident #8's quarterly MDS dated [DATE] indicated a BIMS of 9, indicating moderately impaired. Further review of the MDS indicated R#8 required supervision and setup for ADLS. Record review of R#8's care plan dated 12/11/21 indicated R#8 was incontinent of bowel and bladder. Interventions include monitor for incontinence every 2 hours and PRN, change promptly and turn and reposition PRN. The care plan indicated he was at risk for skin breakdown related to dementia. Interventions included monitor for incontinence every 2 hours and as needed, change promptly and turn and reposition PRN. Record review of R#8's physicians order dated 8/27/21 read in part, hair clean and combed to promote dignity, resident dressed in manner to promote dignity . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/16/22 at 9:46 AM, R#8's family member stated often times when they visit R#8, he is often soiled through his clothes. The family member stated it is often hard to find someone to change R#8 and the staff think that because he is able to walk, he does not need assistance with going to the bathroom, but he does, he does not often remember he needs to go. R#8's family member stated the building often smells of urine and they know it is due to the number of residents who are not being assisted with going to the bathroom. Observation and interview made on 2/16/22 at 10:25 AM, R#8 was lying in bed, on top of the sheets. R#8's pants and shirt were visibly soiled and also the bed linen had a wet ring on the sheets. R#8 stated he could not remember the last time he was changed or had a shower. He stated he had been laying in his bed waiting for someone to assist him. R#8 was going in and out of sleep during the interview. R#8's room smelled of urine. In an interview on 2/16/22 at 10:40 AM, CNA I stated was the CNA for R#8 and stated she assisted him with his ADLs about 40 minutes ago. She stated if he was soiled, it must have just happened, but stated she would go and assist him. She stated she does her rounds every two hours and as needed in between that. In an interview on 2/16/22 at 11:00 AM, LVN K stated she will make sure R#8 and R#9 are showered and changed. She stated the CNAs are to complete their rounds before lunch and after lunch. She stated the CNAS are to do their first round when they get to work to change the residents. She stated timely incontinent care prevents skin breakdown. Resident #9 Record review of R#9's face sheet indicated a [AGE] year-old-male who admitted to the facility on [DATE]. His diagnoses included Dementia, Hyperlipidemia (elevated lipid levels), Heart disease, Hypertension (elevated blood pressure) and Hypothyroidism (underactive thyroid). Record review of R#9's quarterly MDS dated [DATE] indicated a BIMS score of 00, indicating severe cognitive impairment. Further review of R#9's MDS indicated he required extensive assistance from staff for all ADLS. Record review of R#9's care plan dated 1/27/22 indicated R#9 is incontinent of bowel and bladder. Interventions include monitor for incontinence every 2 hours and PRN, change promptly and turn and reposition PRN. Record review of R#9's care plan dated 1/27/22 indicated he was at risk for skin breakdown related to dementia. Interventions included monitor for incontinence every 2 hours and as needed, change promptly and turn and reposition PRN. Observation made on 2/16/22 at 10:14 AM, R#9 was walking around the hallways. R#9's clothes were visibly soiled to the top of his chest and the lower part of his pants. In an interview on 2/16/22 at 10:40 AM, CNA I stated she was the CNA for R#9 and will be giving him a shower. She stated he did not realize that he was soiled and the last time she assisted him with care was around 6:30 AM. CNA I stated rounds are to be made every two hours or as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 Record review of R#11's face sheet indicated a [AGE] year-old-male who admitted to the facility on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease (obstructed airflow in the lungs), Hyperlipidemia (elevated lipid levels), Hypertension (elevated blood pressure) and Hemiplegia and hemiparesis (loss of strength in the body). Record review of R#11's quarterly MDS dated [DATE] indicated a BIMS score of 10, indicating moderate cognitive impairment. Further review of R#11's MDS indicated he required extensive assistance from staff for all ADLS. R#9 also had limited range of motion on one side of his upper and lower extremities. Record review of R#11's care plan dated 1/27/22 indicated R#11 is incontinent of bowel and bladder. Interventions include to monitor for incontinence every 2 hours and PRN, change promptly and turn and reposition PRN. Further review of R#11's care plan indicated he required extensive assistance with ADLS. Record review of R#11's care plan dated 12/22/21 indicated he was at risk for skin breakdown related to impaired mobility, left side weakness and CVA (Stroke). Interventions included monitor for incontinence every 2 hours and as needed, change promptly, and turn and reposition PRN. Observation and interview made on 2/27/22 at 8:45 AM, R#11 was yelling I need to be changed. Hello? I need to be changed. I am soaking wet. Surveyor entered the room and R#11 stated he was soiled and had not been changed all night. He stated he had been waiting for someone to assist him all night but was not able to get anyone. R#11's call light was not within reach for him to press for assistance. R#11 stated the last time he was changed was around 9PM yesterday (2/26/22). He stated he was not sure where the night CNA was. Interview on 2/27/22 at 8:47 AM, the ADON stated he was not sure why R#11 was not changed overnight, but he will go and assist for R#11. Observation of facility scheduled indicated one CNA on shift for 10PM-6AM shift. An attempt was made to contact the CNA that was on duty, message was left, but call was never returned. In an interview on 2/27/22 at 8:50 AM, CNA E stated she went in the room to assist R#11 this morning and he stated he had not been changed all night. She stated when she assisted with his care, his brief was completely soiled and you could tell he had not been changed for a long time. She stated R#11 informed her that she was the last person to assist with his care and he didn't see anyone all night. CNA E stated when she began rounds, it was several residents that needed to be changed due to being really soiled and it occurs often. In an interview on 2/26/22 at 3:32 PM, the Administrator stated he expected staff to provide care to the residents every two hours and as needed. He stated it is important for incontinent care to be completed to avoid residents having new or worsening skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled ADL; Nursing Policies and Procedures dated 3/2006 read in part, the nursing staff will assist the patients/residents with his/her hygiene and self-care needs according to facility practice .Provide incontinent care as necessary .

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 8 residents (CR#1 and CR#2) reviewed for pressure ulcers. The facility failed to ensure CR#1 had preventative measures in place to prevent new or worsening pressure ulcers. The facility failed to promptly intervene when CR#1's wound increase in size within five days, wound was 0.9 x 0.3 cm and increased to 4 x 17.5 x 0.5cm. The facility failed to ensure CR#2 received timely intervention when she was identified as having a pressure ulcer on her sacrum. The facility failed to appropriately assess and document CR#2's skin breakdown and failed to routinely monitor the condition of her skin while on the isolation unit. CR#2 was identified as having skin breakdown on 1/18/22, but there was no documentation after that date of the treatment or progress of the breakdown until CR#2 returned from isolation unit on 2/1/22 (approximately 14 days). An Immediate Jeopardy (IJ) was identified on 2/24/12 at 00:00. While the IJ was removed on 2/27/22 at 00:00, the facility remained out of compliance at scope of a pattern and a severity level of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of developing or worsening of wounds and placing them at risk of infection, a decline in health, pain, hospitalization , or death. Findings include: Record review of CR#1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged to the hospital on 2/6/22. CR#1's diagnoses included chronic obstructive pulmonary disease (limited air flow into the lungs), chronic kidney disease (kidneys inability to function properly), type 2 diabetes mellitus (high blood sugar), hypertension (high blood pressure), and anxiety (increased feeling of uneasiness). Record review of CR#1's quarterly MDS dated [DATE], revealed a BIMS score of 7, which indicated severe impairment of cognition. CR#1 required extensive assistance with one person for bed mobility, dressing and hygiene. CR#1 required extensive assistance from two persons for transfers as totally dependent with 2 persons assist for dressing, toilet use and personal hygiene. CR#1 had impairment to one side of upper extremity and one side of lower extremity. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's care plan with a revision date of 1/20/22 revealed CR#1 was incontinent of bowel and bladder, with a goal of having no skin break down and interventions of changing promptly, applying skin barrier cream and monitor for signs and symptoms of skin break down. Further review of CR#1's care plan revealed she was at risk for skin breakdown related to obesity, pressure areas and incontinent of bowel and bladder. The goal was to have CR#1's skin to be without skin breakdown and interventions to turn and reposition every 2 hours, change promptly, monitor skin breakdown and apply moisturizing lotion as needed. Record review of CR#1's care plan with a revision date of 1/20/22 revealed CR#1 was diabetic and at risk for pressure/venous/statis ulcers. Interventions in place were to monitor skin for changes like redness, circulatory problems, breakdown, and weekly skin assessments. Record review of CR#1's Physician order dated 10/29/21 read, wound consult to sacrum (shear wound). Record review of CR#1's Physician order dated 11/16/21 read, D/C current TX order to sacrum d/t resolved. Record review of CR#1's Physician Order Report for February 2022 indicated an order with a start date of 1/20/22 to clean left heel with [normal saline], pat dry, apply skin prep and cover with dry dressing daily. Record review of CR#1's Physician order dated 2/2/22 read in part, New order for Bactrim . 10 days for infection of sacral wound . Record review of CR#1's Physician treatment order dated February 2022 read, clean sacral wound with n/s, [pat dry], apply [calcium alginate] and cover with protective dressing daily. Record review of CR#1's nursing note written by Wound Care Nurse A dated 1/17/22 read in part, .There is slight redness to sacral area. Barrier cream applied . Record review of CR#1's nursing note written by Wound Care Nurse A dated 1/24/22 read in part, assessed resident sacral area. No redness or irritation noted. Continue barrier cream as a preventative measure. Record review of CR#1's nursing note written by Wound Care Nurse A dated 1/27/22 read in part, .Informed of area by family. Assessed resident skin, there is excoriation noted to left buttock with slight redness. This is a 0.9x0.3 open area with light serous drainage noted. There is maceration around wound bed. New order for alginate/dry dressing. Consult wound physician . Record review of CR#1's nursing note written by Wound Care Nurse A dated 1/30/22 (Sunday) read in part, . Open area noted around sacrum. Increase in size. Awaiting wound physician eval on Tuesday . Record review of Physician A's wound care note dated 2/2/22 read in part, .Wound physician recommends resident to be placed on antibiotics .for infection of sacral wound due to ruptured blister with pus noted . Further review of Physician A's notes indicated CR#1's wound was in an inflammatory stage and is unable to progress to healing phase because of the presence of biofilm. Wound size 4x17.5x0.5cm. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's TAR dated February 2022 indicated CR#1's wound care treatments were signed off on 2/1/22, 2/2/22, 2/3/22. Dates 2/4/22 and 2/5/22 were left blank. CR#1 discharged to the hospital on 2/6/22 per families' request. Record review of Weekly pressure log revealed only CR#1's left, and right heel ulcers were on the log from 1/13/22 through 2/10/22. No indication of CR#1's sacral wound, which was identified as an open area on 1/31/22. Record review of CR#1's weekly skin assessments indicated one assessment completed by Wound Care Nurse A on 2/1/22 for CR#1's sacral wound. Response to treatment read in part, Possible infection from open blister . Preventative measures include turn every 2 hours, offload, float heel and air mattress . In an interview on 2/7/22 at 5:32 PM, CR#1's family member said CR#1 is currently in the hospital in intensive care and according to the hospital, the wound had eaten through CR#1's muscles. CR#1's family said they were able to see CR#1's bone through her bottom. The family said when CR#1 first admitted to the facility, there were no bedsore on the resident. CR#1's family said the wound care nurse made them aware that CR#1 had two wounds on her heels and was also informed the area on CR#1's bottom was the size of a quarter, but they would put preventative measures in place to prevent further breakdown. CR#1's family member said when they went to visit CR#1 at the facility on 2/6/22 she seen the wound only due to assisting with changing CR#1. The family member said they were horrified at the sight of the wound and was not aware it was so big in size and covered her whole bottom. CR#1's family member said they requested for CR#1 to be sent to the emergency room to have the wound looked at due to the concerns the family had with the way the wound looked. In an interview on 2/7/22 at 9:31 AM, LVN B stated any resident with a change in condition, she will notify the physician. She stated residents are to be turned and repositioned every two hours to avoid skin breakdown and to assist prevent further breakdown if they already have pressure sores. In an interview on 2/7/22 at 3:21 PM, WCN A said she only works Sunday-Thursday and if a resident admits on Thursday afternoon or any skin changes occur during that time, she will see the resident on Sunday. She stated the nurses also have weekly skin assessments that they are to complete based on the schedule. She stated if a resident has any breakdown during those assessments, the nurse will write a communication form for her to review. WCN A stated when she is not in the building, the nurses are responsible for completing all treatments for their residents. She stated the nurses are to follow the treatment orders that are placed on the MAR. In an interview on 2/7/22 at 3:41 PM, the ADON said skin assessments are to be done twice a week by the floor nurse. The skin assessments that are completed will be placed in a skin book until the end of the month and then will be filed in the resident's chart. He stated it is important for skin assessments to be completed to monitor the integrity of the resident skin and avoid further breakdown. In an interview on 2/16/22 at 1:00 PM, LVN K said she recalls working with CR#1 for a short time while she was on her unit, in October. She stated during the time of CR#1 being on her unit, she would only apply barrier cream to her bottom. She stated the area on her bottom was not open and had no drainage. LVN K said CR#! left her floor and went to the hospital a couple times, but never treated any open area on CR#1 only preventative measures. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/16/22 at 2:08 PM, the DON said she expects the staff to check on residents daily, provide showers and for nurses to complete skin assessments as ordered. She stated the nurses are to report any changes with the resident to her and also to the physician. She stated residents are to be turned every two hours to prevent skin breakdown. She stated the wound care nurse is responsible for completing weekly skin assessment for residents who have pressure ulcers and the floor nurse is responsible for completing the weekly skin assessment for other residents. Nurses are also expected to change residents dressing when it becomes soiled, and the wound care nurse has already treated the resident. She stated the facility puts interventions in place to avoid wound breakdown like seeing the wound care doctor, pressure relieving devices, completing pericare timely and weekly skin assessments. The DON stated in order to monitor residents' wounds, she will get a weekly wound report from the wound care nurse. She stated she will check the wound care measurements and she will also complete random skin audits. Observation made on 2/16/22 at 4:31 PM of CR#1 at the hospital. CR#1 had a nasogastric tube (tube that carries food and medicine to the stomach through the nose) and being treated by wound care daily, with wound vac observed at bedside. CR #1 was unable to clearly speak, and she required staff to anticipate needs. In an interview on 2/16/22 at 4:35 PM, Hospital RN 1 said CR#1's admitting diagnosis was sepsis and sacral ulcer. She stated CR#1 had a stage 4 pressure ulcer on her sacrum and is currently on a wound vac. Hospital RN 1 stated CR#1's wound is to the bone and was debrided on 2/9/22. She stated CR#1 also had a blister on her left lateral ankle, left and right buttock and both bilateral heels have unstageable wounds. She stated she also has a pressure ulcer on her right outer elbow. Hospital RN 1 stated CR#1 is currently being closely monitored and they're hoping her mentation improves, but the confusion comes from the sepsis. She stated CR#1 is also on IV antibiotics to help with the sepsis. In an interview on 2/18/22 at 3:19 PM, WCN A stated on 1/30/22 was the first time she seen the sacral wound on CR#1. She stated she was previously treating her for left and right DTIs (deep tissue injury) to her lower extremities. She stated after speaking with the wound doctor and having CR#1 treated, there was an order in place to have CR#1 to receive calcium alginate to the sacral wound daily. WCN A stated the nurses also had access to the treatment order due to it being in the resident treatment record. She stated when the wound doctor seen CR#1's sacral wound on 2/1/22 it already had pus around it and it was an open area. She stated on 2/6/22 CR#1 was sent out to the hospital before she could see the actual wound and her last day she seen and treated CR#1's wounds was 2/3/22. She stated she was unsure who treated the residents wounds when she is off on the weekend (2/4/22 and 2/5/22), but believes nurses are doing their own treatments. In an interview on 2/18/22 at 4:15 PM, the DON stated the facility had a PRN wound care nurse who assist with weekend treatments. She stated after the nurses complete wound treatments, they are to document on the treatment book that they have completed the treatments or document in the nursing notes if additional information is needed. In an interview on 2/2/22 at 9:53 AM, LVN C stated she last recalls working with CR#1 on 1/27/22 when a family member came to the nursing station asking why CR#1 had sores on her skin. She stated she went into the room to assess the resident as she recently started working with CR#1. LVN C stated she assisted with incontinent care and seen a little area (about 0.5 cm), on her bottom. She stated the area was not open (on 1/27/22). LVN C stated she did not see CR#1's skin any time after working with her 1/27/22. LVN C stated wound care was consulted on 1/30/22 for the area on CR#1's sacrum. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/22/22 at 10 AM, LVN D stated she briefly recalls working with CR#1 but unaware of any skin breakdown. She stated residents who have compromised skin will usually have a barrier cream placed on their bottom as a preventative measure. She stated the residents are also to be turned and repositioned every two hours or as needed. In an interview on 2/22/22 at 10:13 AM, Physician A stated he recalls working with CR#1 due to the wound to her sacral area. He stated when he seen her on 2/1/22, CR#1's wound was 4x17.5x0.5 cm. Physician A stated the 17.5cm is how wide CR#1's wound was, which stretched across both buttocks. He stated based off reading the wound care notes for CR#1, her wound was a stage 4 on 2/2/22 at time of treatment. Physician A stated he sees the residents weekly at the facility and only seen CR#1 once for the sacral wound but was treating her DTI's. In an interview on 2/22/22 at 11:29 AM, CNA A stated she worked with CR#1 a few times before she went to the hospital. She stated CR#1 had an open area on her bottom, but she was unable to say the size or describe how the open area looked. CNA A was unable to recall the first time she saw the wound for CR#1. In an interview on 2/22/22 at 2:35 PM, WCN B stated she completes wounds on Friday and Saturday as needed. She stated the last time she treated CR#1 was right before she went out to the hospital, and she changed the wound dressing. She stated CR#1 had a wound on both heels and a sacral wound. She stated the wound on her sacral had mild drainage and was small circular area with some slough on the wound. WCN B stated she was unsure of the exact measurements of the wound and also unable to recall the stage of the sacral wound. In an interview on 2/22/22 at 2:43 PM, Hospital RN 2 stated CR#1 admitted with 5 wounds. He stated the wound measurements upon admission were (2/6/22): - Sacral wound 11x15x0.1 cm - Right buttock 2.5x2.5x0.1 cm - Right hip 3.5x3x0.1 cm - Right heel 3.5x3 cm - Left heel 7.5x7.5 cm In an interview on 2/26/22 at 3:17 PM, CNA E stated she recalls working with CR#1 and she had an open area on her bottom. She stated she was unable to recall the size but knows it was a small area and also knows the nurses were aware due to there being a bandage on the wound at times when she would provide incontinent care to CR#1. In an interview on 2/27/22 at 5:53 AM, CA G stated she worked with CR#1 on 2/5/22 and stated CR#1 had a bed sore on her bottom that was open and across her bottom. She stated she was not able to recall the size but does know that the area was open on her bottom. CR #2 (continued on next page)

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	675764	A. Building B. Wing	02/28/2022

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of face sheet for CR#1 revealed an [AGE] year-old female who admitted on [DATE] and discharged on [DATE] to the hospital, and the home with hospice care. Her diagnoses included Dementia, Muscle Wasting and Atrophy, Type 2 Diabetes Mellitus, Hypertension, Generalized Anxiety and Mood disorder. Record review of CR#2's quarterly MDS, dated [DATE], revealed a BIMS score of 7, which indicated severe impairment of cognition. CR#2 required extensive assistance with all ADLS by one person. CR#2 was at risk of developing pressure ulcers and had one unstageable wound with slough and/or eschar. Record review of CR#2's care plan with a revision date of 1/9/22 revealed CR#2 was incontinent of bowel and bladder, with a goal of having no skin break down and interventions of changing promptly, applying skin barrier cream and monitor for signs and symptoms of skin break down. Further review of CR#2's care plan revealed she was at risk for skin breakdown related to incontinent of bowel and bladder. The goal was to have CR #2's skill to be without skin breakdown and interventions to turn and reposition every 2 hours, change promptly, monitor skin breakdown and apply moisturizing lotion as needed. Record review of CR#2's care plan with a revision date of 1/26/22 revealed CR#2 was diabetic and at risk for pressure/venous/statis ulcers. Interventions in place were to monitor skin for changes like redness, circulatory problems, breakdown, and weekly skin assessments. Further review of CR#2's care plan indicated CR#2 had an unstageable pressure ulcer on the sacrum. Interventions in place were to provide pressure reducing device, assist with turn/repositioning every two hours and PRN. Record review of CR#2's Physician order dated 1/7/22 read, clean open area to left buttock with n/s, pat dry with 4x4 gauze, apply zinc oxide q shift until heeled . Record review of CR#2's Physician order dated 1/9/22 read, D/C previous tx order. Clean sacral wound with n/s, pat dry and apply santyl/cover with dry dressing daily. Consult wound physician. Record review of CR#2's physician order dated 1/16/22 read in part, Clean right heel with n/s, pat dry, and apply santyl, followed by calcium alginate and cover with dry protective dressing Record review of CR#2's physician order dated 1/18/22 read in part, .New order to clean right heel with n/s, pat dry and apply santyl and cover with dry dressing . Record review of CR#2's physician order dated 1/21/22 indicated CR#2 was transferred to COVID unit for isolation. Record review of CR#2's physicians order dated 1/26/22 read, Apply Nyortho zero, G-Boot to right foot, every shift, monitor for skin integrity daily. Record review of CR#2's TAR dated January 2022 indicated the treatment to apply g-boot and monitor skin daily were not completed on 1/29/22, 1/30/22, 1/31/22. Record review of CR#2's January 2022 TAR revealed the treatment to clean sacral wound was not completed on 1/28/22, 1/29/22, 1/30/22, 1/31/22. CR#2 was sent to the hospital on 2/1/22 due to a change in condition. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#2's nursing note dated 2/1/22 by LVN B read in part, [CR#2] not easily aroused. Noted pocketing food during lunch. Noted increased weakness and lethargy . [CR#2] to be sent to the hospital . Record review of CR#2's non-pressure skin report dated 1/9/22 (date first observed) indicated CR#2 had a shear to the left buttock in close proximity to sacrum. The new area measured 3.6x2.6x0.1 cm. Record review of CR#2's non-pressure skin condition report for CR#2's right heel revealed: 1. On 1/16/22 (date first observed) indicated CR#2 had right heel trauma. The area measured 9 x 4.0 x 0.2 cm . 2. On 1/18/22 measured 9 x 4.5 x 0.3 cm . Comments: Seen by wound doctor . change in wound status 3. 1/21/22 - On COVID unit 4. 1/25/22 - On COVID unit 5. On 2/1/22 back from COVID unit. New order wound consult and treatment order for santyl and alginate. The measurements were 9 x 4.8 x 0.3 cm Record review of CR#2's weekly pressure injury record for sacral wound revealed: 1. On 1/18/22 unstageable sacral wound measured 3.3 x 2.2 x 0.2 cm 2. 1/21/22 - On COVID unit 3. 1/25/22 - On COVID unit 4. On 2/1/22 unstageable sacral wound measured 3.6 x 2 x.4 cm Record review of CR#2's wound care physician notes dated 1/11/22 read in part, Site 1: Unstageable (due to necrosis) sacrum . wound size (L x W x D): 4 x 2.7 x 0.2 cm . This wound is in an inflammatory state and is unable to progress to a healing phase because of the presence of biofilm . Debridement Procedure: The wound was cleaned . Record review of CR#2's wound care physician notes dated 1/18/22 read in part, Site 1: Unstageable (due to necrosis) sacrum . wound size (L x W x D): 3.3 x 2.2 x 0.2 cm . Wound progress: Improved . Site 2: Wound of the right heel . wound size: 9 x 4.5 x 0.3cm . Recommendations: off-load wound; turn side to side and front to back in bed every 1-2 hours . Record review of CR#2's wound care physician notes dated 1/25/22 read in part, Site 1: Stage 4 Pressure wound sacrum . wound size (L x W x D): 6 x 11.5 x 0.2 cm . Wound progress: Deteriorated . Site 2: Wound of the right heel . Wound size 8 x 7.5 x 0.3 cm . Site 3: Venous wound of right calf . Wound size: 11.5 x 3.9 x 0.4 cm . Plan of care: .Goal for this wound is healing as evidenced by a decrease in surface area . Site 4: Venous wound of the left calf . Wound size: 12 x 0.4 cm . Site 5: Arterial Wound of the left, lateral ankle . Wound size 3 x 3 cm . Site 6: Unstageable DTI of the left heel . Wound size: 8 x 7 cm . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#2's nursing notes did not indicate any wound care treatment being completed for CR#2 between 1/28/22 and 2/1/22. In an interview on 2/7/22 at 3:21 PM, WCN A stated when residents went to the COVID unit, she ended her treatment with them and the nurse on the unit would take care of those resident's treatments. She stated the nurses on the COVID unit were to complete the weekly skin assessments and also the daily wound care treatments. In an interview on 2/16/22 at 1:00 PM, LVN K stated she worked with CR#2 for a short time. She stated she would provide a dressing change to her bottom as needed. She stated she was on her hall for quarantine and only worked with her for about five days and then she transferred back to her normal floor. In an interview on 2/18/22 at 1:20 PM, the DON stated she was not familiar with CR #1 or CR#2 as she recently returned to the facility from a leave of absence. She stated all she recalls from recent conversations is CR#1 had a blister on her buttock that burst, and the wound doctor placed the resident on antibiotics. She stated she was aware that CR#2 was also followed by the wound doctor. In an interview on 2/18/22 at 3:19 PM, WCN A stated she stopped treating CR #2 when she went to the isolation unit on 1/21/22. She stated at that time, she only had a wound on her sacral area, which was considered a trauma wound, due to her constantly scooting in her wheelchair and a wound on her heel. She stated the wound on her sacral area was considered a shear wound, due to it being like a scrap on her bottom, but it was not open. In an interview on 2/22/22 at 2:35 PM, WCN B stated she treated CR#2 and she had a sacral wound and a heel wound but was unable to recall location of which heel wound she had. She stated CR#2 sacral wound had granulated tissues and was starting to heel. She stated she was unable to recall the wound stage. In an interview on 2/27/22 at 5:53 AM, CNA G stated she worked with CR#2 a couple of times and she had skin breakdown. She stated the wound care nurse was treating the wound. She stated if a dressing was needed to be changed, she would notify the nurse or treatment nurse. In an interview on 2/28/22 at 12:50 PM, the Nurse Practitioner for CR#2 stated she worked with CR#2 often and was aware that she had compromised skin. She stated the nurses and wound doctor treated CR#2's wounds until she went out to the hospital on 2/1/22. She stated she was not aware of any deterioration of CR#2's wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Skin Integrity Monitoring System policy dated 12/2017 read in part, A system will be in place to assure that all resident will be assessed and monitored for an type of skin breakdown . residents will be assessed and preventative measure will be in place to prevent the development of pressure injuries . A system will be in place to assure any type of skin conditions that do not constitute pressure injuries, will be monitored closely for any type of complications . All residents will be assessed weekly . Assessments will be done for any type of skin integrity complications . this will include pressure injury and non-pressure related complications . Pressure Injury Stages: A) Deep Tissue Injury . This injury results from intenst and/or prolonged pressure an d shear forces at the bone-muscle interface . B) Unstageable: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer . Goals: 1) Prevent the development of pressure injury by performing routine skin and risk assessments on all residents . 2) Accurately identifying existing tissue destruction and optimize healing by utilizing consistent treatment . An Immediate Jeopardy (IJ) was identified on on 2/24/22 at 4:00PM, due to the above failures. The Administrator was notified of the IJ and the IJ template was provided on 2/24/22 at 4:05 PM. The Plan of Removal was accepted on 2/25/22 at 3:48 PM, and indicated the following: Plan of Removal Spring Branch Transitional Care Center February 25, 2022 Immediate Action: 1) Regional RN Nurse Consultant is in the process of training all nurses on correct method of conducting a comprehensive skin assessment (Training started at 7pm on 2/24/22 and was continued on morning of 2/25/22 to include night shift and morning nurses) No charge nurse will be allowed to work until training is completed. PRN nurses also will be required to have training prior to working. Process of examining entire skin for abnormalities Requires looking at and touching skin from head to toe Identifying any pressure injuries, other lesions or skin related factors that predispose the resident to develop pressure injury 2) Nurses are being instructed on standard protocol for skin assessments including the 5 parameters of the comprehensive skin assessment. Temperature Turgor Color (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Moisture level Skin integrity: skin intact, open areas rashes, etc. Identifying the signs and symptoms of wound infections (nurses were given a copy) Any wound infection or newly identified wounds will be documented in real time. The QAPI committee met 2/25/22 at 11:30 am to discuss the plan of removal and items that are Being put in place. The Physician participated via phone. The root cause has been determined and is part of the QAPI process. Completion Date: February 25, 2022 3) 100% skin audit of all (180) residents has been completed (2/24/22) conducted by nurses (ADON, Wound nurse, Charge nurses, MDS nurses, and unit managers) after they completed the training on how to conduct a comprehensive skin assessment. Skin audit was done by ADON, Wound nurse, Charge nurses, MDS nurses, and unit managers. All nurses that participated in the skin audit were trained in the 7pm 2/24 training prior to conduction of the skin audit. All areas of concern have been documented in the clinical record, resident representatives have been notified. The primary care physicians were notified with orders received and implemented. Results of the skin audit : one resident was identified with a stage II and documentation was done , Dr notified, family notified and tx orders started. Pressure relieving mattress and more frequent turning has been implemented. Completion Date: February 25, 2022. 4) Regional RN Nurse Consultant, DON, ADON, MDS nurse, Treatment nurse are reviewing all findings of skin audits and are checking to ensure that all steps were taken including notifications, implementation of orders for treatments, and any pressure relieving devices used. completion Date: February 25, 2022. 5) All Nurse Aides have been trained by the Regional RN Nurse Consultant or designee on how to identify skin issues during ADL care and the process of documenting those findings. Training included: Turning in the ADL forms to the Charge nurse The charge nurse will sign the form and give a copy to the wound care nurse. Training will be provided to all nurse aides before they can provide ADL care to residents. Nurse aides will be trained on interventions to prevent worsening or development of pressure injuries. Training was started on 2/25/22 and aides will not work until training is done. Aides use the nurse aide Kardex at the nurse's station to identify interventions being used for residents with pressure injuries. Wound nurse and unit managers are responsible for ensuring all equipment for pressure relief is in good condition. Completion Date: February 25, 2022. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6) All Treatment Nurses have been trained on the appropriate steps to take whenever a skin issue is identified to ensure that the physician is notified immediately (not wait for the wound care doctor to make weekly rounds), orders are received and implemented, and that appropriate interventions are implemented, and care planned to prevent further issues. This training has been provided by the RN Nurse Consultant. Nurses have completed a posttest to ensure understanding and compliance. Signs of infection have been reviewed with all nurses. Completion Date: February 25, 2022 7) Wound care nurse for weekends identified as week-end supervisor (after training completed) and if week-end supervisor not available a PRN charge nurse (that has been trained will provide wound care so that all treatments will be done consistently when the main wound care nurse is not at the facility. The person has received all training from the Regional RN Nurse Consultant. The wound care nurse will provide treatments this weekend (2/26/22 and 2/27/22). Completion Date: February 25, 2022 8) 100% audit of resident Braden Scales was done, and high-risk residents identified. All high-risk residents for skin breakdown per the Braden Scale score have been care planned with effective interventions reviewed to ensure they are in place. This task will be completed by the Director of Nursing. Residents that scored for moderate risk have been reviewed and care plan updated as needed. Weekly skin assessments completed by charge nurse except for residents with pressure injuries. Charge nurses have been trained on providing treatments and notifying the wound nurse via phone and writing a referral form to wound nurse. Completion Date: February 25, 2022. 9) Regional RN Nurse Consultant has trained all nurses on how to appropriately care for a pressure injuries. The nurses have all been able to pass a post test and a treatment proficiency check off prior to actually performing wound care. Completion Date: February 25, 2022 Surveyor Monitored the plan of removal as follows: Interviews were started on 02/25/22 at 11:44 AM and continued through 02/27/22 at 7:40 AM with staff across all three shifts, including weekdays and weekends. The staff interviewed regarding the plan of removal: LVN E, CNA B, WCN C, LVN F, LVN G, CNA C, CNA D, LVN H, CNA E, CNA F, CNA G, RN I, RN J, Director of Nursing, LVN D, CNA A, Assistant Director of Nursing and CNA H. All staff interviewed verbalized adequate understanding of plan of removal training received for conducting comprehensive skin assessments, how to properly identify skin issues during ADL care, weekly skin assessments and how to appropriately care for pressure injuries. Record review of facility in-service [NAME] [TRUNCATED]

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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** 35963 Based on interview, observation and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 (Resident #14) of 8 residents reviewed for accidents and hazards. The facility failed to provide adequate supervision to ensure Resident #14 was not outside smoking unsupervised. This failure could affect residents by placing them at risk of harm, injury and death. Findings Included: Record review of Resident #14's Face Sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of: Dementia, Cerebral Infarction (stroke), Hyperlipidemia (elevated lipid levels) and Hypertension (high blood pressure). Record review of Resident #14's admission MDS dated [DATE] indicated a BIMS of 15 for cognitively intact. Further review of Resident #14's MDS indicated he required limited assistance with ADLS. Resident #14's MDS also indicated he had limited range of motion on one side of his upper and lower extremities. Record review of R#14's care plan dated 2/26/22 indicated he is a smoker and at risk for injury. Interventions included monitor R#14 when smoking to ensure safety. Record review of smoking safety evaluation dated 2/26/21 for Resident #14 indicated no was checked for decision making skills are reasonable and consistent. Observation and interview made on 2/27/22 at 6:02 AM, R#14 stated he comes out early by himself due to not wanting to be around the other residents. He stated he often comes out alone to avoid drama with other residents. Observation and interview made on 2/27/22 at 6:08 AM, CNA H came outside to the smoking area and asked R#14 why he was outside smoking alone. R#14 informed CNA H he comes out to smoke alone often. CNA H reminded R#14 about the safety of smoking supervised and R#14 stated he is always safe when he comes out to smoke. In an interview on 2/28/22 at 11:49 AM, LVN D stated she had three residents on her hall, including R#14 that are smokers and all need to be supervised while they smoke. She stated the residents smoking materials are kept behind the nurse's station. She stated the residents only get their cigarettes when they go down and smoke supervised. LVN D was unsure how R#14 got his smoking paraphernalia if he was smoking unattended. In an interview on 2/28/22 at 11:57 AM, R#14 stated one of the staff members gave him a cigarette to go smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt was made to speak with LVN L regarding providing R#14 the cigarettes, however phone call was not returned. In an interview on 2/28/22 at 1:40 PM, the DON stated residents are to be taken down at their allotted smoking time. She stated there has to be someone with the residents while they are smoking. She stated she believes there is one resident in the facility that was considered a safe smoker and did not need supervision. She stated a Safe Smoker means the resident is alert and oriented and can safely place the cigarettes in the area alone and they're not a danger to themselves. The DON stated the nurses are to complete a safe smoking assessment quarterly for the residents. She stated she was not able to recall but believes R#14 was the only safe smoker in the facility and that recently changed. Record review of the facility Smoking times indicated they were 9:30 AM, 1:30 PM, 3:30 PM and 6:30 PM. Record review of the facility undated smoking policy read in part, this facility shall establish and maintain safe resident smoking practices .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on observation, interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for * of *reviewed for care and services. The facility failed to ensure there was adequate staffing on the night shift (2/26/22) to meet the needs of 42 residents on hall 2-East and for 42 residents on hall 3-East . Only one CNA was on duty on the 10pm-6am shift on 3-West and no nurse was on duty for 10pm-6am shift on hall 2-East. The facility failed to ensure there was adequate staff on the night shift (2/26/22) to assist with ADLS for R#11. The facility failed to ensure adequate staff to assist residents with their smoke breaks. Residents #22 and R#23 stated they did not get their smoke break at 1:30 PM due to no staff to assist. This failure placed residents at risk of not having their needs met, wound development, falls, and serious harm in the event of an emergency. Findings include: Record review of daily staffing posting dated 2/26/22 indicated hall 3-east, 10pm-6am shift, was to have one licensed nurse and two CNA's. Record review of daily staffing posting dated 2/26/22 indicated hall 2-east, 10pm-6am shift, was to have one licensed nurse and two CNA's. Record review of R#11's face sheet indicated a [AGE] year-old-male who admitted to the facility on [DATE] on hall 3-East. His diagnosis included Chronic Obstructive Pulmonary Disease (obstructed airflow in the lungs), Hyperlipidemia (elevated lipid levels), Hypertension (elevated blood pressure) and Hemiplegia and hemiparesis (loss of strength in the body). Record review of R#11's quarterly MDS dated [DATE] indicated a BIMS score of 10, indicating moderate cognitive impairment. Further review of R#11's MDS indicated he required extensive assistance from staff for all ADLS. R#9 also had limited range of motion on one side of his upper and lower extremities. Record review of R#11's care plan dated 1/27/22 indicated R#11 is incontinent of bowel and bladder. Interventions include monitor for incontinence every 2 hours and PRN, change promptly and turn and reposition PRN. Further review of R#11's care plan indicated he required extensive assistance with ADLS. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R#11's care plan dated 12/22/21 indicated he was at risk for skin breakdown related to impaired mobility, left side weakness and CVA (Stroke). Interventions included monitor for incontinence every 2 hours and as needed, change promptly, and turn and reposition PRN. R#22 Record review of R#22's face sheet indicated a [AGE] year-old female who admitted on [DATE]. Her diagnosis include Dementia, muscle weakness, chronic obstructive pulmonary disease (limited air flow into the lungs), hypertension (elevated blood pressure) and hyperlipidemia (elevated lipid levels). Record review of R#22's quarterly MDS dated [DATE] indicated R#22's BIMS was 13, indicating she was cognitively intact. Further review of R#22's MDS indicated she required extensive assistance with ADLS. Record review of R#22's care plan dated 1/22/22 indicated R#22 was a smoker and at risk for injury. Interventions include perform smoking assessment, show designated smoking area, monitor smoking to assure safety and staff to supervise during smoking. R#23 Record review of R#23's face sheet indicated a [AGE] year-old female who admitted on [DATE]. Her diagnosis included muscle weakness, chronic obstructive pulmonary disease (limited air flow into the lungs), heart failure (heart muscles not pumping enough blood), anxiety disorder and dementia. Record review of R#23's quarterly MDS dated [DATE] indicated R#23's BIMS was 6, indicating she had severe cognitive impairment. Further review of R#23's MDS indicated she required supervision with ADLS. Record review of R#23's care plan dated 12/3/21 indicated R#23 was not care planned to be a smoker. Observation and interview on 2/26/22 at 3:17 PM, Resident #22 and R#23 were upset due to not having a smoke break since 9:30 AM. The residents stated they missed their smoke break at 1:30 PM due to being short of staff and not having assistance to go smoke. In an interview on 2/26/22 at 3:18 PM, LVN H stated he was not aware that the residents missed their smoke break as he just got to work at 2PM. He stated if residents miss their smoke break the staff will add in an extra smoke break to make up for the time that was missed. He stated he will have HA N take the residents to smoke. In an interview on 2/26/22 at 3:30 PM, Resident #22 stated HA N told them after the surveyor walked away she could not take them down right now due to staffing issues. Resident #22 stated she was informed they would have to wait until next smoke break. In an interview on 2/26/22 at 3:31 PM, HA N stated she was no longer able to assist with the smoke break due to the floor being short of CNAs and her having to watch the residents. (continued on next page)

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	675764	A. Building B. Wing	02/28/2022

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/26/22 at 3:33 PM, the administrator stated he will make sure the residents are taking their smoke breaks at the allotted times. He stated the HA's are able to assist with taking the residents down for their smoke break. In an observation and interview on 2/27/22 at 5:53 AM, CNA F and CNA G said there was no nurse on the floor at night for the 2 East hall. CNA F stated they were to reach out to the nurse on 2 [NAME] if there were any issues with the residents. CNA G stated they have 40 residents on their hall In an interview on 2/27/22 at 5:55 AM, LVN Mwas the nurse for 2 [NAME] hall, she stated she was not aware there was a not a nurse for 2 East hall. She stated she did not go over to the 2-east hall at all over the night shift. LVN M stated she had 31 residents on her hall. In an interview on 2/27/22 at 6:11 AM, LVN H stated when he came on shift, there was not a nurse to give report to. He stated he was not sure who had the keys to the medication cart. He stated he would go to each hall to see who had the keys to the nursing cart so that he could pass his medications. In an interview on 2/27/22 at 6:11 AM, RN J stated he was on the third floor all night and did not go to assist any other floors with anything. He stated he has 38 residents on his hall to assist. In an interview on 2/27/22 at 6:15 AM, RN I stated he did not go to any other floor while working overnight. He stated he was not aware that a nurse did not show up on any other floor. In an interview on 2/27/22 at 7:39 AM, the DON stated she thought that RN J was to go down and check on the residents on 2-east. She stated she was not aware that no nurse went onto the hall at all overnight. She stated she was not aware of who the nurse would be for the 2-east hall, but stated RN J was to go and check the hall periodically to ensure all residents safety. Observation on 2/27/22 at 6:31 AM of the staff sign-in sheet indicated no nurse name was written down for the 2-East hall. Observation and interview made on 2/27/22 at 8:45 AM, R#11 was yelling I need to be changed. Hello? I need to be changed. I am soaking wet. Surveyor entered the room and R#11 stated he was soiled and had not been changed all night. He stated he has been waiting for someone to assist him all night but was not able to get anyone. R#11's call light was not within reach for him to press for assistance. R#11 stated the last time he was changed was around 9PM yesterday (2/26/22). He stated he was not sure where the night CNA was. Interview on 2/27/22 at 8:47 AM, the ADON stated he was not sure why R#11 was not changed overnight, but he will go and assist for R#11. In an interview on 2/27/22 at 12:42 PM, LVN F stated when she looked at the schedule when no one showed up to relieve her from her shift, she noticed no one was on the schedule after her. She stated when she had to leave, she notified RN J, gave him report and the keys for the nursing cart. She stated she was not aware that no one came on the floor at all. She stated there was no medication that was to be passed overnight on the hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/28/22 at 2:39 PM, the Staffing Coordinator stated she was not on call this weekend and was not aware that a nurse did not work on 2-east. She stated the nurse from another unit was to come and assist if a nurse calls in and a replacement is not found. She stated the nurse will be notified at shift change by the outgoing nurse that they are leaving and will come to monitor the other hall. She stated on the weekend, the weekend supervisors are to cover the hall if no nurse is found.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 35963 Based on observation, interview and record review, the facility failed to ensure the daily nursing staffing was posted as required The facility did not post the daily staffing on 02/22/22 through 2/26/22 (5 days). The facility did not post the daily staffing for 2/28/22. This failure could place residents and visitors at risk of not having access to information regarding staffing data. Findings include: Observation made on 2/26/22 at 3:45 PM, revealed posted staffing by the sign in sheet was dated 2/22/22. Observation made 2/28/22 at 2:15 PM, revealed daily posted staffing was dated 2/27/22. In an interview on 2/26/22 at 3:50 PM, the DON stated she would get the posting updated. She stated the staffing coordinator completes the daily postings. In an interview on 2/28/22 at 2:39 PM, the Staffing Coordinator stated the supervisors are to place the facility postings on the units on the weekends. She stated the weekend supervisors are aware that they should replace the staffing to accurately reflect the staff in the building. She stated the posting should be replaced daily to provide visitors with the appropriate staffing.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public as evidenced by The facility failed to ensure: -room [ROOM NUMBER] had trash and food on the floor and under the bed. -The 300-hall smelled of urine, -The bathroom in room [ROOM NUMBER] had a broken toilet seat cover in the tub, -room [ROOM NUMBER] had dried feces smeared on the wall, -room [ROOM NUMBER] had old meat under the air conditioner and beside the residents TV stand and there was dried brown liquid that was on the floor and on the resident's walls. -Several rooms had names on the doors that was written on tongue depressor sticks, wrong names on the doors and some rooms with residents with no names on the doors. These failures could place the residents and staff at risk of living and working in an unsafe, unsanitary and uncomfortable environment. Findings included: Observation made on 2/8/22 at 9:40 AM, room [ROOM NUMBER] with food on the floor and under the bed. Observation made on 2/8/22 at 10:30 AM, the bathroom in room [ROOM NUMBER] with broke toilet seat cover in the shower. Observation made on 2/8/22 at 10:40 AM, the 300-hall smelled of urine. Observation made on 2/8/22 at 10:52 AM, room [ROOM NUMBER] with dried feces smeared on the wall. Observation made on 2/25/22 at 12:25 PM, room [ROOM NUMBER] with a dried brown liquid that was on the floor and on the residents' walls. There was also meat that was under the air conditioner and beside the resident's TV stand. Several observations made on 2/8/22 a 9:45 AM, 2/17/22 at 1:32 PM, 2/27/22 at 10 AM and 2/28/22 at 1:30 PM of residents' rooms that had no name tags, wrong residents' names on the doors or names that were written with tongue depressors and taped on the door. In an interview on 2/8/22 at 11:03 AM, Housekeeper A stated she comes arounds to clean the rooms around 3-4 times during her shift. She stated she pulls the trash and sweeps and mops the floors. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/8/22 at 10:55 AM, CNA X stated the feces on the wall in room [ROOM NUMBER] had been on the wall for about 3 days. She stated room [ROOM NUMBER] was not her assigned room, but she knows about it due to assisting staff with incontinent care in the room. She states she believed they were waiting for housekeeping to clean the room and the wall. In an interview on 2/8/22 at 10:58 AM, LVN K stated she sees the housekeepers come on the hall, but they mainly clean the corridor. She stated she is not aware of the cleaning schedule but knows that housekeeping does come to the hall. She stated she was not aware about the feces on the wall in room [ROOM NUMBER] but will get it taken care of. In an interview on 2/8/22 at 2:20 PM, the Administrator stated the facility does angel rounds to ensure resident satisfaction, but he is currently revamping the program. He stated housekeeping is something he is working on within the facility. He stated the nursing staff are to ensure trash is picked up and placed in the trashcan and housekeeping will empty it and sweep and mop. He stated if there is any feces or bodily fluids in the rooms, the nursing staff is responsible for cleaning it and housekeeping will come to disinfect the area. In an interview on 2/25/22 at 12:38 PM, the director of admissions stated the nurses are responsible for placing the name tags on the resident's doors and updating them accordingly. She stated medical records can also assist as needed. In an interview on 2/25/22 at 12:58 PM, CNA B stated the resident in 241 often throws her food if she does not want something. She stated room [ROOM NUMBER] was not assigned to her today, but she will get with housekeeping to assist with cleaning the room. In an interview on 2/27/22 at 12:38 PM, the Housekeeping Supervisor stated housekeepers clean daily, with a schedule of 7am-3pm and there is one housekeeper from 1pm-8pm. She stated if there is any bodily fluids on the floor or wall, the CNAs will clean off the bodily fluids and housekeeping will come and disinfect the area once they are made aware of the incident. She stated she was not aware of the condition in rooms 241, 336, or 332.