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Form Approved OMB
No. 0938-0391

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	10/17/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review, the facility failed to ensure residents that were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #83) reviewed for incontinent care. -The facility failed to ensure CNA G did not leave Resident #83's Foley catheter (is a sterile tube that is inserted into your bladder to drain urine), on the bed with urine in the bag during incontinent care. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #83's Face Sheet dated 10/24/2024 revealed, a [AGE] year-old male that admitted to the facility on [DATE] and with diagnoses which included: essential (primary) hypertension (high blood pressure) and obstructive and reflex uropathy (blockage in the urinary tract) with a supra pubic Foley catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine). Record Review of Resident's #83's quarterly MDS assessment dated [DATE] reflected Resident #83's BIMS score was 6 indicating moderate cognitive impairment. Resident #83 had a Suprapubic Catheter 12/14/2023. Record Review of Resident's #83's care plan dated 03/1/2024 reflected Resident #83 with deficits in orientation recall. The resident exhibited forgetfulness and impaired decision-making abilities and had supra pubic catheter. Staff were to ensure the tubing was secured to the resident's leg so that the tubing was not pulled and the urine bag was below the bladder. Resident #83 had a foley Catheter and was at risk for increased urinary tract infections. Record Review of Resident #83's Physician's order dated 12/14/23 revealed Check Foley site, and leg strap every shift and document output. Record review of MAR/TAR flowsheet dated 10/1/2024 revealed an initialed Check Foley site, privacy bag, and leg strap every shift that it was done. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #83's antibiotic log reflected he had been receiving antibiotic(s) on the following dates: -10/6/23: Diflucan for diagnosis (Dx) of Candida Auris (fungal infection that can cause serious illness) stop 10/12/2023. - 10/9/23 was on Cipro 10/9/2023; for Dx of UTI (urinary tract infection) stop 10/20/2023. - 11/18/23 was on Meropenem for Dx of UTI; stop Antibiotic receiving: 12/15/2023. - 2/20/2024 was on Cefdinir for Dx of UTI x 7 days Antibiotic receiving: - 03/27/2024 was on Diflucan for Dx of Yeast x 7 days Antibiotic receiving: - 05/23/2024 was on Cefdinir for Dx of UTI x 10 days Antibiotic receiving: - 08/21/2024 was on Bactrim DS for Dx of Suprapubic infection x 10days. Observation on 10/15/24 at 3:09 PM Resident #83's was propelled by CNA S from the TV area to his room for incontinent care. Observation of incontinent care on 10/15/24 at 3:18 pm, was performed by CNA G and CNA S assisting, both CNA's washed their hands, donned PPE and clean gloves. CNA G placed a gait belt on resident #83, pivoted the resident from the wheelchair to the bed. Resident #83 had a supra pubic catheter secured with dressing intact, dated 10/15/24. CNA G left the indwelling catheter on the bed during incontinent care with 50 cc urine in the bag and cloudy urine along the tubing. Interview with CNA G on 10/15/24 at 3:52pm, she said she always placed the urine bag on the bed to prevent the catheter from kinking. CNA G asked the unit manager (LVN H) in the presence of the nurse state surveyor. The Unit manager (LVN H) said it was okay to place the Foley catheter bag on the bed to prevent it from dragging. Record of CNA G date of hire was 4/4/24 and there were no trainings on the chart. In an interview with the DON on 10 /17/24 at 3:20 pm he said he was told of placing the catheter on the bed during incontinent care and it should never be placed on the bed due to infection and he had given in-services to the unit manager and CNA G. Record review of employee mandatory training annual record dated 4/3/24 and 8/13/24 reflected no in-services for incontinent /Foley catheter care: presented by the DON on 10/17/24 at 5:12pm. The DON presented an in-service for incontinent /Foley catheter care on 10/15/24 for the Unit Manager and CNA G. In an interview with the DON on 10/17/24 at 5:00pm, he said he would look for another in-service and he said they had given the state surveyor in-services before referring to in-services done on 10/ 15/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested policy for Foley Catheter Care from the DON on 10/17/24 at 12:00pm, 3:30pm, and it was not provided before exit. Review of the facility's revised 07/01/24 on Perineal Care Checkoff for the unit manager (LVN H) and CNA G dated 10/15/24 revealed, . For male- Using the pre-moistened disposable washcloth- wash the perineal area starting with urethra and working outward. If catheter is present - (make sure catheter is hanging below the bladder freely, DO NOT PLACE CATHETER

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observations, interviews, and record reviews the facility failed to attempt to use appropriate alternatives prior to installing the side or bed rails for 1 of 6 residents (Resident # 44) observed for bedrails. -The facility failed to obtain a physician's order for Resident # 44 who had siderails on both sides of his bed at the head of bed. This failure placed resident at risk for injury, a decline in resident physical functioning, and decrease in quality of life. Findings: Record review of Resident #4's face sheet dated 10/17/2024 reflected that the resident was admitted to the NF on 06/10/2016 and again on 11/25/2018. Resident #4's diagnoseis included cerebral infarction (when blood flow to the brain is blocked), aphasia (language disorder that affects a person ability to communicate), hemiplegia (partial or complete paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting the right side, hypertension (high blood pressure), type two diabetes mellitus (a problem in the way the body regulates and uses sugar for energy), hyperlipidemia (high cholesterol), and heart disease. Record review of Resident #44's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 6 indicating that the resident's cognition was severely impaired. Further review revealed that the resident used a wheelchair as a mobility device. Record review of Resident #44's Physician Orders did not reflect an order for bedrails. Record review of Resident #44's Comprehensive Care Plan date revised 08/30/2024 did not reflect that resident was being care planned for bedrails. Record review of Resident #44's Evaluation for the Use of bed Rails done by the Unit Manager (LVN I) dated 10/03/2024 reflected that the NF was a restraint free facility. Further review reflected Resident #44 was physically able to get in and out of bed with no difficulties and that bed rails were not indicated at this time. Observation on 10/15/24 at 10:35AM Resident #44 was sitting in her room in a wheelchair dressed in street clothing watching TV. Further observation was made of the resident having side rails on both sides of the bed at the head of bed. The resident was not inter-viewable. Observation on 10/17/24 at 7:55AM of Resident #44 sitting up on the side of the bed in his wheelchair. Further observation was made of the siderails still on both sides of the resident bed at the head of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/17/24 at 8:00AM with LVN J said she was Resident #44's nurse. LVN J said a resident was not supposed to have all 4 (four) rails up on their bed because it was considered a restraint. LVN J said she learned this in nursing school. LVN J said she was not aware that Resident #44 had bed rails on his bed . In an interview on 10/17/24 at 8:14AM with Unit Nurse Manager I said none of the residents were supposed to have rails on their bed because it was considered a physical restraint. Unit Nurse Manager I said Resident #44 did not have an order for bed rails to be on his bed. Unit Nurse Manger I said she would contact maintenance to get them removed. In an interview on 10/16/24 at 8:23AM with the DON said bed rails could be on a resident's bed if an assessment was done and the resident was being care planned for the bed rails. The DON said he would have to assess Resident #44 to see if the resident could be considered for bed rails before he answered any further questions from the state surveyor. Record review of the NF Policy on Bed Safety revised 10/17/2024 reflected in part: .To try to prevent deaths/ injuries from beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories) the facility shall promote the following approaches . Procedures: 1)Assess resident for side rail use if indicated or requested ensuring it is not restricting resident access to body movement 2)Obtain consent for side rail use 3)Obtain physician order and implement care planning process .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35897 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure foods were dated as opened/prepared discarded after 72 Hours (3 days) per facility policy 2. The facility failed to ensure that food storage rack be 6 inches off the floor. 3. The facility failed to self-report to the local Department Health for sewage back up in the kitchen. These failures could place residents at risk of food borne illness and disease. Findings Included: Observation of the facility kitchen on 10/15/24 at 8:15 AM revealed the following: 1. A plastic bag of deli ham in the refrigerator dated 10/01/24 with a use by date :10/03/24 2. 3 sandwiches in a plastic bag in the refrigerator dated 10/12/24 3. 2 food racks in the storeroom [ROOM NUMBER] inches off the floor. 4 Kitchen floor was wet with water (odorless) In an interview with the Dietary Food Service Manager on 10/15/24 at 8:30 AM, she stated the leftover food stored in the refrigerator should have been used or discarded prior to the use by date. She stated that food storage racks should be at least 6 inches off the floor due to cross contamination. She stated she or designee, shall be responsible for checking the refrigerator daily for food items that were expiring, and shall be discarded prior to expiration date. In an interview with Dietary [NAME] A on 10/15/24 at 8:15 AM, he stated that when he came in at 6 AM he observed water in the kitchen. In an interview with the Dietary Food Service Manager 0n 10/15/24 at 8:30 AM revealed that this past weekend the kitchen had a water (odorless) back up and that the plumber fixed the problem The Food Service Manager stated that she did not report the water back up to the local health department. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Administrator on 10/15/24 at 10:05 AM, he stated that he was told about air gaps but he never had understood the need of air gaps - He stated there should be at least 1 inch to 1 1/2 inch gap from the floor for pipe drains to prevent contaminated water backflow when water/sewage overflow. He stated that now he understands why air gaps are needed. He stated that no one called the city health inspector, and he asked if they could fix/repair without calling the health inspector because the health inspector will close the kitchen. He then stated that he will call the health inspector and he will close the kitchen for operation. On 10/15/24 at 2:00 PM followed up with administrator, he stated that he called the health department and left message for the health inspector. Called health department on 10/15/24 at 2:45 PM. Spoke to health inspector and he stated no one got the message. He gave a number for facility to call for the health inspector for him to inspect the kitchen. Provided administrator the number to call. In an interview with the City Health Inspector 10/16/24 at 6:00 AM health inspector came in to inspect kitchen. He had a list of repairs, cleaning of equipment, install air gaps and plumbing repairs. He stated that once the facility completed tasks to call him back and he will re inspect kitchen to re-open kitchen. 10/16/24 at 11:00 AM health inspector re- opened the kitchen to operate. Record review of facility's policies and procedures for Food Safety dated 3/ 2011 reflected in part . food racks should be 6 inches off floor . discard potentially hazardous leftovers within 72 hours (3days).