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	04/25/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 34463 Based on interview, observation and record review, the facility failed to ensure the resident's rights to be free from abuse and neglect for 5 (CR#2, Resident #3, Resident #4, Resident #5, Resident #6) of 13 residents reviewed for abuse and neglect. The facility failed to protect Resident #3 from sexual assault by CR#2 who had a history of sexually inappropriate behaviors. The facility failed to protect Resident #4, Resident #5 and Resident #6 from verbal and physical abuse by CR#2 who had a history of physical and verbal aggression. These failures resulted in an Immediate Jeopardy (IJ) situation, the Administrator was notified on 04/13/2022 at 3:55 PM. While the IJ was removed on 04/15/2022 at 4:09 PM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of pattern due to the need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for abuse and neglect. Findings included: 1. Record review of CR#2's face sheet revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with a diagnosis of localized swelling, mass and lump, major depressive disorder, dysphagia, restlessness and agitation, anxiety disorder, hypertension, hyperlipidemia, mood affective disorder, embolism and thrombosis, constipation, gout, end state renal disease, and pain. Record review of CR#2's MDS dated [DATE] revealed he had a BIMS of 11 which meant he had moderate impaired cognition. CR#2 had a physical and verbal behavior symptom towards others. Record review of CR#2's Care Plan dated 03/08/22 revealed CR#2 had behavioral symptoms of physical behavior towards others (e.g. hitting, kicking, pushing, scratching, abusing others sexually.) Staff are were supposed to keep distance between CR#2 and others. Problem start date 3/6/22. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#2's Care Plan dated 2/18/22 revealed CR#2 resides on the secure unit for wandering, elopement risk, and need for controlled environment. Staff are were supposed to monitor every 2 hours and as needed. Problem start date 4/3/21. Record review of CR#2's Care Plan dated 02/18/22 revealed CR#2 has socially inappropriate disruptive behavioral symptoms as evidence by: puts fingers in his rectum and digs out feces and smears it on floor, masturbates in dialysis center, throws self on floor, (updated 4/19/21) has sexually inappropriate behavior, continues to masturbate in other female residents room. Staff are to place CR#2 in a specifically designed area, redirect CR#2, get psych consult and escort to all appointments to dialysis. Problem start date 4/20/21. Record review of CR#2's Behavior Progress Notes dated 2/14/22 revealed Prior Psychiatric Disorder: major depressive disorder, anxiety, mood disorder, restlessness and agitation, dementia, hypersexual behaviors Note written by NP. Record review of Resident #3's face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of nutritional deficiency, muscle wasting atrophy, lack of coordination, anemia, nausea and vomiting, cough, shortness of breath, wheezing, anxiety disorder, constipation, pain, hypertension, hyperlipidemia, chronic viral hepatitis C, and dementia. Record review of Resident #3's MDS dated [DATE] revealed she did not have a BIMS. Resident #3 required supervision with bed mobility, transfers, and eating. Resident #3 required total dependence with dressing, toilet use, and personal hygiene. Observation and interview on 04/13/22 at 11:13 AM revealed Resident #3 was dressed, groomed, no visible signs of injury and Resident #3 was in a pleasant mood. Resident #3 presented as confused and was not able to answer interview questions regarding sexual assault on 04/06/22 involving CR#2. In an interview on 04/12/22 at 12:12 PM the Social Worker stated CR#2 was taken into custody by the police on 04/06/22. The facility will accept him back, but once out of jail but he will need to be on one-to-one monitoring. CR#2 was indicted by D.A. for aggravated sexual assault of a handicap person or senior. CR#2 had prior felonies, but he was not sure of the specific charges. CR#2 spend spent some time in prison. Resident #3 was bleeding, and the police took her undergarments and linen as evidence. CR#2 had a history of wandering and that was why he was on the secured floor. In an interview on 04/12/22 at 12:53 PM CNA A stated on 04/6/22 at approximately 6:20 pm she was doing rounds and went to check on Resident #3. She found CR#2 in his wheelchair in Resident #3's room next to her bed. CR#2 had his penis out and was rubbing on himself. His other hand was under Resident #3's dress. She screamed and asked him to stop. She moved the dress back and CR#2 swung at her. CMA P heard her scream and came into the room. CR#2 started cursing at staff. She saw blood on his fingers. CR#2 went to his room and washed his hands. When they checked Resident #3, she had blood coming from her vagina. Resident #3 was taken to the hospital. The last time she saw CR#2 before the incident was in the morning before dialysis. She was not sure when he returned from dialysis. She may have been assisting other residents when CR#2 returned. CR#2 was smart, and staff needed to keep an eye on him at all times to make sure he did not hit other residents on the unit. CR#2 had a history of slapping other residents on the unit and attacking staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/12/22 at 1:15 PM CMA P stated on 04/06/22 she saw CR#2 next to Resident #3's room prior to CNA A finding him in the room sexually assaulting Resident #3. She told CR#2 not to go into Resident #3's room. She had to deal with another situation with a different resident. When she returned to pass medications, she noticed CR#2's water bottle was on the dining room table. Staff were involved in their normal routines checking and changing residents. She heard a scream from Resident #3's room. When she went into the room, she confronted CR#2 about what happened. CR#2 told her he did not do anything and to ask Resident #3 what happened. CR#2 said Resident #3 could not tell CMA P what happened anyway. CR#2 then stood up out of his wheelchair and smelled his fingers. He then told her he was a part of a gang and he could not go to jail. CNA A and another staff member noticed blood on Resident #3's vagina. Resident #3 was assessed by LVN Q. CR#2 returned from dialysis and went to the dining room to eat around 5:30 PM. CR#2 had a history of masturbating in female resident's rooms and in common areas such as the dining room. He will just sit in the dining room feeling on himself and looking at everyone around. Staff redirect him and he will start cursing out staff. Staff have to try and move other residents away from CR#2 because if they touch his wheelchair, he will hit them. CR#2 did not have any female residents he showed more attention to he would just masturbate around anyone. He would touch female staff inappropriately; they did not want to go to dialysis with him. CR#2 also masturbated in dialysis. Staff just try to redirect him and report the incident to the nurse. CR#2 would always brag about being in a gang and going to jail for selling drugs. CR#2 was very aggressive. She was told CR#2 was being admitted back to the facility on ce out of jail. In an interview on 04/12/22 at 2:29 PM LVN Q stated on 04/06/22 at approximately 6:30 PM, CNA A reported to him that what she witnessed CR#2 in Resident #3's room in his wheelchair with his hand under Resident #3's dress. CR#2 was escorted out of Resident #3's room. He assessed Resident #3 and took her vital signs which were within normal limits. CNA A reported Resident #3 was bleeding. He noticed blood coming from Resident #3 's vaginal area. He did a head-to-toe assessment. He contacted the Administrator, DON, and 911 was notified to send Resident #3 to the hospital per physician's order. The police arrived on the scene with EMS. CR#2 was placed on one to on supervision until taken into custody by the police. CR#2 denied the incident. LVN Q did not see any blood on his fingers. CR#2 usually returned from dialysis between 5pm and 6pm. He noticed CR#2 was in the dining room prior to the incident. He was not sure of any previous incidents with CR#2 he had just started working at the facility. Staff are trained to intervene and document incidents with residents. Record review of Resident #3's incident report dated 04/06/22 revealed Another male resident [CR#2] went into resident's room [Resident #3] and was witnessed sitting in his wheel chair with his penis out from his pants, rubbing on his penis with his hands under the dress of the female resident [Resident #3]. Upon assessment nurse observed blood stains on resident's vaginal area. Written by LVN Q. 2. Record review of Resident #4's face sheet revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with a diagnosis of bipolar disorder, seborrheic dermatitis, vascular dementia, anxiety disorder, Parkinson's disease, seizures, hypertension, schizophrenia, benign prostatic hyperplasia, and traumatic brain injury. Record review of Resident #4's MDS dated [DATE] revealed he had a BIMS of 10 which meant he had moderate impaired cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Incident Report dated 03/12/22 revealed CR#2 was in the dining room area and was upset due to other resident [Resident #4] attempted to take his food. CR#2 started yelling and slapped Resident #4 with an open hand to the right side of his face. Residents were separated and no injury noted. Observation and interview on 04/13/22 at 1:18 PM revealed Resident #4 was ambulating around the unit, resident dressed, groomed, no visible signs of injury. Resident stated he did not remember getting hit by anyone on the unit. He did not remember the incident on 03/12/22 with CR#2. In an interview on 04/12/22 at 2:04 PM LVN Y stated on 3/12/22 Resident #4 attempted to take food off CR#2's plate and he started yelling and slapped Resident #4. In an interview on 04/15/22 at 2:05 PM CMA N stated on 03/12/22 she was coming onto the secure unit from her break. She saw CR#2 stand up and hit Resident #4 in the face. The nurse aides were already in the area. CR#2 just smiled after redirection. CR#2 went to his room. The nurse was notified. After that the staff kept the residents separated. Resident #4 had reached for CR#2's drink. 3. Record review of Resident #5's face sheet revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with a diagnosis of dementia, extrapyramidal movement disorder, hypertension, seizures, restlessness and agitation, pain, major depressive disorder, mood affective disorder, anxiety, paranoid schizophrenia, hyperlipidemia, violent behavior, constipation, and insomnia. Record review of Resident #5's MDS dated [DATE] revealed he had a BIMS of 99 and was unable to complete the interview. Record review of Incident Report dated 03/29/22 revealed Resident [CR#2] was sitting on his wheelchair by the nurse station door. Another Resident [Resident #5] wanted to punch the code and CR#2 started telling to move out the way bitch. He stood up trying to punch the other resident [Resident #5] and they started to wrestle a little bit causing a scratch on his [CR#2's] right index finger. No other bruises or injuries noted. Observation and interview on 04/12/22 at 2:10 PM revealed Resident #5 was ambulating around the unit, resident dressed, groomed, and in a pleasant mood. Resident #5 did not provide a response to incident on 03/29/22 with CR#2. In an interview on 04/12/2022 at 2:45 PM LVN H stated on 03/29/22 Resident #5 was pushing the buttons to the keypad on the wall that by entrance to the unit. CR#2 was going to his room. CR#2 cursed and yelled at Resident #5 to get out the way. CR#2 got up out of his wheelchair and swung at Resident #5. They both were wrestling each other. Resident #5 will fight back if provoked. CR#2's hand as scratched. 4. Record review of Resident #6's face sheet revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with a diagnosis of schizophrenia, muscle weakness, pain, acute respiratory disorder, dementia, major depressive disorder, mood affective disorder, hypertension, and altered mental status. Record review of Resident #6's MDS dated [DATE] revealed Resident #6 did not have a BIMS. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Incident Report dated 02/01/22 revealed CR#2 noted to hit Resident #6 .outside resident room. This is unwitnessed incident. CR#2 stated I hit him The incident is unwitnessed Resident #6 noted bleeding tear to right ear. Observation and interview on 04/13/22 at 1:20 PM revealed Resident #6 was sitting in his wheel chair in his room, no visible signs of injury. Resident was not able to respond to questions regarding incident on 02/01/22 with CR#2. In an interview on 04/12/22 at 2:04 PM LVN Y stated on 02/01/22 CR#2 reported he hit Resident #6. Resident #6 wanders in other resident's rooms. In an interview on 04/12/22 at 2:12 PM HA A stated CR#2 had inappropriate behaviors. CR#2 would be would yell at other residents and hit other residents. CR#2 would tell staff he did not care, and he had been to prison in the past. HA A used to go with CR#2 to dialysis. He would masturbate while in the dialysis chair, she would tell him to stop and that was not the place for him to masturbate. CR#2 would curse out the dialysis staff as well. CR#2 would touch himself and masturbate in the dining room. Staff would just report this to the nurses, but she was not sure if it was being documented. In an interview on 04/12/22 at 2:16 PM LVN H stated she had been at the facility since October of 2021. CR#2 would curse out staff and liked to be defiant. She had not seen any sexual inappropriate behavior with him, but he did masturbate at dialysis. CR#2 had just moved to the 4th floor he may have had some incidents on the 3rd floor. CR#2 would make sexually inappropriate comments about how big his penis was during showers. In an interview on 04/12/22 at 4:17 PM CMA N stated she had never seen CR#2 touch a female resident but he would masturbate on the unit. He would make comments to staff like you have a big butt and come sit on my face. In an interview 04/12/22 at 4:21 PM LVN D stated CR#2 he had a history inappropriate sexual behavior. He would masturbate with his feces. Throw feces on the wall and at other people. CR#2 felt he was untouchable. He would throw feces on the wall from his butt and tell staff they must clean it up. He would go to the Behavior Hospital and come right back and act the same. CR#2 knew what he was doing. CR#2 did these things to get back at staff. He would go into other resident rooms and masturbate or in common areas. He would tell staff he went to prison before, and nobody could do anything to him. In an interview on 04/12/22 at 3:35 PM the DON stated CR#2 was being seen by psych services. The facility had increased supervision for all the residents on memory care unit and CR#2. They didn't have CR#2 on one-to-one monitoring. Staff are supposed to keep an eye on all the residents every 5-15 minutes to see where they are. The facility had a meeting on 2/7/22 and 3/7/22 with psych services to see about medication changes for CR#2 due to behaviors. In an interview on 04/12/22 at 3:57 PM the Administrator stated CR#2 was currently in jail. If CR#2 comes came back, he will would be placed on one-on-one monitoring. Resident #3 was moved to a lower floor. The facility would seek referral to an outside psych facility or seek alternative long-term placement. CR#2 plays with feces but has never crossed the line like this, staff try to keep him by himself. The facility moved CR#2 multiple times, tried to provide him with extra supervision, and sent him to psych facility for services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/13/22 at 11:04 AM the DON stated CR#2 was seen by psych services on 3/7/22 and 2/14/22. He was being seen by the NP for 2 months he was also being seen by someone else before then. CR#2 was on the secure unit for behaviors and risk for elopement. CR#2 was aggressive, plays with feces, shows his penis to staff members, hits staff and yells at them. CR#2 was different, and he was a challenge. They were going to kick him out of dialysis because of behaviors. Now staff have to go with him all the time. CR#2 was on increased supervision, they have a lot of residents that have behaviors on the secure unit. The hospitality aides are there at all times to monitor the residents. She tried to station people in position to monitor them, they have a lot of residents who walk around and wander into other rooms. Most of them are on medications. The facility tried activities to try and redirect them, but activities are not 24 hours a day. CR#2 will show his penis during care, but he had tried not to touch any other residents. The staff redirect him, the NP is aware, psych services are aware of this behaviors. In an interview on 04/13/22 at 12:12 PM the NP stated treatment for CR#2 was different due to him being a dialysis patient with renal failure. He couldn't use a broad spectrum of medications due to his end stage renal failure diagnosis and the effect it would have on his kidney's. There were many instances where CR#2 would not finish the dialysis treatment. He was a safety concerns for the staff that took him to dialysis. He was given an anxiety medication 30 minutes before dialysis. He was also prescribed a mood stabilizer. The goal was to slowly help episodes over time. He told administration CR#2 was a young man and he was not a good fit for the facility due to his previous lifestyle. He brought these issues up during the monthly meetings with the facility. He feels he was a drug kingpin. The NP considered putting CR#2 on hormonal therapy such as Depo-Provera but due to his age that would not work for him. That would not solve his impulses due to his age. These are CR#2's natural sexual tendencies and impulses. CR#2 may not have fully understood what he was doing. CR#2 thought that would get attention from his behaviors, but he was in the wrong environment. The facility contacted him after the incident on 4/6/22. CR#2 needed constant monitoring or 1:1 monitoring at all times to watch his every move, so he does not expose himself to other residents. It was alright for him to masturbate in private but not in other resident's rooms. In an interview on 04/13/22 at 3:12 PM the Administrator stated CR#2 was currently still in jail. He felt CR#2 was appropriate for the facility because none of his actions crossed this recent threshold. Staff did not document these other sexually inappropriate incidents they just redirected him since those were his behaviors. In an interview on 04/15/22 at 2:49 PM the Administrator stated he was the ANE Coordinator. It was important to prevent abuse, neglect, and exploitation because he was the advocate of the residents. It was important to make sure residents are safe and protected from possible harm. Record review of the facility police Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 04/2021 revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems 7. Implement measures to address factors that may lead to abusive situations 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator was notified of the Immediate Jeopardy on 03/02/2022 at 3:55 PM and the IJ template was provided. The Plan of Removal was accepted on 04/14/2022 at 12:27 PM and included the following: Plan of Removal Spring Branch Transitional Care April 13, 2022 Immediate action: 1) CR#1 will not be readmitted to the facility, they discharged [DATE]. All residents on the unit were assessed on 4/14/2022 by nursing management. Social services interviewed the same residents on 4/14/2022 2) All Staff will be in-service on abuse and neglect reporting before they can report to work. The in-service will address preventing and dealing with resident to resident aggression in dementia residents as well as verbal, physical, and sexual abuse. The in-service was initiated by the ADON and regional nurse on 4/13/2022 3) Resident #2 had a head to toe assessment today to ensure her injuries have resolved, by the charge nurse on 4/13/2022. 4) Incident reports are being reviewed for repeat altercations looking back over a 6 month period, by the DON and administrator on 4/13/2022. Residents identified will have interventions put in place to address their specific issues, including referral to psych services, room moves, fifteen minute checks for a specific period of time, or one on one. These interventions will be determined by the DON and administrator. This will be complete 4/14/2022, changes will be added to the care plan. 5) Residents will be reviewed to identify any resident with inappropriate sexual behaviors and physical altercations. Interventions reviewed and the care plans updated. This was initiated on 4/13/2022 and completed it 4/14/2022 by the DON and Administrator. A committee has been developed that will meet weekly to review resident behaviors. The Resident Behavior Committee will consist of the admin, DON, unit managers, Social Services, and MDS (or designees). The committee will review proactive measures that have been put in place. The staff are being trained in reporting escalations in behavior to report immediately to the DON and Administrator. This is included in the in-service on preventing and dealing with aggression in dementia residents initiated on 4/13/2022 and completed 4/14/2022. Topics include: contributing factors and triggers, proactive measures, immediate steps, management of inappropriate sexual behaviors, and what to do after an event. ADON and regional nurse have done the in-service. A protocol is part of the preventing and dealing with resident to resident aggression in dementia residents. 6) The abuse and neglect policies will be reviewed and revised if needed. The DON and regional nurse reviewed the policies 4/13/2022 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident Behavior Committee Review - The resident behavior committee will meet weekly to discuss and review incidents of resident-to-resident altercations. The committee will review interventions that have been put into place and determine if the interventions are appropriate, still working, or changes are needed . - ongoing Policy Review: Protocol for Enhanced Supervision for Residents with Behaviors form - dated 4/14/22 Resident to Resident Altercation Policy - dated 12/2016 Unmanageable Residents Policy - dated 4/2010 Investigating Incidents of Assault, Rape, or Other Violent Crime - dated 4/2021 Behavioral Assessment, Intervention and Monitoring - dated 3/2019 These failures resulted in an Immediate Jeopardy (IJ) situation, the Administrator was notified on 04/13/2022 at 3:55 PM. While the IJ was removed on 04/15/2022 at 4:09 PM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of pattern due to the need to complete in-service training and evaluate the effectiveness of the corrective systems.

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	04/25/2022

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 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** 35822 Based on observation, interview, and record review, the facility failed to ensure they had evidence that all alleged violations involving abuse were thoroughly investigated for 1 of 13 residents (CR #1) reviewed for abuse and neglect, in that: -The facility did not ensure that the allegation of neglect was thoroughly investigated when CR #1 was found unresponsive, not breathing, and no pulse. EMS arrived at the NF and pronounced CR #1 dead on arrival. -CR #1 had a laceration to his right forehead and discoloration of redness around his neck. This failure could place residents at risk for abuse and neglect that could lead to emotional distress, injury, or death. Findings include: Record review of the NF policy on Abuse, Neglect, Exploitation and Investigating revised [DATE] revealed in part: .All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies and thoroughly investigated by facility management .the administrator is responsible for determining what actions (if any) are needed for the protection of residents . Record review of CR #1's face sheet revealed a 68year old male admitted to the NF secure unit on [DATE] with the following diagnoses; dementia (the loss of memory and judgement) with behavioral disturbances, vitamin D deficiency, Hyperlipidemia (elevated cholesterol), heart disease, gastro-esophageal reflux disease, constipation, hypothyroidism (thyroid does not produce enough thyroid hormone), insomnia (sleep disorder), hypertension (high blood pressure), anxiety disorder, and Alzheimer's disease (a disease that destroys the memory and other mental functions). Record review of CR #1's MDS dated [DATE] revealed CR #1 BIMS score not scored indicating cognition level was severely impaired. CR #1's functional status revealed he required supervision in the following areas: bed mobility, ambulation, eating, and extensive assistance with dressing, toilet use, and personal hygiene. Further review revealed that CR #1 was always incontinent of urine and bowel. Record review of CR #1's Care Plan dated [DATE] revealed that CR # 1 was being care planned for advance directive having a guardianship and full code. Further review revealed that CR #1 was being care planned for impaired communication evidence by no speech, rarely/never understood. Record review of CR #1's Physician Orders dated [DATE] revealed CR #1 code status: FULL CODE. Further revealed that CR #1 had an order for Eliquis 2.5mg tablet to administer twice a day with an order date [DATE] for ischemic (lack of blood flow to the heart) heart disease. (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 #1's MAR for the month of [DATE] revealed that the NF was administering medications as prescribed by the physician. Record review of the NF self-report completed on [DATE] by the Administrator revealed the incident happened on [DATE] at 5:00a.m. The incident report revealed in part: .At about 4:00am on [DATE] LVN A performed a routine round and noted CR #1 resting in his room. At about 5:00am CNA C was doing routine rounds. When CNA C came to CR #1's room she noted he was nonresponsive. CNA C summoned the nurse and they transferred CR #1 to the floor to begin CPR. During transfer staff stated they bumped CR #1's head on the floor. This resulted in a laceration and bleeding. They began CPR and continued it until EMS arrived. EMS pronounced CR #1 deceased . The EMS staff pointed out the laceration and discoloration to CR #1's neck. LVN A noted that she had not seen the discoloration before. The police began their investigation and prepared CR #1 for the medical examiner office. CR #1's skin sheet was reviewed and no discolorations nor a laceration was noted .Based on the evidence, staff statements, and facts of the case it is unsubstantiated . Record review of CR #1's Nursing Notes on [DATE] documented by LVN-A revealed in part: . 5:20am CNA called this writer during her rounds that resident was not responsive to touch. On assessment respirations were not noted, without blood pressure, or pulse. A code blue called, and 3 other nurses came to start CPR and 911 called also at this time .at 5:30am 911 in facility and assessed, and took over CPR from staff .5:40am resident was pronounced dead .911 called the police . Interview on [DATE] at 9:08am the Administrator said CR #1 expired at the NF on [DATE]. The Administrator said initially CR #1 was found unresponsive by staff and the staff moved resident from bed to floor to perform CPR. The Administrator said he called the incident in to the state due to injuries of unknown origin of marks around CR #1's neck and a gash on the brow. The Administrator said the NF believed that in the process of transferring resident from bed to floor he incurred these injuries. The Administrator said LVN A was the nurse and did not know what CNA was working with LVN A. The Administrator said CR #1 had resided on 3-West and the time the incident happened on the morning shift. The Administrator said the NF was waiting on autopsy report. Interview [DATE] at 10:05am CR #1's legal guardian said the last time he saw CR#1 was on [DATE]th, 2022 and did not observed CR #1 with any injuries. The legal guardian said CR #1 was not coherent, never making eye contact, and walked around a lot with a history of wandering in other resident(s) room. The Legal Guardian said because he got information from a third person of the injuries to neck, he called it in to the state to rule out any suspicion of foul play in resident death. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview [DATE] at 11:20am via phone LVN A said she worked the 6p-6a shift and worked on [DATE] 3-West. LVN A said when she came to work at 6pm on [DATE], CR#1 was walking on the unit and could not provide the exact time when CR #1 had gone to bed. LVN A said she made rounds around 10:30pm or 11:00pm and CR #1 was in bed sleeping. LVN A said she made rounds again around 12:30pm but did not go in CR #1's room due to another resident was trying to leave the unit. LVN A said she could see from the hallway that CR #1 was in his bed. LVN A said CR #1 was known to sleep some during the night and sometimes would just get up and walk around. LVN A said she saw CR #1 in his room around 4:00am. LVN A said the CNA C went in CR #1's room at 4:00am and came out saying that Resident [NAME] was not responding. LVN A said she immediately went to CR #1's room. LVN A said she found CR #1 in bed not breathing and had no pulse. LN A said herself and CNA C transferred CR #1 from bed to floor, called the nurse from 3-East, and CPR was initiated. LVN A said it was herself and two CNA's working on 3-West on [DATE] on the night shift. LVN A said it was RN B that came to assist her when CR #1 was found unresponsive. LVN A said when she went in CR #1's room, she did not see any injuries on resident neck. LVN A said the injury to CR #1's head happen during transfer from bed to the floor when her and CNA C bumped CR #1 head on floor. LVN A said she could not remember the exact location of the injury but think it might have been above the left eye. LVN A said she never saw any injury (bruising) to resident neck until the police pointed it out to her. LVN A said when EMS arrived too the NF, they did not continue CPR on CR #1 because after they made their assessment, EMS said CR #1 jaw was stiff and therefore pronounced resident deceased . LVN A said EMS said CR #1 had been dead for approximately 20minutes. Interview on [DATE] at 7:35am via phone RN B said he worked at the NF on a PRN basis any shift. RN B said on Tuesday [DATE] he worked the 10p-6a shift on the 3-East. RN B said a resident of 3-West Secured Unit had come over to his unit and he was taking the resident back to 3-West. RN B said he was met by LVN A who looked like something had happen saying she had a CODE. RN B said LVN A told him that CR #1 had CODED and that she had called 911. RN B said when he arrived too CR #1's room, the crash cart was in the room. RN B said CR #1 was on the floor unresponsive, not breathing, and no pulse. RN B said he initiated CPR. RN B said the time was around 5:40am. RN B said he noticed that CR #1 had a laceration to his forehead but could not remember what side of the forehead. RN B said he had been performing CPR for about a minute when EMS arrived and took over. RN B said he went back to his unit. Interview on [DATE] at 10:20am with the Houston Police Department Homicide Division via phone said their investigation was ongoing due to having to speak with some other staff members at the NF and waiting on the autopsy report. The Detective said when he arrived at the NF, he found CR #1 with a gash to his right eyebrow and abrasions around his neck like someone had choked CR #1. The Detective said he spoke with the nurse on duty and was told that CR #1 resident was unresponsive. Interview on [DATE] at 12:25pm the DON said she received a call from the NF on [DATE] around 5:45am that CR #1 had CODED. The DON said by the time she made it to the NF, EMS had pronounced CR #1 expired. The DON said the Police was at the NF and had barricaded Resident [NAME] room off. The DON said the Police Department had taken a picture of CR #1's neck and on the picture CR #1 had had redness around neck like fading red marks. The DON said CR #1 was on a blood thinner and was wearing a hospital gown at the time of change in condition. The DON said she suspected that due to CR #1 wearing a gown, that it might have become snugged around his neck during transfer from the bed to the floor and therefore irritated his neck area. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview [DATE] at 9:45am via phone CNA C said she worked the 10p-6a shift on 3-West on [DATE]. CNA C said her first round on the residents was around 11:00pm. CNA C said at this time when she arrived too CR #1's room, he and his roommate was resting in bed. CNA C said after making rounds, she began to stock her linen. CNA C said she made her second round on the residents around 12:30am or 1:00am and CR #1 and his roommate remained resting in bed. CNA C said she checked CR #1 for incontinent care, and he was not incontinent. CNA C said she made her last round starting at 4:00am because she moved slow and made it to CR #1's room around 4:30am. CNA C said CR #1 roommate was up using the bathroom. CNA C said when she went to check on CR #1 to see if he was clean or required care, CR #1 did not respond. CNA C said she tried to arouse CR #1 by touching him, but he did not respond. CNA C said CR #1 body was warm to touch. CNA C said she step out in the hallway and called LVN A. CNA C said LVN A assessed CR #1 and said she could not get a pulse and CR #1 was not breathing. CNA C LVN A told her that they needed to transfer CR #1 the floor so that CPR could be started. CNA C said herself and LVN A transferred CR #1 from the bed to the floor. CNA C and during the transfer they bumped CR #1's forehead on the right side. CNA C said when they transferred CR # 1 to the floor it was then that LVN A began CPR by doing chest compressions and giving Resident [NAME] breaths using the ambu bag (self-inflated bag). CNA C said LVN A told her to go and call the nurses from the other units to come to assist. CNA C said LVN A came to the room to assist. CNA C said the other CNA working on 3-West on [DATE] on the night shift with her was CNA F. Interview [DATE] at 12:45pm via phone CNA F said she worked the 10p-6a shift on [DATE] on 3-West. CNA F said she was not assigned to CR #1 room but was making her last rounds on her residents when she was called by LVN A to come to CR #1's room. CNA F said when she got to the room, CR #1 was still in bed and she proceeded to help LVN A and ER CNA C in transferring CR #1 from bed to floor. CNA F said CR #1 was unresponsive, but his body felt warm like the change in his condition had just happened. CNA F said when they got CR #1's body on the floor, she noticed an injury to CR #1's right forehead and did not know if they had bumped CR #1's head on the bed or floor. CNA F said it was a lot of tension going on in trying to help CR #1 and could not remember the time. CNA F said LVN A began CPR on CR #1. CNA said she left the room because she was assisting another resident on the unit and did not want that resident to have a fall or accident. Further interview [DATE] at 1:30pm via phone RN B said he went over to 3-West to return a resident from 3-West that had wandered away. RN B the time was around 5:35am or 5:40am. RN B said LVN A was at the nurse station going through files and told him that she had a CODE. RN B said he was alone and went to CR #1's room and found CR #1 on the floor. RN B said he noticed a laceration to CR#1's forehead but could not remember what side. RN B said no one else was in the room and he immediately started CPR. RN B said the crash cart was in the room but did not see an AED machine. RN B said he had done CPR on Resident for 1 minute and by that time EMS had arrived and took over from there. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further interview [DATE] at 1:57pm via phone LVN A said she was called to CR #1's room around 5:00am or 5:15am by the CNA C. LVN A said when she entered the room of CR #1 resident was in the bed unresponsive, not breathing, and had no pulse. LVN A said her and two other CNA's transferred CR #1 to the floor. LVN A said she did not initiate CPR at this time. LVN A said she left the room to go and get the crash cart and too see what was CR#1's code status. LVN A said while she was at the nurse station, she saw RN B on the unit. LVN A said she told RN B she had a code. LVN A said RN B went to CR #1's room while she called 911 and then took the crash cart to the room. LVN A said RN B had initiated CPR and another nurse who was in training was there. [NAME] said she began to help with CPR by assisting with giving breaths. LVN A said an AED machine was never attached to CR #1 because there was none on the unit. LVN A [NAME] said she had been working on the secured unit of 3-West for 2 years and had never seen an AED machine on the unit. [NAME] said she had received CPR and had received in-service on CPR and using and AED machine. LVN A said she received these in-services and training at the NF but could not remember when. LVN A said she had been taught in her CPR class that when a person was found unresponsive, not breathing, and no pulse to not leave the person and start CPR immediately sending who else was around to go and get help. LVN A said the rationale to starting CPR immediately was to increase that person/resident chance for survival. LVN A said she panicked and should have never left CR #1 instead had the CNA's go and get help. Interview on [DATE] at 12:00pm the DON said when she spoke with LVN A, LVN A said she made rounds on the residents on 3-West around 4:00am on [DATE]. The DON said LVN A said around 5:00am or so, CNA F was making rounds and found CR #1 unresponsive and called LVN A too the room. The DON said from there LVN A took over the situation and called EMS and started CPR. The DON said other staff members came to assist. The DON said she did not speak with the CNA's on the unit that worked with LVN A on the night shift on [DATE]. The DON said she only spoke to LVN A and that LVN A painted the perfect picture of the code blue regarding CR #1 and how it was handled. The DON said LVN A said it was CNA F that had found CR #1 unresponsive and that it was CNA F and herself that transferred CR #1 from the bed to the floor when found unresponsive. Further interview with the DON on [DATE] at 12:00pm said when she spoke with RN B when the state was at the NF. The DON said after speaking with RN B, she noticed the times regarding CR #1's change in condition were off. The DON said another flag that went up besides the timing was CR #1's injuries of the gash to CR #1's right forehead. The DON said she thought the point of contact of CR #1's injury would have occurred at the back of resident head when the staff transferred CR #1 from the bed to the floor. Interview on [DATE] at 1:45pm the Administrator said he was the Abuse Coordinator. The Administrator said when he arrived at the NF on [DATE], he did not get to view CR #1's body. The Administrator said the Police Department was at the NF and had blocked off CR #1's room. The Administrator said he was told by the Police Department that CR #1 had a red mark around his neck area. The Administrator said CR #1 was on a blood thinner. The Administrator said he spoke with LVN A and CNA C who both shared that they had bumped CR #1's head during transfer from the bed to the floor. The Administrator did not say what the staff said they bumped CR #1's head on. The Administrator said he did not suspect any abuse.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observations, interview and record review, the facility failed to ensure that personnel provide basic life support including CPR, to a resident requiring such emergency care prior to the arrival of medical personnel and subject to related physician orders and the resident advance directive for 1 resident (CR #1) of 13 residents reviewed for quality of life. -The facility failed to train LVN A to immediately initiate CPR on CR #1 who was a full code on [DATE]. CPR was delayed when LVN A left CR #1 unresponsive with no pulse lying in his bed. - The facility LVN A failed to immediately start CPR and left CR#1 alone in his room after being found unresponsive. -The facility failed to train LVN A to immediately contact 911 for EMS services. -The facility staff failed to obtain and attach AED machine to CR#1 during CPR event. LVNs were not aware where AED was located. -The facility failed to have emergency supplies on 2 of 5 crash carts. The facility did not replace the crash cart with a new oxygen tank after CR#1 had CODED and expired on [DATE] until [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE] at 4:25 pm and the DON was notified. While the IJ was removed on [DATE] at 2:00 p.m. and the DON was notified, the facility remained out of compliance at a scope of isolated and a severity level of 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 affect residents that were full code and place them at risk of not being provided CPR in a timely manner at risk for death. Findings include: Record review of CR #1's face sheet revealed a [AGE] year old male admitted to the NF secure unit on [DATE] with the following diagnoses; dementia (the loss of memory and judgement) with behavioral disturbances, vitamin D deficiency, Hyperlipidemia (elevated cholesterol), heart disease, gastro-esophageal reflux disease, constipation, hypothyroidism (thyroid does not produce enough thyroid hormone), insomnia (sleep disorder), hypertension (high blood pressure), anxiety disorder, and Alzheimer's disease (a disease that destroys the memory and other mental functions). Record review of CR #1's MDS dated [DATE] revealed CR #1 BIMS score not scored indicating cognition level was severely impaired. CR #1's functional status revealed he required supervision in the following areas: bed mobility, ambulation, eating, and extensive assistance with dressing, toilet use, and personal hygiene. Further review revealed that CR #1 was always incontinent of urine and bowel. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's Care Plan dated [DATE] that CR # 1 was being care planned for advance directive having a guardianship and full code. Further review revealed that CR #1 was being care planned for impaired communication evidence by no speech, rarely/never understood. Record review of CR #1's Physician Orders dated [DATE] revealed CR #1 code status: FULL CODE. Record review of CR #1's Nursing Notes on [DATE] documented by LVN-A revealed in part: . 5:20am CNA called this writer during her rounds that resident was not responsive to touch. On assessment respirations were not noted, without blood pressure, or pulse. A code blue called, and 3 other nurses came to start CPR and 911 called also at this time .at 5:30am 911 in facility and assessed, and took over CPR from staff .5:40am resident was pronounced dead .911 called the police . Interview on [DATE] at 11:03am LVN D said she worked 6a-6p shift Monday-Friday. LVN D said CR #1 use to reside on 3-West. LVN D said the last time she saw CR #1 was on [DATE] and he was fine. LVN D said CR#1 walked all the time on the Secured Unit throughout the day and did not go to bed until nighttime. LVN D said CR #1 wandered a lot because he was confused and was total care for everything even with feedings which was the only time he sat down to eat and drink. LVN D said when she returned to work on [DATE] on the Secured Unit, the police were on the unit and had CR #1 barricaded off. LVN D said the nurse on duty for the night shift [DATE] 6p-6a was LVN A. Interview [DATE] at 11:20am via phone LVN A said she worked the 6p-6a shift and worked on [DATE] 3-West in the Secured Unit. LVN A said when she came to work at 6pm on [DATE], CR#1 was walking on the unit and could not provide the exact time when CR #1 had gone to bed. LVN A said she made rounds around 10:30pm or 11:00pm and CR #1 was in bed sleeping. LVN A said she made rounds again around 12:30pm but did not go in CR #1's room due to another resident was trying to leave the unit. LVN A said she could see from the hallway that CR #1 was in his bed. LVN A said CR #1 was known to sleep some during the night and sometimes he would just get up and walk around. LVN A said she saw CR #1 in his room around 4:00am. LVN A said the CNA C went in CR #1's room at 4:00am and came out saying that CR #1 was not responding. LVN A said she immediately went to CR #1's room. LVN A said she found CR #1 in bed not breathing and had no pulse. LN A said herself and CNA C transferred CR #1 from the bed to the floor, called the nurse from 3-East, and CPR was initiated. LVN A said it was herself and two CNA's working on 3-West on [DATE] on the night shift. LVN A said it was RN B that came to assist her when CR #1 was found unresponsive. LVN A said when she went in CR #1's room, she did not see any injuries on resident neck. LVN A said the injury to CR #1's head happened during transfer from the bed to the floor when her and CNA C bumped CR #1 head on the floor. LVN A said she could not remember the exact location of the injury but thought it might have been above the left eye. LVN A said she never saw any injury (bruising) to the resident's neck until the police pointed it out to her. LVN A said when EMS arrived too the NF, they did not continue CPR on CR #1 because after they made their assessment, EMS said CR #1's jaw was stiff and therefore they pronounced the resident deceased . LVN A said EMS said CR #1 had been dead for approximately 20 minutes. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:35am via phone RN B said he worked at the NF on a PRN basis any shift. RN B said on Tuesday [DATE] he worked the 10p-6a shift on the 3-East. RN B said a resident of 3-West LVN A unit 3-West had come over to his unit and he was taking the resident back to 3-West. RN B said he was met by LVN A who looked like something had happen saying she had a CODE (critical status of a resident or patient). RN B said LVN A told him that CR #1 had CODED and that she had called 911. RN B said when he arrived too CR #1's room, the crash cart was in the room. RN B said CR #1 was on the floor unresponsive, not breathing, and no pulse. RN B said he initiated CPR. RN B said the time was around 5:40am. RN B said he noticed that CR #1 had a laceration to his forehead but could not remember what side of the forehead. RN B said he had been performing CPR for about a minute when EMS arrived and took over. RN B said he went back to his unit. Interview on [DATE] at 12:25pm the DON said she received a call from the NF on [DATE] around 5:45am that CR #1 had CODED. The DON said by the time she made it to the NF, EMS had pronounced Resident CR #1 expired. The DON said the Police was at the NF and had barricaded Resident CR #1's room off. Interview [DATE] at 9:45am via phone CNA C said she worked the 10p-6a shift on 3-West on [DATE]. CNA C said her first round on the residents was around 11:00pm. CNA C said at this time when she arrived too CR #1's room, he and his roommate was resting in bed. CNA C said after making rounds, she began to stock her linen. CNA C said she made her second round on the residents around 12:30am or 1:00am and CR #1 and his roommate remained resting in bed. CNA C said she checked CR #1 for incontinent care, and he was not incontinent. CNA C said she made her last round starting at 4:00am because she moved slow and made it to CR #1's room around 4:30am. CNA C said CR #1 roommate was up using the bathroom. CNA C said when she went to check on CR #1 to see if he was clean or required care, CR #1 did not respond. CNA C said she tried to arouse CR #1 by touching him, but he did not respond. CNA C said CR #1 body was warm to touch. CNA C said she stepped out in the hallway and called LVN A. CNA C said LVN A assessed CR #1 and said she could not get a pulse and CR #1 was not breathing. CNA C said LVN A told her that they needed to transfer CR #1 the floor so that CPR could be started. CNA C said herself and LVN A transferred CR #1 from the bed to the floor. CNA C said during the transfer they bumped CR #1's forehead on the right side. CNA C said when they transferred CR # 1 to the floor it was then that LVN A began CPR by doing chest compressions and giving Resident CR #1 breaths using the ambu bag, (self-inflating bag), and providing CR #1 oxygen. CNA C said LVN A told her to go and call the nurses from the other units to come to assist. CNA C said LVN A came to the room to assist with providing oxygen to CR #1. CNA C said the other CNA working on 3-West in the Secured Unit on [DATE] on the night shift with her was CNA F. Interview on [DATE] at 12:37pm via phone LVN E said she worked on [DATE] 10p-6a shift on 4-East. LVN E said it was after 5:00am around 5:30am she received a call from LVN A saying she had a CODE. LVN E said when she got to CR #1's room, there were two nurses (RN B and LVN XX who was in training) performing CPR on CR #1. LVN E said she noticed on the right side of CR #1's forehead a bruise like contusion. LVN E said she did not see an AED machine (Automatic External Defibrillator) connected to CR #1. LVN E said LVN A was at the nurse station on the phone and trying to gather documents. LVN E said she went downstairs to direct EMS to CR #1's room. (continued on next page)

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	675764	A. Building B. Wing	04/25/2022

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview [DATE] at 12:45pm via phone CNA F said she worked the 10p-6a shift on [DATE] on 3-West. CNA F said she worked the Secured Unit but was not assigned to CR #1 room. CNA F said she was making her last rounds on her residents when she was called by LVN A to come to CR #1's room. CNA F said when she got to the room, CR #1 was still in bed and she proceeded to help LVN A and ER CNA C in transferring CR #1 from bed to floor. CNA F said CR #1 was unresponsive, but his body felt warm like the change in his condition had just happened. CNA F said when they got CR #1's body on the floor, she noticed an injury to CR #1's right forehead and did not know if they had bumped CR #1's head on the bed or floor. CNA F said in the process of trying to help CR #1 she could not remember the time. CNA F said LVN A began CPR on CR #1 but did not share that an AED machine was in CR #1's room . CNA F said she left the room because she was assisting another resident on the unit and did not want that resident to have a fall or accident. Further interview with the DON on [DATE] at 1:24pm, the DON said when a resident CODE's (not breathing and no pulse), CPR is initiated right away and 911 is called. The DON said the NF had AED machines and should be placed on a resident during CPR. The DON said the staff had not placed on the AED machine on CR #1 because EMS arrived shortly after CPR had been initiated. Further interview [DATE] at 1:30pm via phone RN B said he went over to 3-West to return a resident from 3-West that had wandered away. RN B said the time was around 5:35am or 5:40am. RN B said LVN A was at the nurse station going through files and told him that she had a CODE. RN B said he was alone and went to CR #1's room and found CR #1 on the floor. RN B said he noticed a laceration to CR #1's forehead but could not remember what side. RN B said no one else was in the room and he immediately started CPR. RN B said the crash cart was in the room but did not see an AED machine. RN B said he had done CPR on the Resident for 1 minute and by that time EMS had arrived and took over from there. Further interview [DATE] at 1:57pm via phone LVN A said she was called to CR #1's room around 5:00am or 5:15am by the CNA C. LVN A said when she entered the room of CR #1, the resident was in the bed unresponsive, not breathing, and had no pulse. LVN A said her and two other CNA's transferred CR #1 to the floor. LVN A said she did not initiate CPR at that time. LVN A said she left the room to go and get the crash cart and to see what was CR#1's code status. LVN A said while she was at the nurse station, she saw RN B on the unit. LVN A said she told RN B she had a code. LVN A said RN B went to CR #1's room while she called 911 and then took the crash cart to the room. LVN A said RN B had initiated CPR and another nurse who was in training was there. LVN A said she began to help with CPR by assisting with giving breaths. LVN A said an AED machine was never attached to CR #1 because there was none on the unit. LVN A said she had been working on the secured unit of 3-West for 2 years and had never seen an AED machine on the unit. LVN A said she had received CPR training and had received in-service on CPR and using the AED machine. LVN A said she received these in-services and training at the NF but could not remember when. LVN A said she had been taught in her CPR class that when a person was found unresponsive, not breathing, and no pulse to not leave the person and start CPR immediately sending who else was around to go and get help. LVN A said the rationale to starting CPR immediately was to increase that person/resident chance for survival. LVN A said she panicked and should have never left CR #1 instead had the CNA's go and get help. In an interview on [DATE] at 1:58 PM LVN D stated the AED machine was on the 2nd floor and the 1st floor. Staff can walk downstairs to get the machine. LVN D was not aware the AED machine was on the 3rd Floor East Wing. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 2:01 PM on 3rd floor [NAME] revealed the crash cart did not have an AMBU bag, the O2 tank was in the red signifying an empty tank, the gauge on the suction machine was missing a needle and the glass/plastic cover was broken. In an interview on [DATE] at 2:03 PM LVN D stated the suction machine still worked. They needed to replace the O2 tank. The night nurses sign off on the Emergency Cart Checklist. In an interview on [DATE] at 2:04 PM the ADON stated the night nurses sign off on the crash cart check list and check cart. The O2 tank was used previously and hadn't been replaced this morning. Observation on [DATE] at 2:15 PM on 3rd Floor East revealed the crash cart was missing O2 tank, humidifier bottles. In an interview on [DATE] at 2:16 PM LVN W stated she used the O2 tank this morning for another. She had not got a chance to replace the O2 tank because she got busy. In an interview on [DATE] at 5:27 PM LVN W stated she was the unit manager for 3rd Floor East. The Unit Manager checks the AED machine and Crash cart weekly. The night nursing staff are supposed to check daily. If the staff cannot get the items at night, they are supposed to replace what was missing in morning. The ADON was trying to take up the slack for the 3rd Floor West. They do not have a unit manager. Observation on [DATE] at 3:10pm was made of the Central Supply staff leaving 3-West with an empty oxygen tank and dusty suction machine. Interview on [DATE] at 3:10pm Central Supply said he was called to come and get the empty oxygen tank off 3-West along with the suction machine. Central Supply said he only replaced equipment on the units when notified to do so. Further interview [DATE] at 3:15pm LVN D said the crash cart was checked on the 10p-6a shift checking to make sure the oxygen tank had oxygen inside of it, Oxygen and suctioning tubing along with suction machine, etc. LVN D said a few days ago 3-West had a challenge with one of the residents coding. LVN D confirmed that the resident that had coded was CR #1. LVN D said all the oxygen in the tank had been used and that Central Supply had just delivered a new Oxygen tank. LVN D said she think the nurse forgot to replace the empty Oxygen tank. LVN D said the AED machine was kept on 3-East. LVN D said Central Supply had just delivered a new suction machine as well because the gauge was broken on the previous suction machine, but it still worked. LVN D said whenever there was a CODE, it was the person who used anything off the cart to replace what was used by filling out a form and notifying Central Supply Department to restock the item used. LVN D said each unit had their own crash cart and that the AED machines could be located on 2,3rd, and 4th floor on the east side. LVN D said an AED machine was also on the 1st floor near the Administrators office. LVN D said she had received CPR/CODE BLUE training at the NF. LVN D said when a resident is was found unresponsive, not breathing and with no pulse, the resident should never be left alone instead, start CPR immediately to increase their chances of surviving. LVN D said that was why CPR is started immediately and not stopped until EMS arrives on the scene. LVN D said the AED should be attached to the resident when the resident was not responding to CPR (no pulse or pulse is very faint). (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 3:48pm DON said AED machines could be located in the NF on 2, 3rd, and 4th floors. The DON said the Unit Managers check the crash carts once a week and the 10p-6a shift check the crash carts if the cart had been used. The DON said it was everyone's responsibility to stock the crash cart when used especially the nurse involved in the CODE ensuring that all items had been replaced that were used in a code blue. The DON said when a resident is found with no pulse, not breathing, the resident should not be left alone, send someone for help, and CPR should be started immediately to try and restart the heart and get blood circulating to increase the resident chance of survival. In an interview on [DATE] at 12:48 PM the ADON stated he tried to check the crash cart on the 3rd Floor [NAME] since they did not have a Unit Manager. He did not check them as much as he should. Record review of the NF Policy on Emergency Procedure -Cardiopulmonary Resuscitation revealed in part: .The chances of surviving sudden cardiac arrest may be increased if CPR is initiated immediately upon collapse . If an individual is found unresponsive and not breathing normally a licensed staff member who is certified in CPR/BLS shall initiate CPR .if the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order-certified staff member arrives . An Immediate Jeopardy (IJ) was identified on [DATE] at 2:45PM, due to the above failures. The DON was notified of the IJ and the IJ template was provided on [DATE] at 2:45 PM and a Plan of Removal was requested. The Plan of Removal was accepted on [DATE] at 11:26 a.m. and included: PLAN OF REMOVAL Name of facility: Spring Branch Transitional Care Center Date:[DATE] Immediate Action: 1) All nurses and cnas will be inserviced on the CPR policy to include the safe transfer of residents from the bed to the floor and protecting them from injury. This will entail verifying code status and immediately beginning CPR on full code residents while another staff member calls 911. The CNAs will be inserviced on their responsibilities during a code This inservice will be done before staff being their work shift. This inservice will be completed by the DON or designee, complete [DATE]. CPR inservice included notifying EMS (911) as soon as a code is called, a staff member will be instructed by the charge nurse to call 911. A timeline with all actions and events will be given to EMS upon Arrival. Timeline will be given to EMS verbally by the charge nurse, if time permits information will be written on the transfer form and sent with EMS. Nurses will be checked off on CPR competency. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 1:45 revealed an AED machines on each floor on the east side with one in the PT room. Interview on [DATE] at 1:48pm CNA I said she worked the 6am-2pm shift on 2-West. CNA I said she had been in-serviced on transferring and repositioning residents, CPR, the location of the AED machines in the NF, calling 911 in the event of a code blue, assisting and communicating with the nurse in a code blue or change in a resident condition, and replacing items that were taken from the crash cart. Interview on [DATE] at 1:55pm CNA J said she worked the 6am-2pm shift on 2-East. CNA J said she had been in-serviced in the following areas: transferring residents, CPR assisting the nurse in a code blue. Interview on [DATE] at CNA K said she worked on 3-East 6pm-6am but was working today 2pm-10pm. CNA K said she had been in-serviced on helping restock the crash cart after a code blue, assisting the nurse during a code blue, where the AED machines were located at in the NF. Interview on [DATE] at 2:15pm CMA L said she had been in-serviced on CPR/AED machines, assisting the nurse in a code blue, calling 911. CMA L said she worked 6am-2pm Monday through Wednesday. Interview on [DATE] at 2:18pm LVN M said she worked 3-East 6am-10pm on the weekends. LVN M said she had been in-serviced on CPR if a resident was found unresponsive, not breathing, and no pulse to not leave the resident but to send someone to call 911 and help, bring the crash cart along with AED machine, and the resident chart to check code status. LVN M said she had also been in-serviced on replacing items used on the crash cart. LVN M said during a code blue a recorder had to be designated so that the information regarding the timeline of events could be provided to EMS upon arrival. Interview on [DATE] at 2:22pm CMA N said she had been in-serviced on CPR, AED machine and the location of the AED machines in the NF. Interview on [DATE] at 2:28pm CNA O said she worked 3-East 2pm-10pm and been in-serviced on AED machines, CPR, transferring residents, and assisting the nurse in a code blue. Interview on [DATE] CMA P working 3-West said she worked 6am-8pm. CMA P said she had been in-serviced on CPR and assisting in code blue calling 911, AED machine, restocking the crash cart when used in an emergency. CMA P said if the crash cart was used during a code blue it would be replaced with a fully stocked crash cart. Interview on [DATE] at 2:40pm LVN Q working 3-West on the 2pm-10pm shift said he had been in-serviced on CPR, calling 911 services, and delegating staff to do certain roles in a code blue, never leaving the resident with the importance of initiating CPR immediately when a resident is found not breathing and no pulse. LVN Q said he had also been in-serviced on the locations of the AED machines in the NF, checking the crash cart each shift, restocking the crash cart when an item is taken from the crash cart, and replacing the crash cart with a fully stocked cart after a code blue. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:48pm LVN R working on 4-East said she had been in-serviced on the locations of the AED machines, CPR, being aware of the resident's code status, checking the crash cart every shift making sure all emergency supplies were on the cart, in a code blue to delegate staff with a role including a designator to be the recorder to provide the EMS a timeline of events of the code blue. Interview on [DATE] at 2:55pm LVN S said he was the weekend supervisor for the 6am-2pm shift. LVN S said he had received in-services in the following areas: CPR, AED machine, crash cart. Interview on [DATE] at 3:00pm CNA T said she worked the 6a-2pm shift on 4-East. CNA T said she had been in-serviced on CPR, AED machine, and assisting the nurse in a code blue. Interview on [DATE] at 8:09pm said she had not been a work and was scheduled to return on [DATE] on the night shift 10pm-6am shift and would be receiving her in-service prior to reporting to work. Interview on [DATE] at 6:34am RN B said he mostly worked PRN on the night shift. RN B said he had been in-serviced on performing CPR when a resident is found unresponsive, not breathing, and no pulse to never leave the resident instead call for help and immediately start CPR. RN B said he had been in-serviced on checking the crash cart each shift, locations of the AED machine, and assigning someone to record the events in a code blue to provide for EMS. Interview on [DATE] at 6:47am RN U said he normally worked the 2pm-10pm shift but also worked other shifts. RN U said he had been in-serviced on CPR, crash cart, and AED machines. Interview on [DATE] at 8:43am LVN V said she had been in-serviced on code blue, crash cart, and AED machines. LVN V said she worked the 10pm-6am shift. Interview on [DATE] at 11:00am LVN W said she worked the 6am-2pm shift on 3-East. LVN W said she had been in-serviced on CPR, crash cart, and AED machines. Interview on [DATE] at 11:05am CNA X said she had been in-serviced on the 4 AED machines that were in the NF, assisting the nurse in a code blue, and transferring a resident. Observation on [DATE] at 11:10am observations were made of crash carts on all floors (2, 3, and 4) with no concerns identified. Interview on [DATE] at 11:20am LVN Y said she worked the day shift and had been in-serviced on CODE blues and designating staff to assist with the code, and the crash carts. The IJ was removed on [DATE] at 2:00 p.m., the facility DON was notified. The facility remained out of compliance at a scope of isolated and a severity level of 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