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	12/16/2022

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 45581 Based on observation, interview and record review the facility failed to ensure residents had the right to receive visitors of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that did not impose on the rights of another resident for 1 of 1 resident reviewed for resident rights. The facility failed to ensure all residents had the right to unrestricted visiting hours. The Night Supervisor failed to ensure that visitors had the right to unrestricted visiting hours. This failure could place residents at risk for isolation, decreased emotional well-being, and a diminished quality of life. Findings include: In an interview on 12/12/22 at 10:05 am with Visitor, she said she came daily to spend time with her spouse. She said the night shift staff slept at night. She said she recently put a camera in his room because her spouse would be soaked in urine when she came to visit in the mornings. She said the staff was not coming to check on the spouse during the night shift. She said she felt night shift staff were sleeping because she would call during the night shift (10 pm to 6 am), and the phone would ring and ring until the phone hung up on her. She said she had never been able to visit her spouse during the night shift. She said she could never get anyone to answer the phone to let them know she was headed to the facility to check on her spouse. She said she spoke to the nursing staff and the Administrator. She said her issue was unresolved. In a telephone interview on 12/15/2022 at 1:50 a.m. with the Night Supervisor, she said visiting hours were from 8 a.m.-8 p.m. and she said this Surveyor had to come back in the morning. She asked this Surveyor if they had family in the building and asked for the resident's name. This Surveyor verified with the Night Supervisor that visiting hours were 8 a.m.- 8 p.m. and requested entry. The Night Supervisor told this Surveyor to contact their office and return in the morning. This Surveyor identified himself as being with the State of Texas to which she replied, I'll be right down. In an observation and interview on 12/15/2022 at 2:07 a.m., the Night Supervisor unlocked the door for the Surveyor, and entry was allowed. The Night Supervisor identified herself as being the person that this surveyor spoke with via telephone to gain entry. (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a telephone interview on 12/15/2022 at 1:24 p.m. with the Administrator, he said he had been with the facility for about three months and when he began employment at the facility and the visitation policy was 9 a. m.-9 p.m. He said he took the posted visitor signage down because the facility did not have restricted visiting hours. He said he was told if someone wanted to visit in the middle of the night, all that needed to happen was to screen the visitor. He said there were no hard curfews and if a loved one was at an end-of-life stage, the facility would set up a bed for family members if they wanted to stay the night. The Administrator said staff thought the facility had restricted visiting hours. He said he could not recall the last time staff were in-serviced on visitation hours. The Administrator said the facility did not have a visitation policy.

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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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review the facility failed to ensure each resident had the right to be free from involuntary seclusion for 1 of 27 residents (Resident #1) reviewed for involuntary seclusion in that: - Resident #1, who was independent and cognitive was placed on the secured unit at admission when she did not have any documentation of any clinical criteria from her physician or recommendation from the interdisciplinary team. As a result Resident #1 felt traumatized, fear, isolation and imprisoned. -The facility failed to train staff and put procedures into place that ensured residents were not placed on secured unit unless criteria for the secured unit was met. An Immediate Jeopardy (IJ) was identified on 12/13/2022 at 2:00 p.m While the IJ was removed on 12/16/2022, the facility remained out of compliance at a severity level of actual harm that is not Immediate Jeopardy and a scope of isolated as the facility continued to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at risk of unnecessary isolation, leading to a decreased quality of life, low self-esteem, and distrust of staff. Findings include: Record review of the admission sheet dated 12/07/2022 for Resident # 1 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), panic attack (a feeling of sudden and intense anxiety) and asthma (a disease that affects your lungs). Record review of the Resident #1's baseline care plan dated 12/07/2022 revealed Cognition -alert/cognitively intact. There was no documentation about being placed on the secured unit, exit seeking behaviors, eloping or suicidal ideation. Record review of Resident #1's admission doctor's orders dated 12/07/2022 revealed no orders to place the resident on the secured unit. Record review of Resident #1's medical records revealed Resident did not have an admission MDS. Record review of Resident #1's Elopement Risk assessment dated [DATE] completed by the Unit Manager reflected in part: physical capability: Ambulates independently or with device. Adjustment to facility: understands and verbalizes acceptance of need for nursing home care. Cognitive skills for daily decision making independent-decisions consistent/reasonable. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	History: No attempts to leave own residence/facility. Behavior: Angry/aggressive behavior. Length of stay in facility: new admission Record review of Resident #1's Elopement Risk assessment dated [DATE] completed by the Unit Manager reflected in part: physical capability: Ambulates independently or with device. Adjustment to facility: statement and/or threats to leave facility, frequent request to go home, verbalizes anger and frustration re: placement. Cognitive skills for daily decision making independent-decisions consistent/reasonable. History: previous attempts to leave residence/ facility: one or more times in last week. Behavior: Angry/aggressive behavior. Length of stay in facility: new admission Record review of Resident #1's Care plan Risk for Elopement dated 12/09/2022 completed by the Unit Manager reflected in part: Problem: Resident is at risk for wandering as evidenced by score of 10 on elopement risk assessment. Goal: the resident will not elope from the facility for the next 90 days. Interventions: door alarms. encourage activities, exercise, or other recreational activities. Other: in a secured unit. Record review of Resident #1's nurses notes for the month of December 2022 revealed there was no documentation about being placed on the secured unit, exit seeking behaviors, eloping or suicidal ideation. Record review of the facility's 24 Hour Report/ Change of condition report dated 12/08/2022 reflected in part: . [Resident #1]. Remarks (Day): To be transfer to 2 East pending. Remarks (Evening): pending transfer Record review of facility's Resident Acute Follow-up Documentation dated 12/08/2022 -24 hour follow up reflected in part:. Shift: 10 p.m. - 6 a.m.- resident s/p admit D-1. Stable resident in bed; call bell in reach; will continue to monitor. Shift: 6 a.m. - 2 p.m.--to be transferred to 2 East. Shift: 2 p.m. - 10 p.m.-: s/p new admit day 1/3 NAR. Record review of the facility's Resident Acute Follow-up Documentation dated 12/09/2022 -48 hour follow up reflected in part: Shift: 10 p.m. - 6 a.m.- resident s/p new admit D-2. Stable resident in bed; call bell in reach; will continue to monitor. Shift: 6 a.m.- 2 p.m.- 4 concerns. Shift 2 p.m. - 10 p.m.- stable no new concerns. Record review of facility's Resident Acute Follow-up Documentation dated 12/10/2022 -72 hour follow up read in part: Shift 10 p.m.- 6 a.m.- resident s/p new admit D-3. Stable; resident in bed; call bell in reach; will continue to monitor. Shift 6 a.m.- 2 p.m.- stable & alert. No distress noted. Shift 2 p.m.- 10 p.m.- stable & alert. No distress noted. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/12/22 at 10:05 a.m., with Resident #1, she said, I am in the wrong place. I don't belong here. Please help me get out of here. I have been praying hard. I heard you outside my room and came out. She said she was alert, oriented, and was independently living on her own but experienced financial hardship and threatened to take a bottle of pills to an EMS worker who was responding to a fall she experienced that injured her knee and she was admitted to a behavioral hospital. She said she had no plans to harm herself. She said the behavioral hospital transferred her to this facility on Wednesday (12/7/22). She said, Couple of weeks ago I had a panic attack when I found out I only had $3 in my bank account, and I didn't want to be homeless. She said she checked her bank account today on her cell phone and the social security funds were transferred and now she had enough money to pay her motel bills. She said she had been seeing a psychiatrist offsite for anxiety and depression. She said she called her psychiatrist from her personal cell phone on Friday (12/9/22) and the psychiatrist said she would call the facility and tell them she was no longer suicidal. She said, I feel traumatized. I feel like I am a prisoner. I have no voice; nobody is listening to me. Anytime I brought concern to the staff they dismiss me and say go sit down, go to your room. She said she was going to call the ombudsman. She said she had been a nurse for the last [AGE] years and she knew how to contact the ombudsman and knew she did not belong in the secure unit. She said, This was an inhumane treatment. I haven't had a shower since I have been to the facility. I have no toothpaste, no toothbrush not even a pillow to lay on. I am a smoker and not had a chance to smoke since I have been here. I tried to talk to staff but they dismiss me. She said she asked to speak with the facility's social worker but was unable to reach the social worker. She said she was admitted to the secure unit on Wednesday (12/07/22) and on Thursday (12/8/22) a gentleman came to her, and she expressed her concern that she wanted to go back home but there had not been any follow up. She said, I stay in my room with [the] door closed because I'm scared while I'm sleeping someone will come and hurt me. Residents in this unit have behaviors. I am unable to sleep because I hear people screaming and yelling at night. She said she was not provided a code to the secure unit to go out to get fresh air. In an interview on 12/12/2022 at 10:20 a.m., with LVN A, she said she was charge nurse for the 4th floor secure unit. She said the criteria for a resident to be in the secure unit was risk for elopement, exit seeking behavior, wandering, behaviors, dementia and unable to make their own decisions. She said Resident#1 was alert and oriented x3. LVN A said Resident#1 was the only resident on the secure unit that could hold a conversation. She said Resident #1 would continuously ask to leave the facility and to get discharged . LVN A said Resident #1 was admitted for suicidal ideation from the behavioral hospital. Resident has not shown any signs of suicidal ideation since admission. She said Admissions Coordinator A was making rounds on the unit on Thursday (12/8/22) and he spoke to Resident#1 and the resident told him that she wanted to be moved from the secure unit. She said Admissions Coordinator A told LVN A on Thursday (12/08/22) that Resident #1 would be transferred to the non-secure unit but he did not give a specific reason. LVN A said on Friday (12/09/22) Resident #1's psychiatrist called the facility and asked to speak to Resident #1's nurse. She said she spoke to the psychiatrist and the psychiatrist asked her why Resident #1 was residing in the secure unit. LVN A said the psychiatrist said Resident#1 told her she no longer had suicidal ideation and the resident wanted to leave the secure unit and asked what the steps were. LVN A said she referred the psychiatrist to the social workers at that time. She said, I don't know if psychiatrist ever got a chance to talk to the social worker downstairs. In an interview on 12/12/2022 at 10:41 a.m., with CNA AA, she said Resident #1 did not have any behaviors. She said the resident was alert and oriented. She said she did not have dementia and was able to make her needs known. She said residents were not allowed to have codes for the locked units. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/12/2022 at 10:47 a.m., with CNA BB, she said Resident #1 did not have any behaviors. She said the resident stayed in her room with the door closed most of the time and only came out to eat. T In an interview on 12/12/2022 at 11:05 a.m., with the Hospitability Aide, she said Resident #1 did not have any behaviors. She said the resident asked if she could go smoke with the other smokers, but the resident did not have any money to buy cigarettes. She said residents were not allowed to have codes for the locked units. In an interview on 12/12/22 at 11:30 a.m., with the Unit Manager, she said she started working at the facility two weeks ago as a unit manager of the secure unit and was still learning how the facility operated. She said residents on the secure unit were at risk for elopement, behaviors, dementia, and schizophrenia. She said Resident #1 did not have any behaviors. She said Resident#1 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and COPD. She said Resident#1's report from the behavioral hospital mentioned the resident had suicidal ideation. She said she completed the elopement risk assessment on Wednesday (12/7/22) upon her arrival to the secure unit. The Unit Manger said the resident scored a 10 meaning she was at risk for elopement because the resident expressed she wanted to go back home. She said the resident started complaining on Thursday (12/8/22) that she did not want to be in the secure unit, that people had dementia on the unit, and she did not. The Unit Manager said that prompted her to do another elopement risk assessment on Friday (12/09/22) and the resident scored a 17 meaning she was at risk for elopement because the resident continuously expressed concerns that she wanted to go back home. The Unit Manager said she completed the elopement risk assessment and filed it in the resident's medical chart for the social worker to follow up. She said the social worker was not in the facility last week Thursday (12/8/22) and Friday (12/9/22). In an interview on 12/12/22 at 11:43 a.m., with the Unit Manager and LVN A, LVN A said she made a note on Friday (12/9/22) on the 24 hour shift report for nurses to follow up because Admissions Coordinator A told LVN A that resident would be transferred to a non-secure unit but Admission Coordinator A did not mention if the resident would be moving to 2 East or 2 [NAME] non-secure unit. LVN A said she did not work on weekends (Saturday and Sunday) and she returned to work today Monday (12/12/22) and the resident was still on the secure unit. In a telephone interview on 12/12/22 at 11:48 a.m., with Admissions Coordinator A, he said he was making his rounds and met with Resident#1 on Thursday (12/8/22). Admissions Coordinator A said resident should have been off the 4th floor secure unit and moved to the 2nd floor non-secure unit. He said Resident#1 did not necessarily need to be on the secure unit but since the resident came from the behavioral hospital she was placed on the secure unit. He said Resident#1 was moved to the non-secured unit the same day on Thursday (12/8/22). At this time the Surveyor informed Admissions Coordinator A Resident#1 was still residing on a secure unit. He said, It was my understanding [the] resident was moved last week on Thursday (12/8/22). [Admissions Coordinator B] was supposed to move the resident. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 12/12/22 at 12:13 p.m., with the ADON, he said the criteria for a resident to be in the secure unit was risk for elopement, exit seeking behaviors, wandering and behaviors. He said Resident #1 was originally in the secure unit because she came from a behavioral hospital. He said it was brought to his attention on Friday (12/9/22) afternoon the resident wanted to be transferred out of the secure unit. He said there were three beds available on the non-secure 2nd floor the resident could be moved to, but the nurse or the Unit Manager had to do the elopement risk assessment first. He said he was not aware if the elopement risk assessment was completed on Friday (12/9/22). He said he would follow up with the Unit Manager. In an interview on 12/12/22 at 12:43 p.m., with Admissions Coordinator B, she said she started working in the facility in September 2022. She said the previous admission coordinator trained her for 2 days only. She said she was not trained very well. She said, I am learning as I go. She said the nurses and the social worker were responsible for completing the elopement risk assessment and behavioral assessment. She said her responsibility was to get the clinical, highlight the diagnoses and hand it to DON, ADON and the Director of Clinical for review. Admission Coordinator B said once they reviewed the clinical, she took the clinical to MDS to confirm if the resident had the medical necessity and then she would assign a room. She said once a resident was in the facility the nurses and social worker took over and she had no involvement. She said Resident#1 was admitted on the 12/7/22 from a behavioral hospital. She said residents that came from a behavioral hospital had to be on a secure unit for 72-hour waiting period until the elopement risk assessment was completed. She said prior to moving a resident to a secure unit consent for pre-admission to the secure unit had to be signed by the resident's family member. She said on Resident #1's hospital discharge paperwork a family member was listed, but there was no phone number to contact the family member, therefore, the consent was not signed prior to admission. She said the resident came on Wednesday (12/7/22). She said she went to speak with the resident on Thursday (12/8/22). Admission Coordinator B said Resident #1told her that she could not sleep at night and people were screaming. She said at that time she was going have the resident sign the consent form, but the resident said she wanted to move. She said she told the ADON, and the ADON told her that nurses needed to do the elopement risk assessment before the resident could be transferred out of the secure unit. She said Resident #1 could not be moved on Thursday (12/8/22) because she was still on the 72-hour waiting period. Admission Coordinator B said on Friday (12/9/22) the 72-hour waiting period was completed but for some reason the resident was not moved over the weekend to the non-secure unit. She said the nursing department was moving the resident today (12/12/22). She said the resident would be moving to the 2 East non-secure unit. She said there were two female beds available since last week that the resident could have been moved too. She said nursing was responsible for in-house transfer. Record review of Resident #1's doctor's orders dated 12/12/2022 at 2:10 p.m., written by LVN A, reflected in part: .discharged home. TORB: [Doctor/LVN A] In an interview on 12/12/22 at 2:20 p.m., with the Administrator and the Regional Corporate Nurse, the Administrator said the 3rd and 4th floors in the facility were not secured units and residents could be provided the code to exit the unit if they requested. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a subsequent interview on 12/12/22 at 3:40p .m., with the Administrator, he said the 3rd and 4th floors in the facility were secured locked units. He said he was not familiar with the process so he consulted with the ADON who told him there was no 72-hour minimum waiting period policy for residents being admitted to the facility coming from a behavioral hospital to be placed in the secure unit. The Administrator said during the admissions process new admits got the first clean bed/room available. The Administrator said the facility, dropped the ball. In an interview on 12/13/22 at 9:10 a.m., with the ADON, he said for the resident to be admitted on the secure unit the process started at pre-admission. The ADON said the resident or the family would sign the consent to be on a secure unit. The ADON said when the resident arrived at the facility the facility would then get the order from his/her doctor to be on the secure unit and at that time the MDS and care plan were created that the resident was on the secure unit. He said the elopement risk assessment was completed every 90 days and could be re-evaluated at any time. He said he was not aware of a 72-hour waiting period. He said, Staff is making things up as they go. He said if there was no reason for the resident to be on the secure unit, for example a high BIMS score and not displacing behaviors, it would trigger the Unit Manager to do an elopement risk re-assessment. He said the Unit Manger would then complete the elopement risk assessment and file it in the resident's medical chart. He said there was no follow up by the social worker once the elopement risk assessment was filed in the resident's chart. He said Resident #1 was admitted on Wednesday (12/7/22) from a behavior hospital that warranted her to be placed on the secure unit. He said her BIMS should have been done on the next 24 to 48 hours of admission. He said the social worker was not in the facility at that time and the new social worker was scheduled to start on Friday (12/16/22). When this Surveyor asked who was responsible for getting the BIMS and MDS completed in absence of a social worker the he ADON said only the social worker completed the BIMS assessment, therefore, Resident #1's BIMS assessment was not completed within 24 to 48 hours of admission. In an interview on 12/13/22 at 9:19 a.m. with the Social Service Assistant, he said he was responsible for completing the BIMS assessment along with other set of assessments within the MDS. He said his other responsibilities included handling grievances and setting up residents' appointment with dental, audiology and the podiatrist. He said he did not know the criteria for a resident to be on the secure unit. He said whenever he did the BIMS assessment and noted concerns such as high BIMS, self-signer, and the resident said that he/she did not want to be behind the lock door. He said he would take it to the interdisciplinary team to discuss. He said he did not conduct a BIMS assessment on Resident #1 as he was off from work starting Thursday (12/8/22) and returned today (12/13/22). In a telephone interview on 12/13/22 at 12:43 p.m., with Resident #1's doctor, he said he was aware the resident was admitted on the secure unit because of her history of depression and suicidal ideation. He said he did not get the chance to visit the resident as the resident was admitted last week. He said there was no set policy when the resident would be moved out of the secure unit. Resident #1's doctor said the doctors went by the history and obedience of caution. He said he was not made aware by the facility that Resident#1 voiced concerns of being in the secure unit. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's Policy and Procedures on Secure Units (not dated) reflected in part: .Policy-To provide a safe environment for all residents living on the secure care unit. To prevent accidents related to wandering and elopement. Procedures-1. All residents with potential for admission to the secure unit will have an elopement assessment prior to admission as well as a consent signed by the resident representative and a doctor's order for admission to the secure unit. 2. A care plan with interventions to maintain a resident safety based on their elopement risk will be completed. 3. All exit doors are alarmed and code locked and remain on 24 hours per day . Definition: Involuntary seclusion- separation of a resident from others or confinement to their room against the resident's will or the will of the residents representative. Secure unit- part of a building that's access in through a coded door Record review of facility's Resident Rights policy (not dated) reflected in part: .1. Resident rights. The resident has a right to a dignified existence, self- determination, and communication with and access to persons and services inside and outside the facility. 2. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. a. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights Record review of facility's Recognizing Signs and Symptoms of Abuse/Neglect (not dated) reflected in part: . Policy Statement: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/ neglect to the supervisor or the Director of Nursing Services immediately. Policy Interpretation and Implementation: 1. Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 2. Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness Record review of facility's Social Services policies and procedures policy (revision: 4/2012) reflected in part: . Policy: 1. The facilities leadership prohibits neglect, mental or physical abuse, including involuntary seclusion and risk appropriation of a patient's/ resident's property and/or funds On 12/13/2022 at 2:00 p.m. the Administrator, Assistant Administrator, Regional Corporate Nurse, and ADON were notified of the IJ. The IJ template was left with the Administrator and a plan of removal (POR) was requested at that time. The POR was accepted on 12/14/2022 at 5:48 p.m The POR revealed: [facility name] [facility address] December 14, 2022 REVISED: LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY (continued on next page)

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	675764	A. Building B. Wing	12/16/2022

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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On December 12, 2022, at approx. 8:15 a.m., an onsite review of open self-reports and complaints dating to 2020 was initiated by state surveyors. On December 13, 2022, at approximately 2:00 p.m., the facility was notified by the surveyors that an immediate jeopardy had been called and needed to submit a plan of removal. The Facility respectfully submits this Letter of Credible Allegation pursuant to Federal and State regulatory requirements. The alleged immediate jeopardy allegations are as follows: Issue identified by surveyor: F-630 Free from Involuntary Seclusion The facility failed to ensure a resident was appropriate for placement prior to admission and to remain on secure unit following admission. The following plan of action outlines immediate interventions employed by the facility to remove any further concerns surrounding the issues: The resident mentioned in the IJ allegation was interviewed by the Administrator and Regional Nurse Consultant on 12/13/2022 at 3:00 p.m. to determine proper placement in community where she wished to return as she expressed to surveyors in interview. Resident was very pleasant and compliant with interview to assess ability to return to community and recalled to Regional Nurse Consultant how she came to be at the facility because of running out of funds to pay for motel she was living at, and that she was instructed to go to the ER so she wouldn't have to be on the street. At that point she expressed wish to harm herself to ER staff and was admitted to a secure behavioral unit. Regional Nurse Consultant then asked resident if she had any plans to harm herself to which she stated she did not because she had money now and didn't have to live on the street. It was determined by the Administrator and Regional Nurse Consultant that the resident was cognizant, had a stable dwelling to return to in the community, had the funds available at present from Social Security check (as stated by resident and confirmed by state surveyor who assessed resident finances) that were not available to her prior to admission, and her medications were to be filled and picked up by Administrator upon assisting her return to community. The Assistant Director of Nursing received an order from primary care provider, to discharge resident back to the community environment. There was a call from the psychiatrist stating the resident is safe to return to the community. Resident was given transportation to pharmacy to pick up medications, to the store for food provisions and then driven to an extended stay motel where she previously resided. The motel staff remembered the resident and were happy to assist her with re-entering the establishment. Root Cause Analysis of Placement of Resident on Secure Unit: (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Admissions Coordinator training for potential admissions to the secured unit performed by the Administrator and Regional Nurse Consultant that included the use of the Criteria and Consent for Pre-Admission to the Secure Unit completion prior to admission for evaluation of placement prior to resident being in facility for full assessment. Admissions Coordinator will give the Pre-Admission screen to the Director of Nursing, and/or Assistant Director of Nursing, and Administrator for two person signature on placement of inquiring resident following determination by the admissions team, comprised of the Admissions Coordinator, Director of Nursing, and/or Assistant Director of Nursing, and Administrator. This will be communicated by the Director of Nursing and/or Assistant Director of Nursing to receiving Unit Manager of area of placement who will instruct floor staff of impending admission to unit. Consent for placement and practitioner's order for placement will be obtained by the Admissions Coordinator prior to admission and checked off by Director of Nursing and/or Assistant Director of Nursing. Initiated: 12/13/22 Completed: 12/14/22 o Implementation of Departmental Signature Sheet for all incoming admissions to ensure appropriate pre-admission screen indicating proper placement at time of admission with room assignment noted and prepared for incoming resident. The Administrator to implement this sheet beginning with next scheduled admission to the facility with auditing of admission sheets to be done by the Regional Nurse Consultant at each consultant visit, at minimum 2x/month for 2 months. Initiated: 12/13/22 Completed: 12/14/2022 o Administrator to implement program of written departmental manager introduction of key managers to include the Administrator, Business Office Manager, Admissions Coordinator, Maintenance Director, Environmental Director, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Work, Activities, and Unit Manager to begin with new admission going forward. Introductions are to be done within 72 hours and reported to the Administrator to reinforce resident needs are communicated to appropriate personnel in the facility. Initiated: 12/13/22 Completed: 12/13/22 o Review of all resident admissions and re-admissions will be done in each morning meeting that is comprised of department managers 5 days per week, with afternoon meetings as directed by the Administrator if required. Possible weekend admissions and/or readmissions will be reviewed and discussed in Friday's meeting with any new inquiries or admissions on weekends not reviewed previously to be directed to the weekend House Supervisor who will contact the Administrator. This will communicate resident placement and readines [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview and record review, the facility failed to provide evidence that an injury of unknown source that resulted in serious bodily injury was reported to immediately to HHS, but not later than 2 hours after the allegation is made, for one resident (Resident #3) of 7 residents investigated for injury of unknow origin. -Resident presented with a fractured left femur (upper leg bone) three days after she originally complained of pain. The source of the injury was unknown to the facility. The deficient practice placed residents at risk for not having the possible cause of the injury identified, increasing risk for future injury. Findings include: Record review of the Face Sheet for Resident #3 (no date) revealed she was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia, depression, mood disorder, and insomnia. Record review of Resident #3's MDS assessment dated [DATE] revealed Resident #3 scored 6 of 15 on the BIMS, indicative of severely impaired cognition. The MDS reflected Resident #3 resisted care from 1 to 3 days of the 7-day look-back period. The MDS reflected Resident #3 was independent with bed mobility, transfers, and walking in her room. The MDS reflected Resident #3 was not steady when moving from a seated position to a standing position, or from surface to surface. Record review of Resident #3's Care Plan revealed on 12/05/2022 a problem was identified that reflected Resident #3 would place herself on the floor. The Care Plan was dated one day after the resident was x-rayed secondary to left knee pain (12/04/2022). Observation on 12/08/2022 at 12:32 p.m. revealed CNA J and MA K provided incontinent care for Resident #3. The resident was resistant to care and complained of leg pain. The resident did not specify which leg or the location of the pain. Interview on 12/08/2022 at 12:40 p.m. MA K she said Resident #3 usually resisted care but did not usually complain of pain. Record review of Resident #3's x-ray dated 12/04/2022 revealed the left knee was x-rayed and was negative for fracture. Record review of Resident #3's NN dated 12/07/2022 at 9:25 p.m. revealed Resident #3 complained of pain. Her left leg was severely swollen and painful to touch from the groin to the left knee. The hospice provider was notified, and an x-ray was ordered. Review of the NN from 12/03/2022 to 12/08/2022 revealed no documentation of a possible cause for the left knee pain. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a late entry NN dated 12/09/2022 revealed an x-ray was taken of Resident #3's left femur. Interview on 12/13/2022 at 9:37 a.m. RN AAA said Resident #3 was sent to the hospital . Interview on 12/14/2022 at 4:35 p.m. LVN B said Resident #3 had been having leg pain for a week. She said the facility staff called the hospice provider and had the hip x-ray done. Interview on 12/14/2022 at 4:52 p.m. RN AAA said there were NN's in Resident #3's chart from when Resident #3 was sent to the hospital. Record review of Resident #3's chart revealed no NN's from 12/03/2022 to 12/14/2022 that reflected Resident #3 was sent to the hospital. Interview on 12/14/2022 at 5:12 p.m. the ADON said Resident #3 did not have a fall. Record review of the NN on 12/15/2022 at 10:00 a.m. revealed no documentation of Resident #3 being found on the floor or going to the hospital. There were no NN from 12/03/2022 at 4:00 p.m. to 12/07/2022 at 9:25 p.m. Interview on 12/15/2022 at 10:05 a.m. RN AAA said Resident #3 was not back from the hospital. When asked whose responsibility it was to report the injury to HHS, she replied, It's the nurse's responsibility. Everybody . Interview on 12/15/2022 at 11:55 a.m. the ADON said it was the Unit Manager's responsibility to make an Incident/Accident report . Interview on 12/15/2022 at 12:00 p.m. the Administrator said he thought Resident #3 had a fall. He said an initial x-ray was negative for fracture, but the second x-ray was positive for fracture. He said he did call HHS to report the injury after the second x-ray. He said it was a recording, so he did not receive a confirmation number. He said he usually received a confirmation number within one day. He said the call history on his phone did not go back far enough to show the call. He said if it's called in it won't be in TULIP (HHS Provider reporting system). Record review of TULIP revealed 7 facility self-reports called in by the facility from 12/04/2022 to 12/14/2022, but none pertaining to Resident #3. Interview on 12/15/2022 at 12:20 p.m. LVN B said the ADON witnessed Resident #3's fall. Interview on 12/15/2022 at 12:25 p.m. the ADON said he did not witness Resident #3's injury , and that there were no witnesses. He said staff heard a noise and went into the resident's room. He said Resident #3 was not able to tell staff what happened. Interview on 12/15/2022 at 12:33 p.m. the Administrator revealed he said the criteria he used to report to HHS was if a resident had an injury or went to the hospital, he would call it in. When asked for a policy , the Administrator said We just follow what the guidelines say. He said there was no facility policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on interview and record review, the facility failed to maintain accurate medical records for 1 (Resident #2) of 3 residents reviewed for medical records. The facility failed to maintain accurate MDS records for Resident #2 from admission (08/16/2022) until discharge (08/24/2022). The facility failed to accurately transcribe pain medication from physician orders to the MAR for Resident #2. These deficient practices affected Resident #2 and placed other residents at risk of not having their needs met which could result in unnecessary suffering. Findings included: Record review of Resident #2's face sheet dated 08/17/2022 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis was unspecified pain. Record review of Resident #2's Entry MDS dated [DATE] did not address pain management. He had no BIMS score. Record review of Resident #2's Care Plan dated 08/18/2022 read in part . Problem: Chronic neck pain. Goal: pain/discomfort will be relieved within an hour after intervention over the next 90 days. Approach: Monitor for signs and symptoms of increased pain/discomfort; assess resident for possible causes give meds, treatments, physical and relaxation modalities, and assess for relief. Allow to verbalize feelings of pain and discomfort. Monitor for constipating effects of pain medication. Assess and document pain. Lidocaine patch- apply to back of neck Q AM, Take Patch off at H.S., Tylenol #3 PO Q 8 hours as needed for pain, Tylenol 325MG, give 2 tabs PO Q 6 hours as needed for pain. Problem: Resident #3 is at risk for SOB, chest pain, edema, increased BP related to End Stage Renal Disease with Goal of resident will not experience any signs or symptoms or renal failure over the next 90 days. Approach is to administer medication as ordered . Record review of Resident #2's Physician's Orders dated 08/22/2022 read in part . Tizanidine, 2mg, 1 tab, PO, TID & Qn PRN at 7 a.m., 2 p.m., 8 p.m. for diagnosis of pain . Record review of Resident #2's MAR dated August 2022 read in part . Tizanidine, 2mg, 1 tab, PO PRN for diagnosis of pain . The MAR had blanks from the time of admission (08/16/2022) until the resident discharged on [DATE] for Tizanidine, 2mg, 1 tab, PO, TID & Qn PRN at 7 a.m., 2 p.m., 8 p.m. In an interview on 12/14/2022 at 12:31 PM with LVN D, she said she had not seen or heard of residents not getting medications unless they refused to take them. She said if residents refused, the facility staff had to document their refusal on the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/15/2022 at 4:43 PM the ADON reviewed Resident #2's MAR dated 08/16/2022 and physician's orders dated 08/22/2022. He verified the medication Tizanidine was inaccurately transcribed from physician's orders to the resident #2's MAR dated 8/2022. He said nurses were responsible for transferring physician's orders to the MAR. He said the Unit Manager who collected the physician's orders was supposed to review the orders and compare them to the MAR. He said Medical Records were supposed to notify nurses if there were inconsistencies. The ADON said the dates (08/16-24/2022) on resident #2's MAR should have been documented with the date of the physician orders and the nurses' initials. Record review of the facility's policy titled, Nursing Policies and Procedures dated 09/2011 read in part . Medication Management: The facility's Medical Director will have an active role in the oversight of medication management. The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member identifies that the following information, but not limited to, is documented on the MAR: A: Correct physician's order, B: Medication and label are correct, Label and physician's order are correct. 7L: If the patient/resident is unable to take the medication or refuses it, the authorized licensed/certified staff member circles his/her initials on the MAR and documents the reason for refused or not given on the designated area of the MAR (physician is notified as necessary), Physician orders: The qualified nursing personnel will take and implement telephone and verbal orders according to facility practice guidelines. Procedures #3: Telephone and verbal orders are immediately recorded on patient's/resident's medical record. #4: After initiating the steps to carry out the physician's written order (i.e., entering it on the medication sheet, placing order with pharmacy, etc.,) the nurse countersigns and date the order with full signature in the Signature of Nursing Noting Order box .