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	08/20/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on interview and record review, the facility failed to ensure that they notified the resident representative when there was an incident involving the resident which resulted in injury for 1 of 12 residents (CR #1) reviewed for notification of changes. The facility failed to notify CR#1's responsible party when CR#1 was physically assaulted twice by his roommate, Resident #2, causing injuries and failed to notify the RP when Resident #2 threatened to kill CR#1. This failure could place residents at risk of not having responsible party input and involvement in their care and treatment decisions. Findings include: Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. CR#1 had diagnoses which included anxiety disorder (intense, excessive, and persistent worry), Dementia (memory loss), heart disease and unspecified mood affective disorder (impairment in social areas). Record review of CR#1's Quarterly MDS, dated [DATE] revealed CR#1 could not complete BIMS due to cognitive impairment. MDS completed by staff, which indicated CR#1 had memory problems and was severely impaired cognitively. CR#1 did not exhibit behavioral symptoms and required supervision and set up or 1-person physical assist for ADLs. Record review of CR #1's care plan dated 1/27/22 indicated he had impaired communication, evidenced by: no speech, rarely/never understood. Interventions include reduce or remove all interfering environmental stimuli, use terms or gestures [CR#1] can understand and approach in a calm manner. Record review of CR#1's nurses note dated 12/6/2021 written by LVN A read in part, The resident was wandering on his own when another resident hit him on his left eye and gave him a black eye . Record review of CR#1's nurses note dated 4/9/22 written by LVN A read in part, The resident wanders into the room of another resident and the resident hit him on the head and he was cut .The other resident [Resident #2] was transferred to another unit . (continued on next page)

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

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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 0580 Level of Harm - Actual harm Residents Affected - Few	Record review of CR#1's skin assessment dated [DATE] completed by LVN A indicated CR#1 had a cut on his forehead due to an altercation with another resident. Record review of CR#1's Event Report dated 4/9/22 completed by LVN A read in part, The resident was hit by another resident and sustained a cut on forehead . The other resident has been transferred to another unit . Record review of CR#1's skin assessment dated [DATE] written by LVN X indicated CR#1 had a laceration above his left eyebrow and red abrasions/scratch on his neck. In an interview on 8/2/22 at 8:05 AM LVN A she said she recalls a couple times where she had to separate CR#1 and Resident #2 from each other. She said she can't recall the exact incident from January 2022 but said everything should be in her notes. LVN A said CR#1's roommate was more cognitively intact compared to the other residents on the 3West, which is the unit CR#1 lived on. She said CR#1 and his roommate did not get along, so she voiced her concerns to the social worker and administrator to have the roommate moved. She said she does not recall if she informed CR#1 responsible party, but all families should be notified of any changes or any issues with the residents in the facility. In an interview on 08/03/22 at 12:30 PM with LVN L stated that if a resident is aggressive or have behaviors, the residents are to be separated and assessed. She said the nurse is to immediately notify the Administrator, DON, the resident's doctor, notify the family and document the incident in the nurses' notes and complete an incident report. She said the Administrator can be notified via phone or in person if they are in the building . In an interview on 08/03/22 at 4:20 PM with the Social Service Assistant she said that if there is a resident-to-resident aggression, the staff that witnessed the incident must separate the residents and make sure that both residents are assessed. She said after that, the nurse is to call the administrator, the doctor and notify the residents RP. The nurse is to also document all communication and who was notified of the incident. The Social Service Assistant said she was not aware of CR#1 being threatened by his roommate or assaulted a few days before his death. She said she is not aware of any incidents where CR#1 was harmed. In an interview on 08/03/22 at 5:11pm with DON she said she was not aware of CR#1 being assaulted twice by Resident #2. She said she was not aware of CR#1's roommate hitting him in January 2022 or threatening to kill him. The DON said if a resident has any behaviors or aggression towards staff or residents, the staff are to immediately separate the residents and assess them. She said the nurse is to notify the Administrator and herself of the incident and then notify the doctor and the resident's responsible party. She said an incident report should also be completed and nurses should document in their nursing notes any issues and interventions put in place . The DON said the nurses are to report any issues that occurred over their shift or the previous shift during the morning meeting. She said without notifying the families, it doesn't give them the chance to intervene or assist with the residents' care. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	In an interview on 08/04/22 at 9:05 AM with CR #1's responsible party, he said he was not aware of any incidents with CR#1 and his roommate except one time in 2021. The RP indicated he was not aware of CR#1 being threatened or physically assaulted by his roommate (Resident #2). He said he would have intervened and possibly moved the CR#1 or asked for him to be moved off 300-West. CR#1's responsible party said he was made aware of altercations that CR#1 and his roommate had after he passed away. Record review of the facilities policy regarding to Change in a Resident's Condition or Status date 4/2017 read in part, The facility is to notify a residents, responsible party and physician when there has been an incident or accident involving a resident .

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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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35963 Based on interview, observation and record review, the facility failed to ensure the resident's rights to be free from abuse and neglect for 1 (CR#1) of 12 residents reviewed for abuse and neglect. The facility failed to protect CR#1 who was deliberately physically assaulted by his roommate (Resident #2) on several occasions causing injuries. Resident #2 had a history of physical and verbal abuse. The facility neglected to ensure that staff were trained to supervise CR #1 to prevent him from expiring do to ligature strangulation. These failures resulted in an Immediate Jeopardy (IJ) situation; the Administrator was notified on [DATE] at 1:15 PM. While the IJ was removed on [DATE] at 1:45 PM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated 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 include: CR#1 1. Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and died in the facility on [DATE]. CR#1 had diagnoses which included anxiety disorder (intense, excessive, and persistent worry), Dementia (memory loss), heart disease and unspecified mood affective disorder (impairment in social areas). Record review of CR#1's Quarterly MDS, dated [DATE] revealed CR#1 could not complete BIMS due to cognitive impairment. MDS completed by staff, which indicated CR#1 had memory problems and was severely impaired cognitively. CR#1 did not exhibit behavioral symptoms and required supervision and set up or 1-person physical assist for ADLs. Record review of CR #1's care plan dated [DATE] indicated he had impaired communication, evidenced by: no speech, rarely/never understood. Interventions include reduce or remove all interfering environmental stimuli, use terms or gestures [CR#1] can understand and approach in a calm manner. Record review of CR#1's nurses note dated [DATE] written by LVN A read in part, The resident was wandering on his own when another resident hit him on his left eye and gave him a black eye . Record review of CR#1's nurses note dated [DATE] written by LVN A read in part, The resident wanders into the room of another resident and the resident hit him on the head and he was cut . Reported to the abuse coordinator .The other resident [Resident #2] was transferred to another unit . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's skin assessment dated [DATE] completed by LVN A indicated CR#1 had a cut on his forehead due to an altercation with another resident. Record review of CR#1's Event Report dated [DATE] completed by LVN A read in part, The resident was hit by another resident and sustained a cut on forehead . The other resident has been transferred to another unit . Record review of CR#1's skin assessment dated [DATE] written by LVN X indicated CR#1 had a laceration above his left eyebrow and red abrasions/scratch on his neck. Resident #2 Record review of Resident #2 face sheet dated [DATE] revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the diagnosis of Hypertension (high blood pressure), bipolar and psychosis (mood swings). Pneumonia (infection in the lungs) Pleural effusion (buildup of fluid on the lungs), atrial fibrillation (irregular heart rate), Polyneuropathy (nerve damage), Hypokalemia (low potassium), Lymphedema (swelling of arms and legs), and Chronic obstructive pulmonary disease (inflammation of the lungs). Record review of Resident#2's MDS, dated [DATE] revealed he had a BIMS of 13, indicating he was cognitively intact. Resident #2 required total assistance from staff with bed mobility, dressing, and toilet use. Further review of Resident #2's MDS indicated behaviors of threatening others, screaming, and cursing at others. Record review of Resident #2's care plan dated [DATE] indicated he had potential to be abusive, both physically and verbally, as evidence by history of threats of violence to other and curse staff and residents. Interventions included monitor Resident #2's behavior, analyze triggers for behaviors and psychiatric evaluation. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] was hitting another resident when the nurse redirected, he started cursing . Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] said he was going to kill the roommate. The roommate messed with the room. The nurse redirected him, and he started cursing. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] refused to take his medications. He said he is not interested, and nothing is wrong with him . In an interview on [DATE] at 11:19 AM with CNA R, she said she was the CNA that was assigned to CR#1 on [DATE]. She said she recalls seeing CR#1 lying in bed around 11 PM and he was sleeping in bed. CNA R said two hours later when she went to check on CR #1, his head was towards the headboard, and he was unresponsive. She said she called LVN X to come assist and that he was unresponsive. CNA R said she did not notice the marks on CR#1's necks or anything abnormal with him. She said she did see his forehead bleeding, but nothing on his neck. She said she did not see anyone on the 300-West unit that was not supposed to be there. CNA R said if she does see any kind of abuse, she is to immediately notify the Administrator, who is the abuse coordinator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:30 PM with Resident #2, he said he was recently moved over to the other side of 300 hall due to him and his previous roommate (CR#1) constantly getting into altercations. He said CR#1 would constantly bother him by walking into his room, peeing on his floor and in the trashcan. Resident #2 said he and CR#1 were in the same room for a long time, until the facility moved CR#1 next door. He said CR#1 would constantly come into the room and urinate on the floor and bother him. Resident #2 said he remembers hitting CR#1 in the head, twice, because he would not leave him alone. He said he hit him once for bothering him and then again just because. During the interview with Resident #2, he said there was another time where he put his hands on CR#1 due to him still coming into his room and urinating on the floor. Resident #2 said he went into CR#1's room, and while he was in the bed, put his hands around his neck to shake him up a bit. Resident #2 said a staff member came to get him out of the room, but unable to recall who it was. Resident #2 said CR#1 stayed in the bed, but sure he did get back up because he never stays sitting long. In an interview on [DATE] at 10:39 AM with the Psychiatric Nurse Practitioner he said around [DATE] he was asked to see Resident #2 due to an altercation with another resident and the death/possible suicide of a resident in the facility. He said Resident #2 admitted to hitting CR#1 in the head with a cup. The Psychiatric Nurse said he was informed by the facility social worker that there was a death of a resident and that Resident #2 had recently gotten into an altercation with him. He said Resident #2 did not appear to know anything about CR#1 being deceased . The Psychiatric Nurse said the facility asked him to speak with Resident #2 regarding the death of CR#1. He said he was aware that CR#1 was found deceased and had marks around his neck. He said since his first evaluation on [DATE], he had been seeing Resident #1 on a routine, weekly basis. In an interview on [DATE] at 11:13 AM with the DON, she said on [DATE] when she arrived to work, she entered the 300-West unit, but was not allowed to enter CR#1's room due to it being considered a crime scene by law enforcement. She said she was informed that there was a suspicion of homicide. The DON said she began asking questions to LVN X, CNA Q and CNA R, who all worked on the 300-West Hall that night. She said LVN X informed her when EMS arrived and performed CPR that they saw marks on CR#1's neck that no one could explain. She said LVN X told her the marks could have been from CR#1's gown rubbing his neck, during the process of CPR. She said initially she thought he died of natural causes, until she saw the pictures of CR#1 that the detectives showed her of CR#1. The DON said she is aware that a couple days prior ([DATE]) that CR#1 was hit in the head with a cup by Resident #2 because CR#1 was invading his personal space . She said she was not aware of Resident #2 and CR#1 having any issues or that Resident #2 threatened to kill CR#1 in January for bothering him. She said anytime there is an aggressive resident, staff are to immediately intervene and separate the residents. She said psych is to be consulted to help with behaviors and possible medication adjustments, after the social worker makes the referral. She said residents who are really aggressive will be place on one-to-one until they are able to be sent out to a behavioral hospital . She said if a resident physically assaults a resident, she will have them sent out to the behavioral hospital as well. The DON said there have been behavior meetings, which started in May. She said the meetings are every Friday and they address residents' behaviors. She said staff are to call her and document any resident-to-resident behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:50 AM with Administrator 2, he said he was not aware of the cause of death for CR#1. He said he saw the pictures of the laceration on his forehead, which he was aware occurred when the staff transferred him to the floor to perform CPR. He said CR#1 had an abrasion around his neck but he was not aware of where it came from. He said any time there was a resident-to-resident altercation, psych services are to be involved and possibly send the aggressive resident out to the hospital for evaluation. He said staff were to report any issues to him and also the DON, if he was not available. He stated he had provided the staff in-services about reporting abuse or neglect. In an interview on [DATE] at 5:12 PM with the DON, she said she was not aware Resident #2 requesting to move rooms from CR#1 in [DATE]. She said she knows the only time there was a room change was when Resident #2 hit CR#1 in [DATE]. She said she was also not aware that Resident #2 threatened to kill CR#1. Resident #2 is not currently under supervision as he has not had any recent behaviors due to his decline in health. Record review of the facility police Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated ,d+[DATE] 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 The Administrator was notified of the Immediate Jeopardy on [DATE] at 1:15 PM and the IJ template was provided. The Plan of Removal was accepted on [DATE] at 8:20 PM and included the following: PLAN OF REMOVAL IMMEDIATE ACTION: Neglect [DATE] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Upon being informed by the State Surveyor of an immediate jeopardy being added to the previous survey, an inservice was started by the ADON and DON on neglect. Abuse and Neglect inservice/training is being done for All facility staff to include dietary, housekeeping, laundry, receptionist, Business office manager and all administrative staff as well as all nursing staff to include all PRN staff. Inservice to be completed [DATE] at 6:30am An inservice on supervision of residents from any physical or verbal aggression from residents with this behavior was started at 2:30pm on [DATE] and will be completed by 6am on [DATE]. Inservice also covered residents will be supervised using one on one if needed, keeping in visual sight and using redirection. All residents will be free of neglect and abuse. No staff member will be allowed to work until the abuse and neglect inservice has been completed. The facility uses no agency personnel. Resident #2 is currently in the psychiatric hospital and will continue one on one upon his return. 2. NOTE: THIS PROCESS WAS STARTED ON ,d+[DATE] /22 AND STAFF IS BEING RE-TRAINED [DATE]. The assistant administrator interviewed the following staff to identify any resident that has had or currently has any aggressive behavior or anger issues. The following staff were interviewed, nurse aides on duty, charge nurses, unit managers, dietary aides (that deliver meal carts to floor) and activity department. Interviews started at [DATE] at 4:00pm. And will completed by 12pm [DATE]. The assistant administrator re interviewed staff at random on [DATE] at 3 pm. All facility staff are being inserviced and retrained by the Administrator, Assistant Administrator, ADON and the DON on what should be recognized as a behavior and how to provide supervision to prevent any neglect or abuse to residents. This includes residents that express homicidal threats against other residents, threats of physical violence against other residents, and any expressions of agitation by other residents' behavior. Retraining for all staff includes reporting immediately to the Abuse Coordinator (Administrator) supervisor, DON, Assistant Administrator any comment by any resident on homicidal threats, threats of physical violence against another resident and any voiced comment regarding being agitated by another residents behavior. No facility staff member will be allowed to work until inservice and pre and posttest are done. This will be completed by 5pm on [DATE]. Social service reviewed assessments(PQH9 and PTSD checklist) for any resident with aggressive behavior or anger issues to be completed by [DATE] at 12pm. Care plans were reviewed and revised with any new interventions being added if needed. MDS will be responsible for Care Plan updates to be completed by 5:00pm [DATE]. This process was reviewed on [DATE] by the administrator/designee to ensure compliance is ongoing. This review will be completed by 6am [DATE] 3. All facility staff are being in-service and retrained by the Administrator, Assistant Administrator, ADON and the DON on what should be recognized as a behavior to include residents that express homicidal threats against other residents, threats of physical violence against other residents, and any expressions of agitation by other residents' behavior. Retraining for all staff includes reporting immediately to the abuse coordinator, supervisor, DON, Assistant Administrator any comment by any resident on homicidal threats, threats of physical violence against another resident and any voiced comment regarding being agitated by another residents behavior. Social service reviewed assessments (PQH9 and PTSD checklist) for any resident with aggressive behavior or anger issues to be completed by [DATE] at 12pm. Care plans will be reviewed and revised with any new interventions being added if needed. MDS will be responsible for Care Plan updates to be completed by 6am [DATE] These processes are in place and have been in place since [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. A behavior communication form has been implemented to include the identified behavior, time of the behavior, and location of behavior. The form will be reviewed by the unit manager and will check off on Dr. being notified, documentation and social services being notified as follow up, then information will be taken to the morning clinical meeting. DON will in-service Charge nurses on the new Behavior communication form on [DATE] and was completed by 5:00pm on [DATE]. Charge nurses were re in-service by the DON on [DATE] and will be completed by [DATE] at 6am.The unit manager will be responsible for reviewing documentation to include Dr. notification and notifying social services if psych referral is needed. A spread sheet is being developed by the social workers to include: Resident name, date referral was received, date and time referral was made to psych service for, date and time psych saw the resident and reason for referral. This will be completed by 5:00pm on [DATE]. The social worker was re-in-service by the administrator on [DATE] and reviewed to ensure tracking is complete from original date of [DATE]. All residents with aggressive behavior and anger issues were identified by the DON, unit managers and Regional Nurse have developed an acute care plan to include, type of behavior resident exhibits, what triggers the behavior if known and the intervention to be implemented. The acute care plan is kept in a notebook at each nursing unit and will kept updated by the unit manager. Acute care plans will be completed by 5pm [DATE] and charge nurses and aide's in-service by the DON. This has been an ongoing process since [DATE] and is continued as of [DATE] indefinitely. The behavior committee meets every Friday to review all identified residents with any new or newly identified aggressive behaviors. The Behavior Committee met at 2:30pm on [DATE] as scheduled for every Friday at this time to review any behavior and protect and prevent any neglect from residents to residents. The administrator, DON, assistant administrator, and Regional Nurse reviewed the list of residents that were identified. Social services did an updated PQH 9 and a PTSD checklist questionnaire with scoring system to further identify any resident with aggressive behavior, Social services did a PQH9 and PTSD checklist completed for these residents on [DATE] and all new residents admitted since [DATE] with any aggressive disorder either physical or verbal has has a PQH9 and PTSD checklist completed. This is an ongoing process with an indefinite stop date. After review of the information an acute care plan is developed. The Acute Care Plan system identifies the behavior, triggers if known and interventions to include , 1on 1 will be initiated if needed , Adm.and Don will be notified, Dr called and resident the transferred to psych facility if behavior cannot be managed at the facility and the Dr orders transfer. The initial Acute care plans were completed [DATE] and the process has continued through [DATE] and is an ongoing indefinite process with all new admissions and any other resident that displays any aggressive or verbal aggressive behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Charge nurses and nurse aides were re-trained on identification and recognizing behaviors for immediate intervention. (Retraining was done on [DATE] and again on [DATE] at 2:30pm and will be completed by [DATE] at 6:30am) Staff are being re-trained on rounding and being monitored by the unit manager, Adm., Assistant Administrator and DON. The staff named will come on various shifts at various times to monitor resident care and review of the 24 hr report. Each administrative staff making rounds will complete the rounding form with issues identified and how the issue was corrected on site. All forms will be reviewed the following day by the administrative team and issues tracked to identify patterns weekly. Administrative team will be inserviced on what to look for when rounding and how to inservice staff if needed immediately. After hours rounding to begin by administration staff [DATE] and will be 7 days a week for the next 30 days and reevaluated. Administrative staff reinserviced on [DATE] at 2:00pm The inservice is limited to administrative staff on areas to look for during rounds due to the administrative staff having the knowledge and authority to review documentation, give on site inservice to staff, teach on areas that need to correct and review Incident reports for family notification, physician notification and other pertinent facts as well as investigating incident if needed. The facility wants to ensure anyone rounding after hours has general as well as specific areas to review on each unit. Surveyor Monitored the Plan of Removal as follows: Observations were started on [DATE] at 11:50 PM and continued through [DATE] at 1:45 PM. Resident #2 was currently out of the building being evaluated at behavioral hospital due to threatening a staff member. Interviews were started on [DATE] at 11:50 PM and continued through [DATE] at 1:45 PM with staff across all three shifts, including the weekdays and weekends. That staff interviewed regarding the plan of removal: LVN A, RN B, LVN C, LVN D, RN E, CNA F, LVN G, HA H, HA J, CNA K , LVN L, RN M, CNA N, CNA O, LVN P, CNA Q, CNA R, LVN S, CNA T, RA U, CNA V, CNA W, LVN Y, RN Z, Social Service Director, Social Service Assistant, Housekeeping, Maintenance, Administrator, Director of Nursing and Unit Manager 4. All staff interviewed verbalized adequate understanding of plan of removal training received regarding supervision of residents with any physical and verbal aggression, abuse and neglect, recognizing behaviors, threats, agitation and homicidal thoughts. Inservice's were started on [DATE] and staff were retrained on [DATE] and completed on [DATE]. Record review of the POR binder revealed: Staff completed Abuse/Neglect inservice and quiz regarding signs of abuse, reporting to the administrator and the administrators phone number. Resident review for behaviors on Unit 2, 3 and 4: All residents identified with behaviors were documented with their triggers and interventions. Social Services department reviewed PHQ-9 and PTSD checklist for residents with aggressive behaviors or anger issues. Care plans were reviewed and revised with any new interventions being added if needed. A behavior communication form was implemented to include the identified behavior, time of the behavior, and location of behavior. An acute care plan was implemented for residents with behaviors and the interventions to be implemented. Inservices reviewed were Residents with behaviors, charting and documentation, abuse and neglect and behavior assessments. All were completed on [DATE]. (continued on next page)

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	675764	A. Building B. Wing	08/20/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policies reviewed were Abuse and Neglect, dated ,d+[DATE]. In an interview on [DATE] at 1:30 PM with the Administrator, he stated he is the abuse coordinator in the facility and made sure when he started in [DATE], that all staff were in serviced on who to report any abuse or neglect to. He said any issues in the facility, he has informed the staff to call him first and if they are not able to reach him, they should call the DON. He said all incidents that occur with the residents should be immediately reported to him. The Administrator stated he was not fully aware of the incidents that occurred with CR#1 and Resident #2 as he was new in the facility. He stated he was made aware that CR#1 was found deceased in his room but was not aware of the cause of death. In an interview on [DATE] at 1:30 PM with the Administrator, he stated he has made new badges for the staff so that they are aware of the types of abuse, who to report it to and to make sure they have his contact information to report any incidents. He stated he has in-serviced the staff to report abuse immediately. He stated to prevent further incidents from happening, they have created binders for each station that has the residents' behaviors and triggers in it. They are talking about residents' behaviors weekly and if any issue occurs overnight, the nurses report that during the morning meeting as well. Residents who become aggressive are to immediately be placed on one-to-one until a safe intervention is given. If the resident becomes too aggressive and hits another resident, they are to be sent out to be evaluated by inpatient behavioral hospital. He stated he believes this situation came about due to lack of communication. He stated staff have been retrained and will continue to be retrained on reporting any issues and notifying him of any abuse, neglect, resident-to-resident aggression or any behaviors that occur in the facility. While the IJ was removed [DATE] at 1:45 PM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to the need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 12 residents (CR#1) reviewed for accidents and supervision. The facility failed to provide adequate supervision to CR#1 on the secure unit. As a result, CR #1 was not protected from physical harm after Resident #2 physically assaulted CR #1 on three different occasions and threatened to kill him. CR#1 was found deceased in his room on [DATE]. CR#1's autopsy report indicated the cause of death was ligature strangulation (external object placed around the neck). An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of a isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures resulted in an Immediate Jeopardy (IJ) situation; the Administrator was notified on [DATE] at 2:15 PM. While the IJ was removed on [DATE] at 7:30 AM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to the need to complete in service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not being properly supervised resulting in physical harm. Findings included: 1. Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and died in the facility on [DATE]. CR#1 had diagnoses which included anxiety disorder (intense, excessive, and persistent worry), Dementia (memory loss), heart disease and unspecified mood affective disorder (impairment in social areas). Record review of CR#1's Quarterly MDS, dated [DATE] revealed CR#1 could not complete BIMS due to cognitive impairment. MDS completed by staff, which indicated CR#1 had memory problems and was severely impaired cognitively. CR#1 did not exhibit behavioral symptoms and required supervision and set up or 1-person physical assist for ADLs. Record review of CR #1's care plan dated [DATE] indicated he had impaired communication, evidenced by: no speech, rarely/never understood. Interventions include reduce or remove all interfering environmental stimuli, use terms or gestures [CR#1] can understand and approach in a calm manner. Record review of CR#1's nurses note dated [DATE] written by LVN A read in part, The resident was wandering on his own when another resident hit him on his left eye and gave him a black eye . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's nurses note dated [DATE] written by LVN A read in part, The resident wanders into the room of another resident and the resident hit him on the head and he was cut . Reported to the abuse coordinator .The other resident [Resident #2] was transferred to another unit . Record review of CR#1's skin assessment dated [DATE] completed by LVN A indicated CR#1 had a cut on his forehead due to an altercation with another resident. Record review of CR#1's Event Report dated [DATE] completed by LVN A read in part, The resident was hit by another resident and sustained a cut on forehead . The other resident has been transferred to another unit . Record review of CR#1's skin assessment dated [DATE] written by LVN X indicated CR#1 had a laceration above his left eyebrow and red abrasions/scratch on his neck. Record review of CR#1's Event Report dated [DATE] written by LVN X read in part, Immediate Nursing Intervention: Resident was noted with abrasions, red across his neck was when 911 person showed it . No complete assessment was done due to resident was dead and asked to [not] touch or move by 911 . Conclusion: CNA called this writer to resident room and on assessment resident in bed and unresponsive. Resident was transferred to the floor and during transfer bumped head on floor . CPR started and 911 called . 911 in facility and assessed resident and stated resident had expired . During assessment that was when 911 showed this writer the abrasions on resident neck .[sic] Record review of CR#1's autopsy report dated [DATE] read in part, Cause of Death: Ligature strangulation, Manner of Death: Homicide, date of death [DATE] . Postmortem Examination on the body of [CR#1]: Postmortem changes: there is moderate rigor mortis of the upper extremities, neck and jaw . Injuries, External and Internal: There are minor blunt trauma injuries of the head and extremities. There are ligature furrows [groove in the tissue, hard on touch due to drying or abraded skin] around the neck and upper extremities . Ligature Injuries of Neck: An incomplete ligature [NAME] partially encircles the neck, encompassing the left, anterior, and right side of the neck. On the left side of the neck, it is composed of a 0. 6 centimeter wide red and brown [NAME] . A 1.0 by 0.5-centimeter blue contusion is inferior to the [NAME] and left side of the neck. The [NAME] is approximately 10.5 centimeters inferior to the left external auditory meatus. In the anterior neck, the [NAME] extends horizontally just below the cricoid cartilage (ring of cartilage around the trachea) , 8 centimeters from the tip of the chin . Internally, a focus of hemorrhage is seen on the anterior right sternocleidomastoid muscle (large muscle in the front of neck) measuring 1.0 by 0. 8 centimeters . Multiple areas of hemorrhage are seen on the posterior left splenius capitis muscle (thick flat muscle) and on the deeper muscles of the left posterior side of the neck. Fracture(s) are palpated around the [NAME] of the hyoid (u-shaped bone in the neck, supports the tongue) bone . Record review of CR#1's autopsy report dated [DATE] read in part, Pathological Findings: I. Ligature [NAME] around neck: A) Ligature [NAME] around lower portion of neck with internal neck hemorrhage, B) Fracture of hyoid bone, C) Anthropology Consultation: Bilateral fractures of greater hyoid [NAME] with sharp margins are consistent with compression of neck at or around time of death, D) Scant petechiae present [tiny purple, red or brown spots on the skin]. II. Blunt trauma of head: A) Abrasions and laceration of head and neck . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	III. Blunt trauma to extremities: A) Abrasions and lacerations of arms and feet, B) Iron stains show hemosiderin in foot contusions (blood leaking out of tiny vessels). IV. Ligature furrows of arm: A) Ligature furrows of upper extremities later to axillae bilaterally (near the chest), B) Deep avulsion (injury) pockets in musculature . Record review of CR#1's Autopsy and Anthropology Report with a completion date of [DATE] read in part, Summary: Acute blunt force trauma is present on the hyoid bone of [CR#1]. The bilateral fractures of the greater hyoid [NAME] are sharp margins are consistent with compression of the neck at or around the time of death . In an interview on [DATE] at 10:37 AM with LVN S, she said on [DATE] she had arrived to work around 5:30 AM. She said she heard LVN X page that there was a code blue for CR#1's room, and she went to assist. She said when she entered the room, she observed CR#1 lying on the floor with a hematoma (clotted blood) on his forehead and he also had a scar around his neck that looked partially healed and then also a red mark below the mark, that was around his neck. LVN S said she was not sure what occurred and does not work with CR#1 but was shocked at what she saw on his neck. In an interview on [DATE] at 10:51 AM with LVN A, she said she worked on [DATE] when Resident #2 hit CR#1 in the head with a water pitcher. She said Resident #2 hit CR#1 because he comes around to his room and urinates on the floor and by his bed. She said CR#1 kept going into the room that Resident #2 was in due to them being roommates for a while. She said Resident #2 was moved on the outside of 300-West to 300-East. During the interview with LVN A said she worked with CR#1 on [DATE] from 6AM-10PM, as she had worked a double that day. She said when she left CR#1, he was fine, walking around as he normally did. She said CR#1 needed constant redirection due to his cognition but did not have any other behaviors. She said when she left for the night, CR#1 did not have any marks or bruising around his neck. In an interview on [DATE] at 10:59 AM with CNA Q she said she worked on the 300-West Hall on the night of [DATE] but was not assigned to CR#1's room. CNA Q said around midnight, she saw CR#1 walking out of his room and in the hallway. She said she had the front half of the 300 hall and CR#1 was close to the front of the unit. She said CR#1's room was right by the nurses station. She said she can't recall the time, but during the code blue for CR#1 she went into the room to assist. CNA Q said her and LVN X placed CR#1 on the floor to begin compressions. She said CR#1's head was at the head of the bed, she said saw a cut up under his neck but does not recall a cut on his head. She said under CR#1's neck there was blood, that looked like it was a deep cut under his neck. She said she is not able to recall seeing anyone there on the 300-West Hall that was not a resident. In an interview on [DATE] at 11:19 AM with CNA R, she said she was the CNA that was assigned to CR#1 on [DATE]. She said she recalls seeing CR#1 lying in bed around 11 PM and had his head towards the footboard. CNA R said two hours later when she went to check on CR #1, his head was towards the headboard, and he was unresponsive. She said she called LVN X to come assist and that he was unresponsive. CNA R said she did not notice the marks on CR#1's necks or anything abnormal with him. She said she did see his forehead bleeding, but nothing on his neck. She said she did not see anyone on the 300-West unit that was not supposed to be there. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:40 AM with LVN X she said she was working with CR#1 on [DATE] and recalls the last time seeing him was around 10 or 11 PM. She said when CNA R came to her to tell her that CR#1 was unresponsive, it was close to 5 AM. LVN X said when she went to perform CPR, her, and CNA Q placed CR#1 on the floor. LVN X said she did not notice the bruising on CR#1's neck until EMS pointed it out to her. She said the marks on his neck looked like a scratch to her and was not bleeding. She said CR#1 was difficult to transfer to the floor and his body was a little stiff. She stated she does not recall another resident coming over to her unit that she was not aware of. In an interview on [DATE] at 1:39 PM with LVN Y she said on [DATE] she was working on 400-hall when LVN X called for code blue for CR#1's room. She said when she entered the room to assist, based on her years of experience, she could tell CR#1 was already deceased . She said she observed a gash on his forehead, which was close to his temple . LVN Y said that you could tell something was around his neck, but she was not able to identify what it was. She said the abrasion around his neck was red, but not really bleeding. LVN Y said she was not sure how the marks got on his neck. In an interview on [DATE] at 8:53 AM with RN Z he said he usually works on 300-East, which is in front of 300-West. He said on [DATE] he was working and had to keep bringing a resident back to the 300-West Hall due to her wandering into residents' rooms on his unit. RN Z said the second time he brought a resident back to 300-West, LVN X said she had a code in CR#1's room. RN Z said when he got to CR#1's room he was already on the floor, and he seen saw a laceration on his forehead. He said when he saw CR#1 his mouth was open, eyes were fixed and dilated. RN Z said he was not aware of any of his residents going over to 300-West. 2. Record review of Resident #2 face sheet dated [DATE] revealed a [AGE] year-old male was admitted to the facility on [DATE] with the diagnosis of Hypertension (high blood pressure), bipolar and psychosis (mood swings). Pneumonia (infection in the lungs) Pleural effusion (buildup of fluid on the lungs), atrial fibrillation (irregular heart rate), Polyneuropathy (nerve damage), Hypokalemia (low potassium), Lymphedema (swelling of arms and legs), and Chronic obstructive pulmonary disease (inflammation of the lungs). Record review of Resident#2's MDS, dated [DATE] revealed he had a BIMS of 13, indicating he was cognitively intact. Resident #2 required total assistance from staff with bed mobility, dressing, and toilet use. Further review of Resident #2's MDS indicated behaviors of threatening others, screaming, and cursing at others. Record review of Resident #2's care plan dated [DATE], with a revision date of [DATE], indicated he had potential to be abusive, both physically and verbally, as evidence by history of threats of violence to other and curse staff and residents. Interventions included monitor Resident #2's behavior, analyze triggers for behaviors and psychiatric evaluation. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] was hitting another resident [CR#1] . Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] said he was going to kill the roommate [CR#1]. The roommate messed with the room. The nurse redirected him, and he started cursing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:30 PM with Resident #2, he said he was recently moved over to the other side of 300 hall due to him and his previous roommate (CR#1) constantly getting into altercations. He said CR#1 would constantly bother him by walking into his room, peeing on his floor and in the trashcan. Resident #2 said he and CR#1 were in the same room for a long time, until the facility moved CR#1 next door. He said CR#1 would constantly come into the room and urinate on the floor and bother him. Resident #2 said he remembers hitting CR#1 in the head, twice, because he would not leave him alone. He said he hit him once for bothering him and then again just because. During the interview with Resident #2, he said there was another time where he put his hands on CR#1 due to him still coming into his room and urinating on the floor. Resident #2 said he went into CR#1's room, and while he was in the bed, put his hands around his neck to shake him up a bit. Resident #2 said a staff member came to get him out of the room, but unable to recall who it was. Resident #2 said CR#2 stayed in the bed, but sure he did get back up because he never stays sitting long. In an interview on [DATE] at 10:39 AM with the Psychiatric Nurse, he said around [DATE] he was asked to see Resident #2 due to an altercation with another resident and the death/possible suicide of a resident in the facility. He said Resident #2 admitted to hitting CR#1 in the head with a cup. The Psychiatric Nurse said he was informed by the facility social worker that there was a death of a resident and that Resident #2 had recently gotten into an altercation with him. He said Resident #2 did not appear to know anything about CR#1 being deceased . The Psychiatric Nurse said the facility asked him to speak with Resident #2 regarding the death of CR#1. He said he was aware that CR#1 was found deceased and had marks around his neck. He said since his first evaluation on [DATE], he had been seeing Resident #2 on a routine, weekly basis. In an interview on [DATE] at 11:13 AM with the DON, she said on [DATE] when she arrived to work, she entered the 300-West unit, but was not allowed to enter CR#1's room due to it being considered a crime scene. She said she was informed that there was a suspicion of homicide. The DON said she began asking questions to LVN X, CNA Q and CNA R, who all worked on the 300-West Hall that night. She said LVN X informed her when EMS arrived and performed CPR that they saw marks on CR#1's neck that no one could explain. She said LVN X told her the marks could have been from CR#1's gown rubbing his neck, during the process of CPR. She said initially she thought he died of natural causes, until she saw the pictures of CR#1 that the detectives showed her of CR#1. The DON said she is aware that a couple days prior ([DATE]) that CR#1 was hit in the head with a cup by Resident #2 because CR#1 was invading his personal space . She said during that altercation, Resident #2 was moved off 300-West and placed on 300-East. The DON said based on CR#1's cognition and strength, there is no way he could have committed suicide and based off the injuries, she does not believe he died of natural causes as she previously thought. She said if there were any incidents during [DATE], Resident #2 should have been moved off the 300-West unit to avoid any resident-to-resident issues. She said she was not aware of Resident #2 and CR#1 having any issues or that Resident #2 threatened to kill CR#1 in January for bothering him. She said anytime there is an aggressive resident, staff are to immediately intervene and separate the residents. She said psych is to be consulted to help with behaviors and possible medication adjustments, after the social worker makes the referral. She said residents who are really aggressive will be place on one-to-one until they are able to be sent out to a behavioral hospital . She said if a resident physically assaults a resident, she will have them sent out to the behavioral hospital as well. The DON said there have been behavior meetings, which started in May. She said the meetings are every Friday and they address residents' behaviors. She said staff are to call her and document any resident-to-resident behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:50 AM with Administrator 2, he said he was not aware of the cause of death for CR#1. He said he saw the pictures of the laceration on his forehead, which he was aware occurred when the staff transferred him to the floor to perform CPR. He said CR#1 had an abrasion around his neck but he was not aware of where it came from. He said any time there was a resident-to-resident altercation, psych services are to be involved and possibly send the aggressive resident out to the hospital for evaluation. In an interview on [DATE] at 5:12 PM with the DON, she said she was not aware Resident #2 requesting to move rooms from CR#1 in [DATE]. She said she knows the only time there was a room change was when Resident #2 hit CR#1 in [DATE]. She said she was also not aware that Resident #2 threatened to kill CR#1. Resident #2 is not currently under supervision as he has not had any recent behaviors due to his decline in health. The Administrator was notified of the Immediate Jeopardy on [DATE] at 2:15 PM and the IJ template was provided. The Plan of Removal was accepted on [DATE] at 12:07 PM and included the following: PLAN OF REMOVAL IMMEDIATE ACTION: Accidents and Supervision [DATE] 1. On [DATE] the State Surveyor interviewed resident #2 and shared the results with the Administrator and DON. The Administrator and the DON initiated one on one for resident #2 on [DATE] at 4pm. The roommate was relocated to another room at this time also. The one on one has continued and will be continued indefinitely. The resident has not been out of bed and has no behaviors in the past 48 hours. Psych services were notified on [DATE] and findings of surveyor was shared with Psych NP by DON. Resident #2 was seen by NP on [DATE] with no changes made to medications. The residents PCP was notified of surveyor findings by the DON on [DATE] with no new orders received. 2. The policy for completing incident reports has been reviewed by the DON and Administrator on [DATE] and charge nurses will be in-serviced on this policy by 6pm on [DATE]. Incident reports for the last 30 days have been reviewed to ensure the physician, family and investigations have been completed. This review will be done by the DON, Assistant administrator, Administrator by 6pm on [DATE]. If any negative findings the revision will be done and dated for [DATE] when the review was done. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The policy and procedure for Behavioral Assessment and Monitoring has been reviewed and revised by the DON, Administrative and Regional nurse on [DATE]. All nursing staff is being in-service on the Behavioral assessment and Monitoring policy.Policy includes what is a behavior, developing a care plan for behavior, interventions and approaches for behaviors, possible causes of behavior to include physical and medical changes, emotional, psychiatric and/or psychological stressor, functional, social or environmental factors, with examples of each cause. Monitoring of behaviors by the Behavior Committee that meets weekly. The charge nurses and aides are being given a pre and posttest on behavior assessment and monitoring. The in-service was started at 4:30 on [DATE] and will be completed by [DATE] at 12:00pm. Inservice's are being done by the ADON and the DON. Staff that are not working and PRN staff will be in-serviced and given pre and posttest prior to being allowed to work their next shift. This facility does not use any agency staff. 4. The assistant administrator started interviewing the following staff to identify any resident that has had or currently has any aggressive behavior or anger issues. The following staff were interviewed, nurse aides on duty, charge nurses, unit managers, dietary aides (that deliver meal carts to floor) and activity department. Interviews started at [DATE] at 4:00pm. And will completed by 12pm [DATE]. All facility staff are being in-serviced and retrained by the Administrator, Assistant Administrator, ADON and the DON on what should be recognized as a behavior to include residents that express homicidal threats against other residents, threats of physical violence against other residents, and any expressions of agitation by other residents' behavior. Retraining for all staff includes reporting immediately to supervisor, DON, Assistant Administrator and/or the administrator any comment by any resident on homicidal threats, threats of physical violence against another resident and any voiced comment regarding being agitated by another resident's behavior. No facility staff member will be allowed to work until inservice and pre and posttest are done. This will be completed by 5pm on [DATE] Social service reviewed assessments (PQH9 and PTSD checklist) for any resident with aggressive behavior or anger issues to be completed by [DATE] at 12pm. Care plans will be reviewed and revised with any new interventions being added if needed. MDS will be responsible for Care Plan updates to be completed by 5:00pm [DATE]. 5. A behavior communication form will be implemented to include the identified behavior, time of the behavior, and location of behavior. The form will be reviewed by the unit manager and will check off on Dr. being notified, documentation and social services being notified as follow up, then information will be taken to the morning clinical meeting. DON will inservice Charge nurses on the new Behavior communication form on [DATE] and will be completed by 5:00pm on [DATE]. The unit manager will be responsible for reviewing documentation to include Dr. notification and notifying social services if psych referral is needed. A spread sheet is being developed to include: Resident name, date referral was received, date and time referral was made to psych services, date and time psych saw the resident and reason for referral. This will be completed by 5:00pm on [DATE]. Once all residents with aggressive behavior and anger issues are identified the DON, unit managers and Regional Nurse will develop an acute care plan to include, type of behavior resident exhibits, what triggers the behavior if known and the intervention to be implemented. The acute care plan will be kept in a notebook at each nursing unit and will kept updated by the unit manager. Acute care plans will be completed by 5pm [DATE] and charge nurses and aides in-serviced by the DON. Incident reports were also reviewed on [DATE] by the Administrator, Assistant adm., DON and regional Nurse for the past 60 days to identify any resident with aggressive behavior or anger issues. (continued on next page)

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	675764	A. Building B. Wing	08/20/2022

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator, DON, assistant administrator and Regional Nurse reviewed the list of residents that were identified. Social services did an updated PQH 9 and a PTSD checklist questionnaire with scoring system to further identify any resident with aggressive behavior Social services will have PQH-9 and PTSD checklist completed for these residents by [DATE] at 5:00pm. After review information will used to develop the acute care plan. The Acute Care Plan system will identify the behavior, triggers if known and interventions to include, 1on 1 will be initiated, Adm. and Don will be notified, Dr called, and resident transferred to psych facility if behavior cannot be managed at the facility and the Dr orders transfer. Acute care plans will be completed by 5pm [DATE]. Charge nurses and nurse aides are re-trained on identification and recognizing behaviors for immediate intervention. Staff are being re-trained on rounding and being monitored by the unit manager, Adm., Assistant Administrator and DON. The staff named will come on various shifts at various times to monitor resident care and review of the 24 hr report. Each administrative staff making rounds will complete the rounding form with issues identified and how the issue was corrected on site. All forms will be reviewed the following day by the administrative team and issues tracked to identify patterns weekly. Administrative team will be in-serviced on what to look for when rounding and how to inservice staff if needed immediately. After hours rounding to begin by administration staff [DATE] and will be 7 days a week for the next 30 days and reevaluated. The inservice is limited to administrative staff on areas to look for during rounds due to the administrative staff having the knowledge and authority to review documentation, give on site inservice to staff, teach on areas that need to corrected and review Incident reports for family notification, physician notification and other pertinent facts as well as investigating incident if needed. The facility wants to ensure anyone rounding after hours has general as well as specific areas to review on each unit. Surveyor Monitored the Plan of Removal as follows: Observations were started on [DATE] at 1:50 PM and continued through [DATE] at 7:30 AM. Resident #2 was observed throughout the day and was observed to have a one-on-one sitter. No concerns with supervision noted. Resident #2 appears to be in bed and sleeping on and off throughout the day. The facility removed Resident #2's current roommate as a precaution. Interviews were started on [DATE] at 1:50 PM and continued through [DATE] at 7:30 AM with staff across all three shifts, including weekdays and weekends. That staff interviewed regarding the plan of removal: LVN A, RN B, LVN C, LVN D, RN E, CNA F, LVN G, HA H, HA J, CNA K , LVN L, RN M, CNA N, CNA O, LVN P, CNA Q, CNA R, LVN S, CNA T, RA U, CNA V, CNA W, LVN Y, RN Z, Social Service Director, Social Service Assistant, Housekeeping, Maintenance, Administrator, Director of Nursing and Unit Manager 2 and Unit Manager 4. All staff interviewed verbalized adequate understanding of plan of removal training received regarding Behavior Health Assessment, monitoring behaviors, interventions, psychological services, communicating behaviors, recognizing behaviors for immediate intervention, and conducting rounds to identify any issues. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 7:46 AM with the DON, she said all residents with behaviors will be closely monitored with the new behavior monitoring system in place. She stated every week, they will continue their behavioral health meeting to address residents' behaviors. She stated she will be notified by the nurses if there are any issues in the facility with residents. She said Resident #2 will be on one-to-one indefinitely. She stated the hospitality aides that are on the halls are to be observant of behaviors to ensure all residents are safe and no one is being harms. Record review of the POR binder revealed: Resident review for behaviors on Unit 2, 3 and 4: All residents identified with behaviors were documented with their triggers and interventions. Social Services department reviewed PHQ-9 and PTSD checklist for residents with aggressive behaviors or anger issues. Care plans were reviewed and revised with any new interventions being added if needed. A behavior communication form was implemented to include the identified behavior, time of the behavior, and location of behavior. An acute care plan was implemented for residents with behaviors and the interventions to be implemented. In-services reviewed were, Behavioral Assessment, Intervention and Monitoring - completion date [DATE], Unmanageable Residents - completion date [DATE], One on One Care - completion date [DATE], Accidents and Supervision - completion date [DATE] and Recognizing and Reporting Behaviors - completion date [DATE] Policies Reviewed were Behavioral Assessment, Intervention and Monitoring dated ,d+[DATE], Accidents and Supervision dated ,d+[DATE], Unmanageable Residents dated ,d+[DATE], Resident Rights dated , d+[DATE], and Abuse and Neglect dated ,d+[DATE]. While the IJ was removed [DATE] at 7:30 AM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to the need to complete in service training and evaluate the effectiveness of the corrective systems.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **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 behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being 1 of 12 residents (Resident #2) reviewed for behavioral health. The facility failed to assess and implement interventions when Resident #2 had behaviors of aggression, hitting his roommate, and threatening to kill his roommate on separate occasions. Resident #2 asked for a room change in [DATE], but it was not completed until [DATE]. The facility failed to immediately provide psychological services for Resident #2. On [DATE] an order for a psych consult was written for Resident #2 to be evaluated due to his behaviors. Resident #2 was not evaluated until [DATE] by psychological services. These failures resulted in an Immediate Jeopardy (IJ) situation; the Administrator was notified on [DATE] at 2:15 PM. While the IJ was removed on [DATE] at 7:30 AM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to the need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures affected residents living in the facility at risk of not receiving behavioral health services and decline in quality of life. Findings include: Record review of Resident #2 face sheet dated [DATE] revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the diagnosis of Hypertension (high blood pressure), bipolar and psychosis (mood swings). Pneumonia (infection in the lungs) Pleural effusion (buildup of fluid on the lungs), atrial fibrillation (irregular heart rate), Polyneuropathy (nerve damage), Hypokalemia (low potassium), Lymphedema (swelling of arms and legs), and Chronic obstructive pulmonary disease (inflammation of the lungs). Record review of Resident#2's MDS, dated [DATE] revealed he had a BIMS of 13, indicating he was cognitively intact. Resident #2 required total assistance from staff with bed mobility, dressing, and toilet use. Further review of Resident #2's MDS indicated behaviors of threatening others, screaming, and cursing at others. Record review of Resident #2's care plan dated [DATE] indicated he had potential to be abusive, both physically and verbally, as evidence by history of threats of violence to other and curse staff and residents. Interventions included monitor Resident #2's behavior, analyze triggers for behaviors and psychiatric evaluation. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] was hitting another resident when the nurse redirected, he started cursing . (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] said he was going to kill the roommate. The roommate messed with the room. The nurse redirected him, and he started cursing. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] refused to take his medications. He said he is not interested, and nothing is wrong with him . Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] has a new order for psych consult and wanting to change his room. This has been given to SW who said she had a conversation with the resident about group homes or moving to another floor. SW will visit and get back with clinical staff. Record review of Resident #2's behavioral health notes dated [DATE] written by the Psychiatric Nurse read in part, Encounter - [DATE], facility requested for psychiatric evaluation and medication management for depressive moods and noncompliance . Record review of Resident #2's MAR did not indicate that his medications were adjusted. Record review of Resident #2's nursing progress notes dated [DATE] written by LVN A read in part, [Resident #2] hit another resident on the head and gave him a cut . Reported to abuse coordinator . [Resident #2] to transfer to 4th floor . In an interview on [DATE] at 1:30 PM with Resident #2, he said he was recently moved over to the other side of 300 hall due to him and his previous roommate constantly getting into altercations. He said his roommate would constantly bother him by walking into his room, peeing on his floor and in the trashcan. Resident #2 said he and his roommate were in the same room for a long time, until they moved his roommate next door. He said his roommate would constantly come into the room and urinate on the floor and bother him. Resident #2 said he remembers hitting his roommate in the head, twice, because he would not leave him alone. He said he hit him once for bothering him and then again just because. During the interview with Resident #2, he said there was another time where he put his hands on his previous roommate due to him still coming into his room and urinating on the floor. Resident #2 said he went into his previous roommate's room, and while he was in the bed, put his hands around his neck to shake him up a bit. Resident #2 said a staff member came to get him out of the room, but unable to recall who it was. Resident #2 said his roommate stayed in the bed, but sure he did get back up because he never stays sitting long. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 6:37 AM with the Director of Social Services, he said he was not familiar with any altercations between Resident #2 and his previous roommate. He said every morning, the facility has a morning meeting, and they are to discuss with the nursing staff about any resident issues that occurred. He said the direct care staff will notify him during his rounds if there are any issues with residents, that might not have been addressed during the morning meeting. The Director of Social Services said every Friday the management team has a behavioral meeting to discuss all the residents with behaviors. He said there is a monthly GDR that is held with the psych team to go over resident medications. He said he is not aware of any resident-to-resident threats, but if a resident hits another resident, they are to be sent out immediately for a psych evaluation at an inpatient behavioral hospital. He said if a resident does hit another staff or resident, he said he will issue a 30-day discharge notice to the resident and assist with alternative placement. The Director of Social Services said it is up to the nursing staff to notify him of any behaviors that the residents may have. He said the Unit Mangers will notify the DON of any incidents and the DON will notify the Social Services department. All incidents are to be documented in the nursing notes. In an interview on [DATE] at 8:05 AM LVN A she said she recalls a couple times where she had to separate Resident #2 and his roommate from each other. She said she does not recall the exact incident from [DATE] but said everything should be in her notes. LVN A said Resident #2 was more cognitively intact compared to the other residents on the 3West, which is the unit Resident #2 lived on. She said Resident #2 and his roommate did not get along, so she voiced her concerns to the social worker and administrator to have the roommate moved. In an interview on [DATE] at 10:22 AM with the Social Service Assistant, she stated she is the social worker over the 300-hall, both East and [NAME] side and should be notified of any issues or concerns the residents might have. She said any physical altercation between residents, the aggressive resident will be sent out for psych evaluation. She said any issues with the residents, she will discuss with the Director of Social Services and come up with a plan on how to address the behaviors. She said at times nurses might handle aggressive residents without notifying her of an issue for her to provide an intervention. The Social Service Assistant said she was not aware of any issues that might have occurred between Resident #2 and his roommate and was not aware of any behaviors that Resident #2 might have had. The Social Service Assistant said when she was reviewing Resident #2's care plan, she saw that she had behaviors that she was not aware of, but since he has had a decline in health, she has not seen any behaviors. In an interview on [DATE] at 10:39 AM with the Psychiatric Nurse Practitioner, he said around [DATE] he was asked to see Resident #2 due to an altercation with another resident and the death/possible suicide of a resident in the facility. He said Resident #2 admitted to hitting his previous roommate in the head with a cup. He said he was informed by the facility social worker that there was a death of a resident and that Resident #2 had recently gotten into an altercation with him. He said Resident #2 did not appear to know anything about his previous roommate being deceased . In an interview with the DON on [DATE] at 11:13am, she said that when a resident is physically aggressive with resident or staff, a meeting is held with the Administrator, DON, ADON, and Social Worker to determine what interventions are needed to stabilize the aggressive resident's behavior. She said it is important to do this to maintain the safety of all the residents in the facility, including the one who has behaviors . The DON stated the facility had not met to discuss interventions for Resident #2's previous behaviors. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] with the Psychiatric Nurse Practitioner, he stated [DATE] was the first encounter that he had with Resident #2. He said he was not made aware of a referral to see Resident #2 before his initial visit. The Psychiatric Nurse said he comes to the building on a weekly basis to see those who are on his services . The Psychiatric Nurse stated after his initial evaluation of Resident #2, he began seeing him on a weekly, routine bases. In an interview on [DATE] at 4:24 PM with the Social Service Assistant, she said when there is a resident-to-resident altercation, she said social services usually provide interventions for the residents. She said the IDT will usually have a meeting on what has happened, any previous interventions or if the resident needs to be sent out for evaluation. She said it is determined if a resident needs to go out, based on the severity of the act. She said the patient can be moved to another floor, depending on the behavior that occurred. She said if a resident hit another resident and the other resident sustained a bruise or laceration, that could be a reason to have the aggressive resident to be moved. The Social Service Assistant said being moved means they would be moved to a different floor or possibly a different room. She said if a resident can't move to a different floor, they'd move across halls, but there is not a lock on the door that would prevent the other resident from coming from east to west side of 300-hall. She said if there is aggression, staff are to do 15-minute checks to make sure the residents are not exhibiting behaviors. She said any issues that occur over the evening, management with discuss during the morning meetings. The Social Service Assistant said the social services department is to notify psych right away of any resident-to-resident incidents . She said psych might take a day or two to come out to assess the resident, but it is usually a quick process. She said she does not recall any incident that occurred with Resident #2 and his previous roommate. She said it is the responsibility of social services department to notify psych services to see residents. In an interview on [DATE] at 5:12 PM with the DON, she said she is aware of an incident that occurred in [DATE] when Resident #2 hit his roommate in the head with a cup, which caused a laceration to his head. She said Resident #2 was moved off 300-West to 300-East. She said she is not aware of any incident that occurred in [DATE] that Resident #2 asked for a room change. The DON said the only time that she recalls a room change is during the recent incident in [DATE]. She said residents on the 300-hall often wander around and there should always be staff monitoring the residents and their whereabouts. She said for room moves, usually the IDT team agrees to move residents' rooms as an intervention for behaviors. The Administrator was notified of the Immediate Jeopardy on [DATE] at 2:15 PM and the IJ template was provided, and a Plan of Removal was requested. The Plan of Removal was accepted on [DATE] at 12:07 PM and included the following: PLAN OF REMOVAL Behavioral Health Services [DATE] IMMEDIATE ACTION: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the State Surveyor interviewed resident #2 and shared the results with the Administrator and DON. The Administrator and the DON initiated one on one for resident #2 on [DATE] at 4pm. The roommate was relocated to another room at this time also. The one on one has continued and will be continued indefinitely. The resident has not been out of bed and has no behaviors in the past 48 hours. Psych services were notified on [DATE] and findings of surveyor was shared with Psych NP by DON. Resident #2 was seen by NP on [DATE] with no changes made to medications. The residents PCP was notified of surveyor findings by the DON on [DATE] with no new orders received The policy and procedure for Behavioral Assessment and Monitoring has been reviewed and revised by the DON, Administrative and Regional nurse on [DATE]. All nursing staff is being in-service on the Behavioral assessment and Monitoring policy. Policy includes what is a behavior, developing a care plan for behavior, interventions and approaches for behaviors, possible causes of behavior to include physical and medical changes, emotional, psychiatric and/or psychological stressor, functional, social, or environmental factors, with examples of each cause. Monitoring of behaviors by the Behavior Committee that meets weekly. The charge nurses and aides are being given a pre and posttest on behavior assessment and monitoring. The in-service was started at 4:30 on [DATE] and will be completed by [DATE] at 12:00pm. In-services are being done by the ADON and the DON. Staff that are not working and PRN staff will be in-serviced and given pre and posttest prior to being allowed to work their next shift. The assistant administrator started interviewing the following staff to identify any resident that has had or currently has any aggressive behavior or anger issues. The following staff were interviewed, nurse aides on duty, charge nurses, unit managers, dietary aides (that deliver meal carts to floor) and activity department. Interviews started at [DATE] at 4:00pm. And will completed by 12pm [DATE]. Social service reviewed assessments (PQH9 and PTSD checklist) for any resident with aggressive behavior or anger issues to be completed by [DATE] at 12pm. Care plans will be reviewed and revised with any new interventions being added if needed. MDS will be responsible for Care Plan updates to be completed by 5:00pm [DATE]. A behavior communication form will be implemented to include the identified behavior, time of the behavior, and location of behavior. The form will be reviewed by the unit manager and will check off on Dr. being notified, documentation and social services being notified as follow up, then information will be taken to the morning clinical meeting. DON will inservice Charge nurses on the new Behavior communication form on [DATE] and will be completed by 5:00pm on [DATE]. The unit manager will be responsible for reviewing documentation to include Dr. notification and notifying social services if psych referral is needed. A spread sheet is being developed to include Resident name, date referral was received, date and time referral was made to psych services, date and time psych saw the resident and reason for referral. This will be completed by 5:00pm on [DATE]. Once all residents with aggressive behavior and anger issues are identified the DON, unit managers and Regional Nurse will develop an acute care plan to include, type of behavior resident exhibits, what triggers the behavior if known and the intervention to be implemented. The acute care plan will be kept in a notebook at each nursing unit and will kept updated by the unit manager. Acute care plans will be completed by 5pm [DATE] and charge nurses and aides in-serviced by the DON. Incident reports were also reviewed on [DATE] by the Administrator, Assistant adm., DON and regional Nurse for the past 60 days to identify any resident with aggressive behavior or anger issues. (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator, DON, assistant administrator and Regional Nurse reviewed the list of residents that were identified. Social services did an updated PQH 9 and a PTSD checklist questionnaire with scoring system to further identify any resident with aggressive behavior. Social services will have PQH-9 and PTSD checklist completed for these residents by [DATE] at 5:00pm. After review information will used to develop the acute care plan. The Acute Care Plan system will identify the behavior, triggers if known and interventions to include, 1on 1 will be initiated, Adm. and Don will be notified, Dr called, and resident transferred to psych facility if behavior cannot be managed at the facility and the Dr orders transfer. Acute care plans will completed by 5pm [DATE]. Charge nurses and nurse aides are re-trained on identification and recognizing behaviors for immediate intervention. Staff are being re-trained on rounding and being monitored by the unit manager, Adm., Assistant Administrator and DON. The staff named will come on various shifts at various times to monitor resident care and review of the 24 hr. report. Each administrative staff making rounds will complete the rounding form with issues identified and how the issue was corrected on site. All forms will be reviewed the following day by the administrative team and issues tracked to identify patterns weekly. Administrative team will be in-serviced on what to look for when rounding and how to inservice staff if needed immediately. After hours rounding to begin by administration staff [DATE] and will be 7 days a week for the next 30 days and reevaluated. Surveyor Monitored the Plan of Removal as follows: Observations were started on [DATE] at 1:50 PM and continued through [DATE] at 7:30 AM. Resident #2 was observed throughout the day and was observed to have a one-on-one sitter. No concerns with supervision noted. Resident #2 appears to be in bed and sleeping on and off throughout the day. The facility removed Resident #2's current roommate as a precaution. Resident #2 will continue on psych services and will be placed on one-on-one indefinitely. Observations and interviews made from [DATE] at 1:50 PM through [DATE] at 7:30 AM with HA H, HA J, LVN D and Dietary Aide 1 , all stated they were responsible for sitting with Resident #2. All stated that at any time they needed to leave, they were to notify staff to ensure someone was watching Resident #2. Staff indicated they are to complete 15-minute checks and document of a form if there are any issues and the times they checked on the resident. Interviews were started on [DATE] at 1:50 PM and continued through [DATE] at 7:30 AM with staff across all three shifts, including weekdays and weekends. That staff interviewed regarding the plan of removal: LVN A, RN B, LVN C, LVN D, RN E, CNA F, LVN G, HA H, HA J, CNA K , LVN L, RN M, CNA N, CNA O, LVN P, CNA Q, CNA R, LVN S, CNA T, RA U, CNA V, CNA W, Social Service Director, Social Service Assistant, Housekeeping, Maintenance, Administrator, Director of Nursing and Unit Manager 2 and Unit Manager 4. All staff interviewed verbalized adequate understanding of plan of removal training received regarding Behavior Health Assessment, monitoring behaviors, interventions, psychological services, communicating behaviors, recognizing behaviors for immediate intervention, and conducting rounds to identify any issues. Record review of the POR binder revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675764	A. Building B. Wing	08/20/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident review for behaviors on Unit 2, 3 and 4: All residents identified with behaviors were documented with their triggers and interventions. Social Services department reviewed PHQ-9 and PTSD checklist for residents with aggressive behaviors or anger issues. Care plans were reviewed and revised with any new interventions being added if needed. A behavior communication form was implemented to include the identified behavior, time of the behavior, and location of behavior. An acute care plan was implemented for residents with behaviors and the interventions to be implemented. In-services reviewed were, Behavioral Assessment, Intervention and Monitoring - completion date [DATE], Unmanageable Residents - completion date [DATE], One on One Care - completion date [DATE], Recognizing and Reporting Behaviors - completion date [DATE] Policies Reviewed were Behavioral Assessment, Intervention and Monitoring dated ,d+[DATE], Unmanageable Residents dated ,d+[DATE], Resident Rights dated ,d+[DATE], and Abuse and Neglect dated ,d+[DATE]. While the IJ was removed [DATE] at 7:30 AM and the Administrator was notified, the facility remained out of compliance at a severity level of actual harm at a scope of isolated due to the need to complete in-service training and evaluate the effectiveness of the corrective systems.